York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 24th June 2026
Time: 9:30am – 12:45pm
Venue: PGME Discussion Room, Scarborough Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:30
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 27 May 2026** To be agreed as an accurate record.	Chair	Report	5	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	17	
6.	**Patient's Story** To consider.	Steph Williams, Head of Nursing, Cancer, Specialist and Clinical Support Services	Verbal	-	9:35
7.	**True North Report** To review the report.	Chief Executive	Report	18	9:45
8.	**Chair's Report** To review the report.	Chair	Report	36	9:55

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	39	10:00
10.	**Quality Committee Report** To receive the June meeting summary report.	Chair of the Quality Committee	Report	To follow	10.20
11.	**Resources Committee Report** To receive the June meeting summary report.	Chair of the Resources Committee	Verbal	-	10.30
12.	**Trust Priorities Report (TPR)** May 2026 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Chief Operating Officer Medical Director & Chief Nurse Deputy Director of Workforce Chief Digital & Information Officer Finance Director	Report	79 84 130 146 157 165	10:40
Break 11:25					
13.	**Trust Strategy Scorecard** To receive the Year 1 progress report.	Chief Operating Officer	Report	180	11:35
14.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	191	11:45

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Maternity and Neonatal Report** 15.1 Saving Babies' Lives Care Bundle 15.2 Maternal Care Bundle Interim Review To consider the reports	Chief Nurse - Executive Maternity Safety Champion	Report Report Report	197 208 216	11:50
16.	**Infection Prevention and Control Annual Report** To consider the report.	Chief Nurse	Report	227	12:05
17.	**10 Point Plan: Improving Resident Doctors' Working Lives** To consider the report.	Medical Director	Report	271	12:15
18.	**Q4 Mortality Report - Learning from Deaths** To consider the report.	Medical Director	Report	288	12:25
19.	**Guardian of Safe Working Hours Annual Report** To consider the report.	Medical Director	Report	305	12:35
Governance					
20.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
21.	**Time and Date of next meeting** The next meeting held in public will be on 29 July 2026 at 9am at York Hospital.				
22.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
23.	**Close**				12:45

Minutes
Board of Directors Meeting (Public)
27 May 2026

Minutes of the Public Board of Directors meeting held on Wednesday 27 May 2026 in the Trust Headquarters Board Room, York Hospital. The meeting commenced at 9.00am and concluded at 12.30pm.

Members present:

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

Executive Directors
- Miss Clare Smith, Chief Executive
- Mr Andrew Bertram, Finance Director and Deputy Chief Executive
- Mr Joe Hague, Chief Nurse and Executive Maternity & Neonatal Safety Champion
- Ms Claire Hansen, Chief Operating Officer
- Dr Karen Stone, Medical Director
- Mr James Hawkins, Chief Digital and Information Officer
- Ms Lydia Larcum, Interim Director of Workforce and Organisational Development

Corporate Directors
- Mr Chris Norman, Managing Director, YTHFM
- Mrs Lucy Brown, Director of Communications

In Attendance:
- Dr Roisin Bradley, Consultant Radiologist and Director of Breast Screening for North Yorkshire (For Item 6)
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 16)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Linda Wild, Elected Governor and Lead Governor – Public
- Mr Graham Lake, Elected Governor – Public
- Ms Jean Flanagan, Elected Governor – Public
- Ms Julie Southwell, Elected Governor – Staff
- Cllr Tim Norman, Appointed Governor, East Riding of Yorkshire Council
- Three members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

2 Apologies for absence

Apologies for absence were received from:
Ms Julie Charge, Non-Executive Director
Mr Mike Taylor, Associate Director of Corporate Governance

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 29 April 2026

The Board approved the minutes of the meeting held on 29 April 2026 as an accurate record of the meeting.

5 Matters arising/Action Log

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

BoD Pub 62 (25/26) *Allocate time in a Board Development Seminar for further discussion on consideration of patient experience reports.*
The due date was deferred.

BoD Pub 64 (25/26) *Add comparative figures from month to month in the National Operational Framework rank oversight in the TPR.*
Ms Hansen advised that this was a work in progress but should be available in the next version of the Trust Priorities Report (TPR). The due date was deferred.

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

BoD Pub 74 (25/26) *Present a report on the work undertaken by KPMG and its outcomes.*
The report would be presented at the Private Board meeting. The action was closed.

BoD Pub 77 (25/26) *Present the Staff Survey improvement plan to the Resources Committee and to the Board for approval.*
The plan had been presented to the Resources Committee on 19 May and was presented to the Board under Item 17. The action was closed.

BoD Pub 01 *Check if a pay award for resident doctors has been implemented.*
Ms Larcum advised that the pay award was added to salaries paid in June, backdated to 1 April. The action was closed.

BoD Pub 02 *Bring more information to the Board on the Chief AHP's work with primary care networks on the health inclusion agenda.*
Ms Hansen would circulate a paper to the Board. The action was closed.

BoD Pub 03 *Report to the Board on the mitigations in place re: returning colorectal cancer referrals with no FIT to primary care.*
Ms Hansen advised that an audit would be undertaken in Quarter 2 and she would report to the Board once this was complete. The due date was deferred.

BoD Pub 05 *Bring further information to the Board on the local birth rate in relation to the population, age range and other measures.*
Ms Wells-Munro reported that the decrease in the birth rate experienced by the Maternity Service was small in comparison with others and there was no evidence that women were choosing to book elsewhere. It was noted that the birth rate for York was significantly lower that the national average. The action was closed.

BoD Pub 06 *Discuss with Mr Barkley how the Board Assurance Framework will be updated for 2026/27.*
This action had been completed.

BoD Pub 07 *Add to the Quality Committee's terms of reference a function to gain assurance around the implementation of actions arising from clinical audits.*
This action had been completed, and the amended terms of reference would be presented to the Quality Committee.

6 Patient's Story

Dr Bradley joined the meeting to share details of a project to develop breast screening facilities for wheelchair users, following a complaint from a patient. Dr Bradley began by describing the work of the breast screening service. She outlined the nature of the complaint, which was that there was currently no facility nationally for breast screening wheelchair users, her initial response to it and how she had come to reframe her view and to work with the researchers from the University of York on a solution.

Board members agreed that Dr Bradley's story was very powerful. Ms Hazelgrave asked when a breast screening service for wheelchair users was likely to be available. Dr Bradley explained that funding was being sought for the next stage of development, but the capability could be available within the next 3-4 years. Dr Bradley confirmed that the commercial potential of the technology was recognised and would be developed appropriately. The Trust's collaboration with University of York colleagues in research and innovation was proving fruitful in a number of areas.

Miss Smith noted that the use of complaints data was key to service improvement.

Dr Bradley was thanked for her presentation and she left the meeting.

7 True North Report

Miss Smith presented the report. She referenced first the staff survey metrics and noted that, following on from her 100 day report which had now been communicated to the organisation, the drive to eliminate corridor care and the reaffirmation of the Trust's values and behaviours would support improvement in both metrics and would link to the planned Continuous Quality Improvement (CQI) programme and to a new integrated accountability framework. The contract for the CQI was out to tender and Miss Smith underlined that this programme was a significant opportunity for the Trust to move forward.

Miss Smith highlighted the improvement in the Urgent and Emergency Care (UEC) metrics but cautioned that the further improvement would be temporarily stalled by the implementation of the new Electronic Patient Record (EPR) as this and other new systems in the Emergency Departments needed time to embed.

Miss Smith assured the Board that the Cancer Faster Diagnosis Standard (FDS) continued to be a priority as did improvement in the Referral To Treatment (RTT) waiting list position.

Mr Hague advised that he was reviewing the approach to preventing incidences of Category 2 pressure ulcers and Trust onset MSSA bacteraemia.

Mr Floyd asked, in relation to the metrics, what would be realistic targets for the next six to twelve months. Miss Smith responded that the current True North metrics were very different in terms of their drivers and the actions needed. There was evidence of improvement in UEC and FDS metrics but those related to the staff survey would take much longer to improve.

Mr Taylor asked how the various initiatives, such as the new Clinical Strategy and the CQI programme, would be aligned and communicated to staff. Miss Smith explained that the new initiatives would be presented as facilitators for better patient care and would be underpinned by a reset of the Trust's culture and values to enable to staff to work better together.

8 Chair's Report

The Board received the report.

Mr Barkley reflected that it had been a huge honour and privilege for the Trust to co-host the visit of the King with Macmillan to the new Cancer Care Centre on 26 May.

9 Chief Executive's Report

Miss Smith also referenced the King's visit and recorded her thanks to Mrs Brown and Mr Norman and their respective teams for the work which had preceded the visit. Miss Smith agreed with Mr Barkley that the visit had been a fillip for staff at a difficult time and noted that the Centre would be a great asset to the Trust once completed.

Miss Smith highlighted the following points from her report:

- the increased visibility of the Executive team across the Trust's sites;
- her continuing efforts to engage with local MPs, councillors and patient groups;
- the publication of her 100 day report;
- the major transformation for the organisation ensuing from the implementation of the new EPR; the first tranche of the system was implemented successfully with good colleague engagement whilst maintaining patient safety; the contractor, Nervecentre, had underscored the success of the rollout; Miss Smith recorded her thanks to Mr Hawkins and his team, particularly Kevin Beatson who had been the architect of the CPD system which the EPR was replacing, and to the Chief Pharmacist and his team;
- the planning update in Section 3 of the report;
- the process around the proposed closure of the Bridlington Care Unit which had been established in 2021 as part of a system-wide response to the pandemic; whilst the closure was not considered a substantial variation in service, a wider

consultation process had proved necessary following a meeting of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee on 11 May;
- the first annual Scarborough Coastal Health and Care Research Collaborative (SHARC) event which took place in April.

Miss Smith welcomed the new Chief Nurse, Joe Hague, and recorded her thanks to Ms Filby for her leadership as Interim Chief Nurse and drew attention to the Star Award nominations.

Mr Floyd asked about the benefits and opportunities of the new EPR. Mr Hawkins explained that the original Business Case had been developed to move away from an in-house patient record system but the new system would improve patient care through more structured processes and pathways, and more streamlined administration. He confirmed that the benefits were being tracked and he expected that the system would provide a significant return on investment.

10 Quality Committee Report

Mr Barkley presented the escalation report from the meeting of the Quality Committee on 19 May 2026. He highlighted the Trust's Sentinel Stroke National Audit Programme (SSNAP) scores and expressed concern that these had not been escalated to the Committee given that the Trust had the lowest possible rating of E. Mr Barkley noted that whilst the standards expected had increased, there were only 11 Trusts nationally with a lower rating. He had therefore requested that SSNAP data should be escalated to the Board via the Quality Committee and queried whether the correct balance of staff was in place in the unit, given the low score for therapy input. Ms Hansen reported that the SSNAP score had been higher in recent years and the stroke service was highly regarded but acknowledged that workforce issues in therapy services had had a negative impact. Work was underway to address the issues.

There was a brief discussion on how key metrics, such as the SSNAP score, should be reported to the Board and Miss Smith advised that the TPR would be fully reviewed in the light of the CQI programme and the integrated accountability framework.

11 Resources Committee Report

Ms Grantham outlined the main discussion points from the meeting of the Resources Committee on 19 May 2026. The Committee had undertaken two focussed reviews, on the Waste Reduction and Productivity programme and on the staff survey improvement plan. There had been a detailed discussion on finances and how the position would be recovered, and the level of information which needed to be provided to the Committee. Committee members had been supportive of the staff survey improvement plan which identified fewer priorities for a sharper focus. Ms Larcum had agreed to report to the Committee in July on work to improve Trust culture.

The Committee had received an update on diagnostic waiting times which were being impacted by ageing and unreliable equipment and by workforce challenges. The Committee had received a paper on strategic partnerships and had requested more information. The Committee had noted the improvement in UEC metrics and also the improved compliance with the Emergency Preparedness, Resilience and Response (EPRR) standards.

12 Group Audit Report

Ms Hazelgrave reported the key discussion points from the meeting of the Group Audit Committee on 12 May 2026 which included an update on internal and external audit processes. The Committee had received the internal audit reports finalised since the last meeting and had noted a common theme of inconsistent processes across the Trust. Ms Hazelgrave referenced the internal audit report on backlog maintenance, noting that the significant assurance outcome related to processes not to the completion of the maintenance. The Committee had received an update from the Counter Fraud team and Mr Hawkins had attended the meeting to provide an update on his internal audit actions. He had also reiterated his concern around the increased threat from cyber-attacks.

Ms Hazelgrave reported that the Head of Internal Audit had provided a draft overall opinion of significant assurance for 2025/26.

Mr Barkley queried the outstanding internal audit actions under Mr Norman's remit. Mr Norman explained that recent changes in staffing had delayed the completion of the actions and that some due dates would be revised. Ms Hazelgrave reported that a new, more robust, process for revising due dates had been agreed.

13 Well-Led Action Plan Progress Report

Miss Smith presented the report which demonstrated progress against the Well-Led Action Plan. She reminded the Board that the external Well-Led review report had identified areas to be addressed which included visibility of leaders, mistrust of management and other cultural concerns, and that the action plan had been agreed collectively. Miss Smith reported that all actions due in 2025/26 had been completed and the 2026/27 Quarter 1 actions were all on track. The Board noted this positive progress and looked forward to the next update report in July.

14 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen advised that there would be a dip in performance against the Emergency Care Standard (ECS) in May due to the implementation of the new EPR. However, the new pathways introduced ahead of the EPR implementation had made for a smoother transition.

Ms Hansen reported that, in respect of RTT data, the Trust had met all its year-end trajectories apart from a small number of patients waiting more than 52 weeks, mainly to be seen by the Pain Service. Improved performance against the Cancer metrics had been sustained and the FDS metric in April was the best ever recorded by the Trust but there was still much improvement to be made. Cancer performance had been impacted by delays to diagnostic procedures.

Ms Hansen noted that the focus on eliminating corridor care would also support improvement in the ECS and in reducing 12 hour waits in Emergency Departments (ED). Another priority was work on pathways with primary care to manage the number of referrals and to ensure that all referrals were appropriate.

Mr Taylor reflected that a fundamentally different way of engaging with primary care was needed. Ms Hansen explained that work on key specialty pathways with Primary Care Networks had already begun; there would be opportunities as part of this work. Ms Abeysekera noted that there may be a role for a Non-Executive Director on the Strategy and Partnership Sub-Committee.

Ms Hazelgrave drew attention to the long waits being experienced by children and young people for some services. Ms Hansen described some of the strategies being developed to reduce waiting times, which included clinic days set aside for children and clinics being held at different sites across the Trust.

Mr Barkley was pleased to note the very low number of 12 hour trolley waits in ED. He queried the doubling of attendances to Same Day Emergency Care (SDEC). Ms Hansen explained that this was due to a change in the pathway. Mr Hawkins added that the number would change in future reports as patients attending SDEC would no longer be counted as inpatients. Miss Smith observed that the key to more improvement was to ensure that patients were seen in ED by senior clinical decision makers at the earliest opportunity as this would reduce admissions and would help direct patients to more appropriate care settings.

In response to a query, Ms Hansen confirmed that an improvement plan was being developed for colorectal cancer referrals.

Quality and Safety

Mr Hague reported that improvement plans for infection prevention and to reduce pressure ulcers were being refreshed.

Maternity

There were no questions or comments on this section.

Workforce

Ms Larcum reported that sickness absence rates continued to decrease as would be expected at this time of year, alongside a programme of sickness absence reduction across the organisation. Turnover and vacancy rates were low and below the target threshold. The number of Health Care Support Worker (HCSW) vacancies had increased but this was in part due to the HCSW establishment being expanded. The bulk of HCSW vacancies were with the Medicine Care Group; leaders were being supported to recruit to fill these vacancies. Significant progress had been made and a career pathway for HCSWs was being developed. Mr Barkley challenged that the Trust should not be increasing the number of HCSWs when it was required to reduce its overall headcount. Mr Hague responded that the decision had been made following establishment reviews and was not a cost pressure.

Discussion followed on the actions being taken by the Trust to ensure staff were able to return to work promptly from sickness absence. Ms Larcum observed that reduced sickness absence would result from an improvement in staff culture. She confirmed that the Trust held detailed data on the reasons for staff absence and there were actions to address specific issues, for example, additional physiotherapy support was offered for staff experiencing musculoskeletal issues. Whilst the granular level of this data was not presented in the TPR, the overwhelmingly consistent message from staff was that wellbeing issues were caused by working in the organisation. Mr Barkley commented that the moral injury to staff caused by corridor care was also a factor and added that the Trust would benefit financially from investing in actions to reduce long term sickness absence. .

Ms Larcum advised that the Sickness & Absence policy was currently under review. She added that a more detailed workforce report would be presented to the Resources Committee in future. Miss Smith highlighted that the level of sickness absence should be considered in the context of the majority of committed colleagues working in the organisation.

Mr Barkley queried the administrative bank staff usage recorded in the report. Ms Larcum explained that administrative bank shifts were only sanctioned where patient safety was at risk.

Digital and Information Services

Mr Hawkins was pleased to report that the migration to Tranche 1 of the new EPR had been very smooth overall: there had been no downtime and no need for any recourse to paper systems or other workarounds. The changeover had been a team effort as part of a highly supportive culture. The Trust had benefited from central funding to prepare the digital infrastructure for the new EPR so there had been very few complaints about the performance of the system. Mr Hawkins shared further information about the implementation process, which demonstrated the support which had been in place and the engagement with the new system. The Board recorded its congratulations and thanks to Mr Hawkins and his team.

Finance

Mr Bertram advised that the financial position and the progress of the WRAP programme had been reported and discussed in detail at the recent meeting of the Resources Committee. The Committee had made suggestions on how the reporting templates might be improved.

Mr Bertram reported that the financial position was £384k adverse to plan in Month 1. There had been a shortfall in the WRAP programme of £1.9m in Month 1 although £17m of the £62m target had been delivered in full year terms, of which almost £15m was recurrent savings. Mr Bertram noted the need to accelerate progress in delivering efficiencies across the organisation and advised that Executive Directors had taken a decision to use £1.5m from the planned investment in additional activity to offset the in-month shortfall as the Trust must limit the expansion of its cost base if the required savings were not being delivered. The focus would be on accelerating the WRAP programme to recoup the investment funds.

Mr Bertram assured the Board that Elective Recovery Fund activity would be managed over the financial year to avoid the risk of an overtrade. The cash position however would deteriorate over the year if deficit support funding was not received. Miss Smith underlined that the WRAP programme must be triangulated with delivering activity and balancing income and expenditure. A Senior Leadership Forum was scheduled for 2 June at which this would be discussed. The new Clinical Strategy would inform decisions around the use of income which would result in improved patient care and staff experience.

Mr Bertram explained the RAG rating which had been applied to the schemes in the WRAP programme, noting that there were still many schemes which had not been fully worked up. He outlined how WRAP targets were allocated and recorded in local budgets.

15 CQC Compliance Update

The Board received the report.

Mr Hague reported that the CQC had undertaken an unannounced inspection of the renal dialysis unit at Easingwold. Inspectors had received positive feedback from patients. The formal report was awaited.

16 Maternity and Neonatal Report

Ms Wells-Munro presented the report and drew out the following points:

- the Trust had received £470k from NHS Resolution to address Safety Actions 3 and 6 from Year 7 of the Maternity Incentive Scheme;
- Maternity Services were successfully delivering the RSV vaccination programme with uptake at 79% of pregnant women using the service, against a national average of 64%; work had begun to track the impact of the vaccination on neonatal admissions;
- the Sands and Tommy's Policy Unit paper on *Better board oversight needed to save babies' lives* had been included in the papers for directors' information; Ms Wells-Munro assured the Board that the recommendations were already covered;
- there had been an increase in cases of Post-Partum Haemorrhage over 1500mls to 5.1% (16 cases) in March; each case had been individually reviewed but there had been no common themes;
- the latest recruitment exercise for midwives had attracted over 320 applicants but most were newly qualified Band 5 midwives; Ms Wells-Munro cautioned that appointing newly qualified midwives was an extra cost to the Trust so the advertisement had been closed to Band 5 midwives, with only Band 6 midwives being sought;
- a maternity and neonatal equalities dashboard had been included in the report: the Trust was above the national average in all areas; Ms Wells-Munro outlined future actions which included better recording of ethnicity and a focus on reasons for pre-term births; a comprehensive review of the data would be presented to the Maternity Assurance Group and to the Quality Committee;
- a summary of the MBRRACE-UK perinatal mortality report for 2024 had been included in the report;
- a new Safety Action in Year 8 of the Maternity Incentive Scheme was concerned with the responsibilities of Trust Boards; there was an opportunity for directors to join webinars to learn more and Ms Wells-Munro encouraged as many directors as possible to attend.

In response to a question about suspensions of the Home Birth service in York and Scarborough, Ms Wells-Munro explained that the metrics would improve but the service was constrained by the 12 hour limit on midwife shifts.

Ms Wells-Munro was asked to add further detail to midwife vacancy and recruitment table in the report.

Action: Ms Wells-Munro

In respect of the complex governance oversight of maternity services, Ms Wells-Munro noted that it was the responsibility of the Director of Midwifery to ensure that the Board was presented with the correct information, and it was agreed that her attendance at Board meetings was an important escalation route. A greater level of detail was presented to the Quality Committee. In answer to a question, Ms Wells-Munro confirmed that Directors of Midwifery across the ICB met to share good practice and learning.

Mr Barkley referred to the deprivation data for maternity bookings and observed that it would be interesting to see this split between York and Scarborough. 52% of women

booking into the Service were in deprivation quintiles 4 and 5, whereas nationally this was 32%. This reflected the comparatively low level of deprivation in the Trust's catchment population.

17 Staff Survey Improvement Plan

Ms Larcum presented the report which contained analysis of the free text comments submitted as part of the 2025 national staff survey. The colleague experience improvement plan was also presented. Ms Larcum advised that there was a strong focus on fewer, deliverable, actions in four key areas. The actions and areas correlated with the Chief Executive's 100 day report and other sources of colleague feedback and were fully integrated with other Trust strategies.

In response to a question, Ms Larcum advised that the aim was to engage colleagues via consistent messaging. The Big Conversation initiative would be a driver to improve colleague experience, as would the CQI programme.

Mr Barkley noted that the action in the plan to ensure that the workforce had access to the fundamentals should also include improved servicing of toilets and cleaning of offices. Ms Larcum advised that the plan would be amended in response to comments.

The Board supported the delivery of the 26/27 Colleague Experience Improvement Plan in all areas of the Trust.

18 Research and Innovation - Annual Report

Dr Stone presented the report, reminding the Board that a new Trust Research and Innovation Strategy had been published in 2025. She referred to the strategic scorecard included in the report and advised that the Trust had exceeded trajectories in all but one of the metrics. The report also included details of successful grant applications and awards, clinical trials and partnerships. Dr Stone noted that the Trust ranked well nationally and regionally against peers in terms of the number of research students and accruals.

Dr Stone referenced new internal innovation engagement which included training videos and an inaugural innovation competition which had attracted 90 applications submitted by staff across the Trust. Miss Smith added that all ideas would be reviewed even if not shortlisted for the award.

Dr Stone highlighted new expectations on Trusts to develop more research and to enrol patients more quickly.

Ms Abeysekera asked about the success rate of bids for grant funding. Dr Stone responded that whilst a specific success rate was not included in the report, it had risen as bid writers had been recruited to the team. She would ask for the success rate to be included in future reports.

Action: Dr Stone

Mr Floyd asked if there were any lessons learnt from unsuccessful bids. Dr Stone responded that bid activity had increased due to the receipt of a large amount of funding for one study and it was important to dovetail bids with individuals' interests. She outlined different routes for bidding opportunities. She agreed with Mr Floyd that the aim was for research to support organisational priorities; SHARC was an example of this.

Mr Barkley referred to the grant awarded for the evaluation of Martha's Rule and commented that it would be interesting to see the outcome of this research.

19 Emergency Preparedness Resilience and Response (EPRR) Action Plan Update

The Board received the report and congratulated the EPRR team on the progress towards compliance with the standards.

20 Corporate Governance Update

Proposed Changes to the Constitution

The Board of Directors approved the proposed amendments to the Trust's constitution.

21 Questions from the public received in advance of the meeting

Mr Barkley referred to a petition from Mr Charlie Dewhirst, Member of Parliament for Bridlington and the Wolds, regarding the proposed closure of the Bridlington Care Unit which Miss Smith had referenced above. This would be discussed at the Private Board meeting before a formal response was made. The Trust would undertake the structured engagement as requested by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee. Mr Barkley acknowledged that Trust leaders needed to regain the confidence of the local community.

Mr Barkley advised that a further petition had been received from councillors representing wards local to York Hospital which is reproduced here:

Thanks for the opportunity to speak with Chair this morning along with my two Guildhall Ward colleagues, Cllrs. Tony Clarke and Rachel Melly.

Guildhall ward covers the stretches from the city centre east side up to the Cocoa works at the top end of Haxby and Wigginton Roads including the York Hospital site. Many of our residents directly experience the impacts of the hospital related traffic congestion in the area. Concerns have been raised with us since we first stood in the ward three years ago, and the queues spread at peak times back through the Crichton Avenue and the Clarence Street / Haxby road junction and even the Clarence Street / Lord Mayor's Walk / Gillygate one at times. The impact in delays and disrupted journeys for everyone, unreliable bus services, noise, pollution, vehicle intrusion, dangerous driver behaviours such as driving the wrong way down the opposite traffic lane to get into the hospital, have all been flagged to us.

We therefore set up a petition to ask yourselves and the City Council "to work together to urgently undertake measures to address the serious and regular congestion and queuing back from the hospital car park into Wigginton Road".

1830 primarily local people have signed our on-line petition on the Change,org platform and we separately provide their names in the attachment. Many are hospital patients with comments about the difficulties, delay and consequential stress about getting to their appointments on time. We also picked up a lot of suggestions for solutions and means to tackle the problems, some in the Trust's gift, some in the Council's and some needing a joint approach. They range from simple low cost administrative ones like ensuring all

appointment letters outline the limited car parking availability on site and outlining alternative means of accessing the site and other nearby car parks through to more difficult and expensive measures - see appendix for the ones pertinent to the trust – will be flagging others to the Council similarly in the near future.

However our biggest ask is that the Trust develop and adopt, hopefully with the Council's assistance, a strategic approach and proper plan for managing access to and parking at the hospital and optimising use of alternatives to the car that keeps parking within the site's capacity and avoids queue back into the junction with Wigginton road and in the process helping to ensure that patients, staff, visitors and suppliers can reliably access the hospital site, and that the surrounding community, road and local bus users past the hospital no longer suffer the repeated current congestion problems.

Appendix:

- *Better info in appointment letters, and on the York Hospital website regarding the limited on site parking, less busy times if a visitor, alternative local car parks, bus services past or close to the hospital and nearest bus stop locations, cycle parking facilities on site;*
- *Better management of car parking – booking system linked to priority for patients with limited mobility / remote location / other needs requiring car transport to the hospital, ensuring no non-hospital related usage;*
- *Optimisation of different NHS facilities and the appointment system to shift those services that can be provided nearer where patients live as much as possible and that patient appointments are made to the nearest service point as far as reasonably possible so as to reduce the pressure for car journeys to the hospital;*
- *Alterations to shift and visiting times to spread the arrival times;*
- *Physical alterations within the hospital curtilage to remove the queues off Wigginton road (on road alterations including signing on arrangements when the car park is full will be raised with the Council);*
- *Creation and adoption of a strategic travel plan to cover all journeys to and from the hospital to ensure non-car mode use is increased sufficiently, including development of additional offers, such as reinstatement of a dedicated Park and Ride service to the hospital to intercept car journeys and transfer them to more efficient way of getting people (staff, patients where appropriate and visitors) to the hospital, and to ensure that queuing from the site never normally stretches back into Wigginton Road.*

There were no questions from members of the public.

22 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 24 June 2026 at 9.30am at Scarborough Hospital.

Action Ref.	Date of Meeting	Item Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	Status
BoD Pub 62 (25/26)	25-Feb-26	10	Quality Committee report	Allocate time in a Board Development Seminar for further discussion on consideration of patient experience reports	Associate Director of Corporate Governance/Chair	Update 29.04.26: Mr Taylor would discuss with Mr Barkley that week. The due date was deferred. Update 27.05.26: the due date was deferred.	Jun 26 from Mar 26	Delayed
BoD Pub 64 (25/26)	25-Feb-26	12	Trust Priorities Report	Add comparative figures from month to month in the National Operational Framework rank oversight in the TPR	Chief Operating Officer	Update 29.04.26: This was still being discussed by Ms Hansen and Mr Hawkins. The due date was deferred. Update 27.05.26: work was progressing to include the information. The due dae was deferred.	Jun 26 from Apr 26	Delayed
BoD Pub 70 (25/26)	25-Mar-26	7	True North Report	Bring a recommendation for the True North metrics for 2026/27 to the next meeting.	Chief Executive	Update 27.05.26: Miss Smith advised that a recommendation would be presented at the meeting in May. The due date was deferred.	Jun 26 from Apr 26	Delayed
BoD Pub 73 (25/26)	25-Mar-26	13	Trust Priorities Report	Present an improvement plan for 2-hour Urgent Community Response compliance	Chief Operating Officer	Update 29.04.26: It was agreed that the due date should be deferred to June.	Jun-26	On Track
BoD Pub 76 (25/26)	25-Mar-26	16	Mortality Review – Learning from Deaths Report	Consider including crude mortality trends within the Learning from Deaths report	Medical Director		Jun-26	On Track
BoD Pub 03	29-Apr-26	12	Trust Priorities Report	Report to the Board on the mitigations in place re: returning colorectal cancer referrals with no FIT to primary care	Chief Operating Officer	Update 27.05.26: Ms Hansen advised that an audit would be undertaken in Quarter 2 and she would report to the Board once this was complete. The due date was deferred.	Oct 26 from May 26	Delayed
BoD Pub 04	29-Apr-26	12	Trust Priorities Report	Include a graph in the TPR showing actual WTE compared with the plan	Interim Director of Workforce & OD		Jun-26	On Track
BoD Pub 08	27-May-26	16	Maternity and Neonatal Report	Add further detail to midwife vacancy and recruitment table in the report	Director of Midwifery		Jun-26	On Track
BoD Pub 09	27-May-26	18	Research and Innovation - Annual Report	Ensure that R&I bid success rates are included in the next annual report	Medical Director		May-27	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

June 2026

True North – Introduction

York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

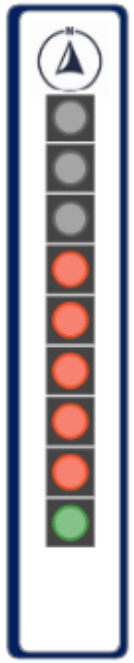
This is the single point of reference to measure our progress.

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

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

True North – User Guide

Understanding the Thermometer Reading (Examples Only):



3 do not have a monthly trajectory

5 are not achieving monthly trajectory

1 is achieving monthly trajectory

Indicator has improved since previous month

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

Indicator has deteriorated since previous month

Objective Status (top right of indicator page):

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

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

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

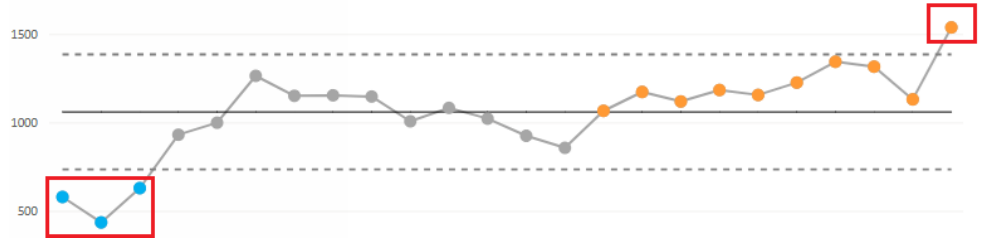
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

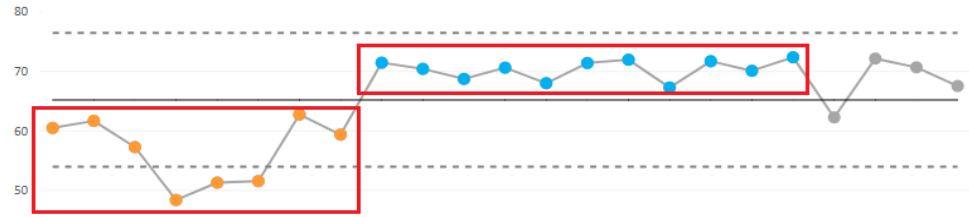
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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

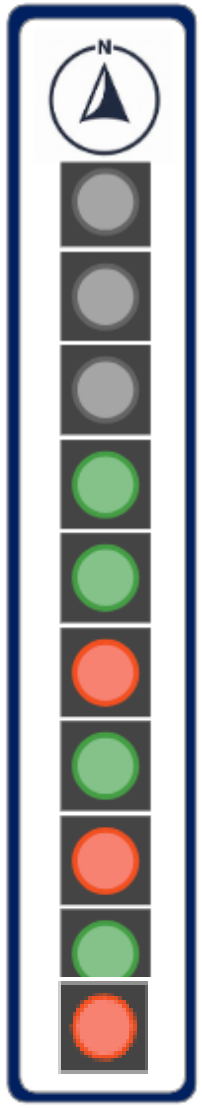


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



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

True North Report



Performance Improvement Overview

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

Staff Survey: Recommend Care

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

Staff Survey: Recommend Work

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

Inpatient: Reduce Bed Days Lost to NCTR

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

Urgent Emergency Care: Improve Emergency Care Standard (ECS)

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

Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

Elective: Cancer: Improve the Faster Diagnosis Standard

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

Elective: Improve RTT

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

Q&S: Reduce Category 2 Pressure Ulcers

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

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

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

Finance: Achieve Financial Balance

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

True North Report

Objective Status ○ No Trajectory

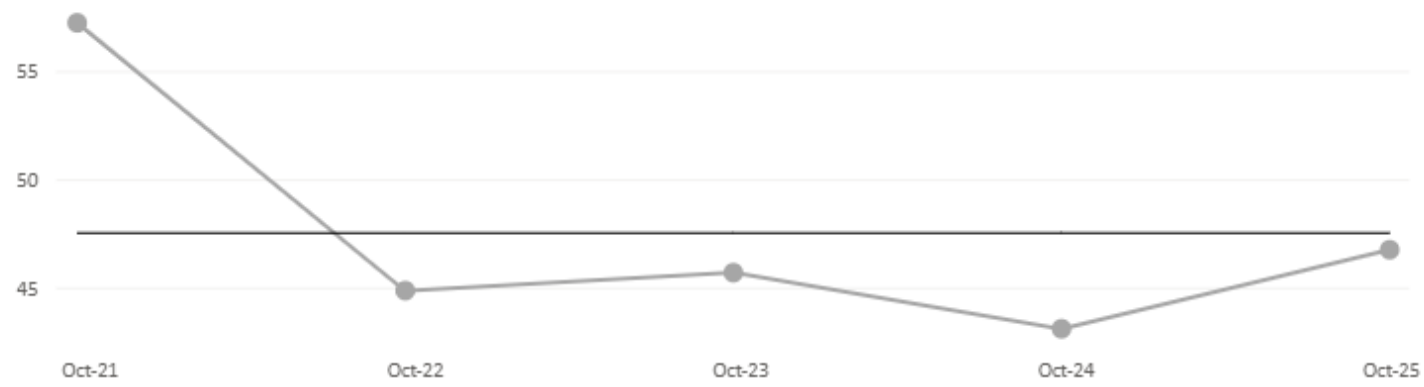
Staff Survey: Recommend Care

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

Lead Director: Karen Stone

Operational Lead:

Committee: Resources



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

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

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

True North Report

Objective Status — No Trajectory

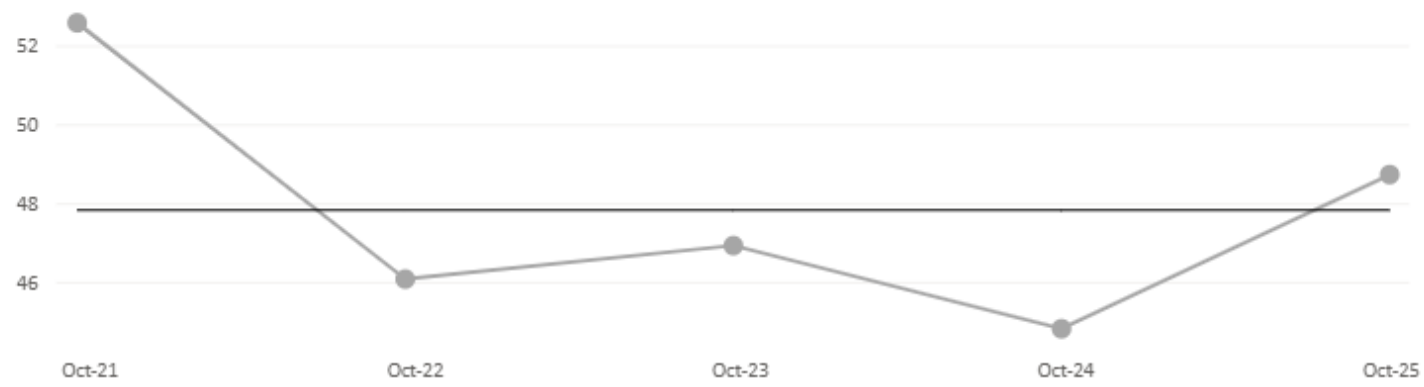
Staff Survey: Recommend Work

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

Lead Director: Lydia Larcum

Operational Lead: Vicki Mallows

Committee: Resources



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

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

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

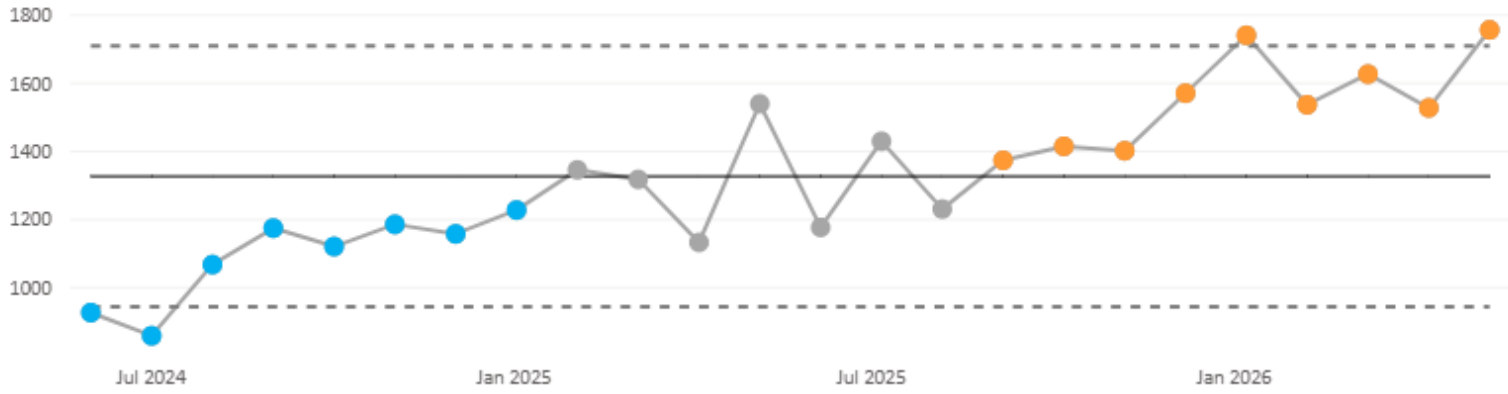
True North Report

Objective Status — No Trajectory

Inpatient: Reduce Bed Days Lost to NCTR

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

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



Is there special cause variation?

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

4 found

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

Occurs

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

Does Not Occur

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Target Mar 2027
Value	1537	1174	1427	1228	1371	1412	1399	1568	1738	1534	1624	1525	1754	
Trajectory														

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

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

What are we doing about them?

- New discharge readiness form went live with Nervecentre. Early feedback is that local authorities are still adjusting to the revised lower level of information within these, and the concept of 'describe, not prescribe' which is at its core.
- Daily escalation meetings continue.
- Working in partnership with the system to operationalise Pathway 1 Bridging Services across York and North Yorkshire.

True North Report

Objective Status Up Is Good

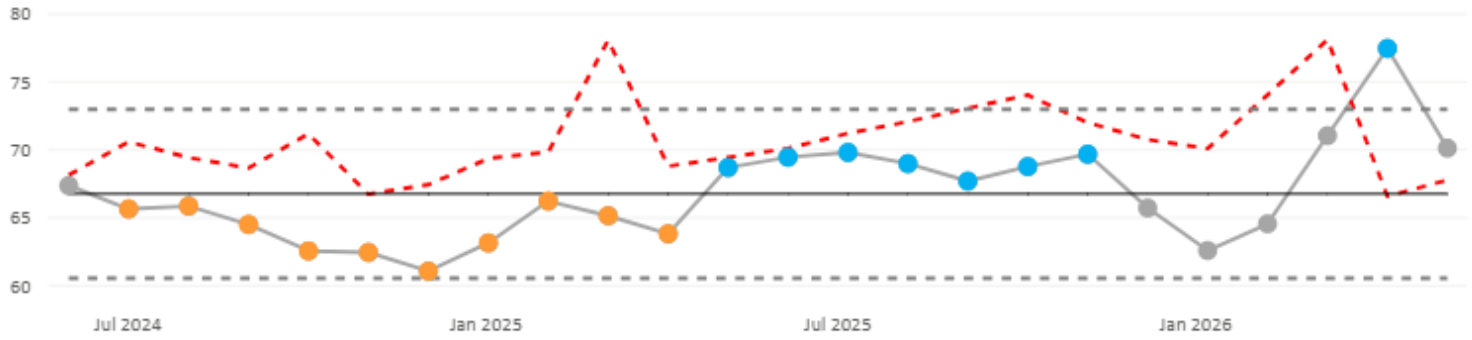
Urgent Emergency Care: Improve Emergency Care Standard (ECS)

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

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

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

1 found

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

Occurs

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

Does Not Occur

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Target Mar 2027
Value	68.6%	69.4%	69.7%	68.9%	67.6%	68.7%	69.6%	65.7%	62.5%	64.5%	71%	77.4%	70.1%	82%
Trajectory	69.4%	70%	71.1%	72%	73%	74%	71.9%	70.7%	70%	74%	78%	66.5%	67.7%	

What are the organisational risks?

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

How are we managing them?

- Daily UEC huddles, weekly improvement plan meetings and fortnightly performance meetings are in place.
- The team continues to use escalation tools and frameworks as appropriate.

What are the current challenges?

- High volume of attendances including an increase in ambulance arrivals – indicating more patients with high acuity needs.
- Transition to Nervecentre has caused disruption both to processes in ED and to flow through the hospitals.
- Workforce challenges at both EDs, including recruitment issues and poor staff morale.
- Financial constraints limiting options for testing new ways of working.

What are we doing about them?

- Workshop took place 2nd June 2026 to identify recovery actions including further communications to all ED and Acute staff clarifying some misconceptions about Nervecentre processes.
- Progressing a business case for additional medics for our front-door services including Emergency and Acute physicians.

True North Report

Objective Status | Down Is Good

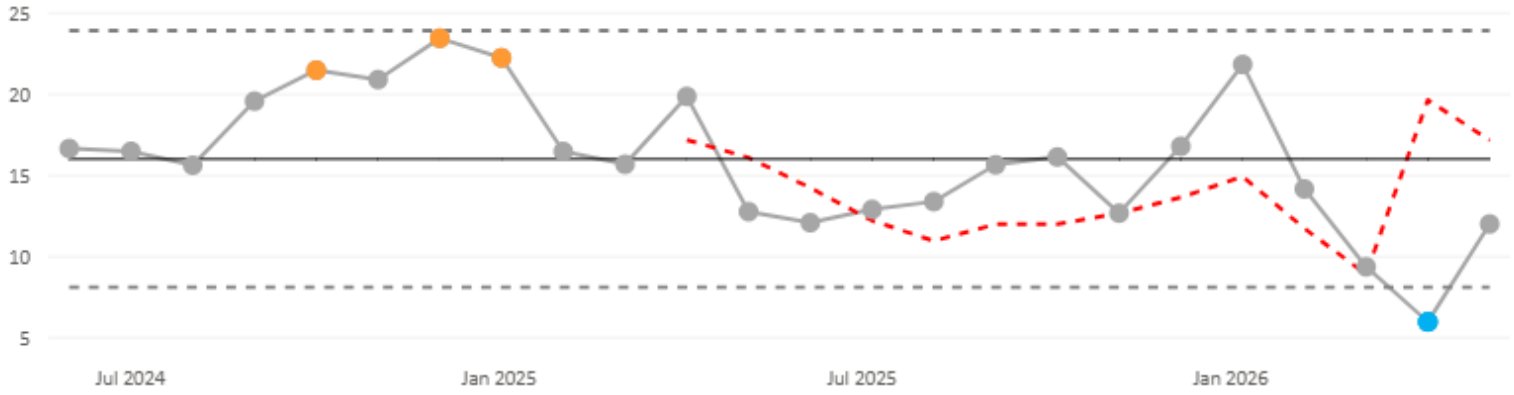
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

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

1 found

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

Does Not Occur

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

Does Not Occur

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

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

- Transition to Nervecentre has caused disruption to processes both in ED and the wider hospital
- High attendance levels.
- High number of patients with high acuity.
- High demand for side rooms.
- Workforce: capacity, skill mix, sickness rates.
- High sickness levels in community / primary care
- Financial constraints mean limited options for testing new ways of working.

What are we doing about them?

- EAU supported a significant reduction in 12 hours delays in ED in April, so the team knows this is an important pathway for managing flow and reducing 12 hour delays. As the team adjusts to using Nervecentre, ensuring EAU is operating well at both sites is a priority.
- At Scarborough there has been a request from the Lead for Acute Medicine that EAU is staffed with a senior acute physician as a priority, after instances of Lilac having multiple acute physicians and EAU a medical registrar.

True North Report

Objective Status | Up Is Good

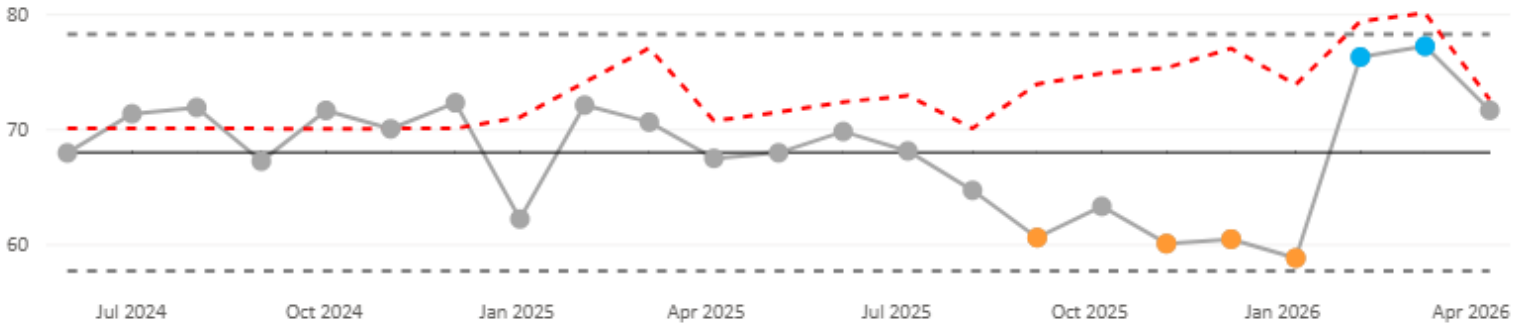
Elective: Cancer: Improve the Faster Diagnosis Standard

Increase the percentage of people who receive diagnosis of cancer, or the all clear, within 28 days of referral to achieve an average of ≥ 80% over 2026/27

Lead Director: Claire Hansen

Operational Lead: Kim Hinton

Committee: Resources



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Target Mar 2027
Value	67.4%	67.9%	69.8%	68.1%	64.7%	60.6%	63.3%	60%	60.4%	58.8%	76.2%	77.2%	71.6%	84.3%
Trajectory	70.7%	71.4%	72.3%	72.9%	70%	73.9%	74.8%	75.3%	77%	73.8%	79.3%	80.1%	72.5%	

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

- Urology, gynaecology and colorectal pathway delays.
- Full coverage of skin referrals not yet accompanied with picture impacting ability to triage patients effectively because of GP action, resulting in increasing demand and deteriorating performance.
- Diagnostic delays in CT (4wks)
- Increase in suspected cancer referrals month on month from May 2025. 5% increase in April 26.

What are we doing about them?

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

True North Report

Objective Status Up Is Good

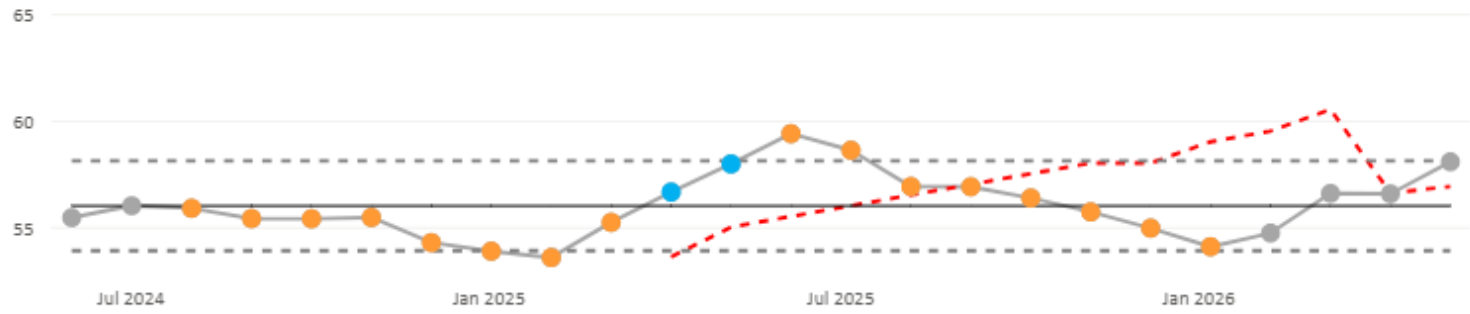
Elective: Improve RTT

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

Lead Director: Claire Hansen

Operational Lead: Kim Hinton

Committee: Resources



Is there special cause variation?

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

4 found

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

Occurs

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

Occurs

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Target Mar 2027
Value	58%	59.4%	58.6%	56.9%	56.9%	56.4%	55.7%	55%	54.1%	54.7%	56.6%	56.6%	58.1%	67.5%
Trajectory	55%	55.5%	56%	56.5%	57%	57.5%	58%	58%	59%	59.5%	60.5%	56.6%	56.9%	

What are the organisational risks?

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

How are we managing them?

- Weekly elective recovery meetings with all specialities to review progress and use of Power BI tool to track all end of month breaches at patient level.
- Individual speciality meetings for most challenged specialities.
- Weekly diagnostic improvement meeting.
- Risk stratified scheduling and pathway validation.
- Staff training.
- Use of activity related investment monies to support high risk specialities.

What are the current challenges?

- Validation of non RTT waiting lists resulting in an increase of patients with RTT clock.
- Diagnostics delays across radiology, physiology and endoscopy.
- Underlying demand and capacity mis match in specialties.
- Workforce vulnerabilities impact delivery of activity in plan.
- Delays in delivery of capital programme, impacting delivery of activity in plan.
- Pain speciality most challenged speciality impact on RTT improvement metrics

What are we doing about them?

- Undertaking focused validation of cohorts of patients that could result in clock stops.
- Implementation of service delivery plan with oversight at monthly delivery boards.
- Commenced fortnightly performance and activity meeting with each care group to identify corrective actions.
- Discussion with ICB regarding increase in referrals across specific specialties
- Increase validation resource through patient not present tariff.
- Undertaking targeted insourcing.
- Pain improvement plan being developed

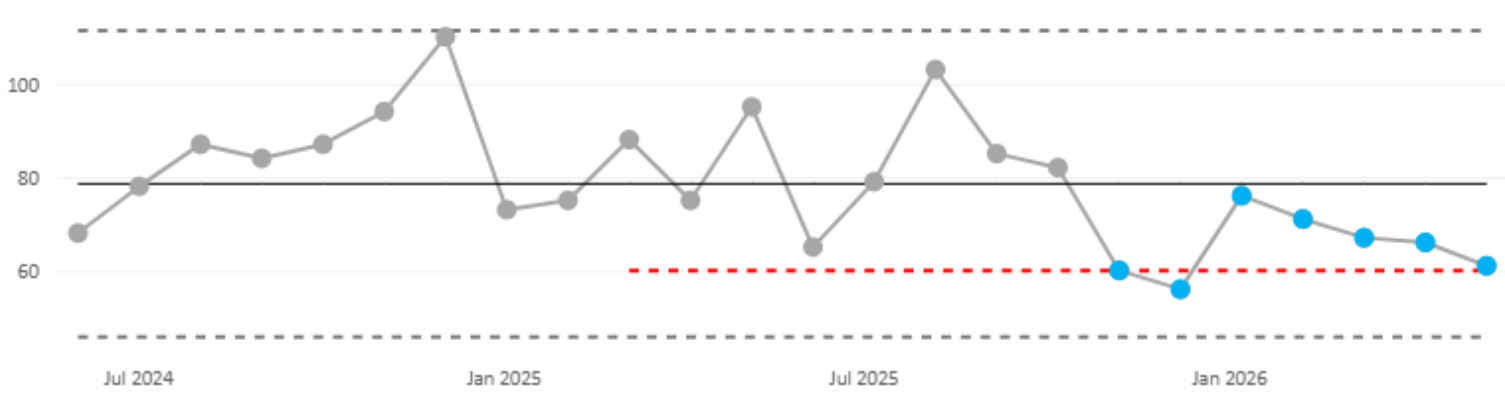
True North Report

Objective Status — Down Is Good

Q&S: Reduce Category 2 Pressure Ulcers

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

Lead Director: Joe Hague
Operational Lead: Emma Hawtin
Committee: Quality



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0 found

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

Occurs

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

Does Not Occur

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Target Mar 2027
Value	95	65	79	103	85	82	60	56	76	71	67	66	61	60
Trajectory	60	60	60	60	60	60	60	60	60	60	60	60	60	

What are the organisational risks?

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

How are we managing them?

- Work continues to improve recognition and accurate categorisation of pressure ulcers, led by care groups with TVN support, focusing on hotspot areas.
- The introduction of photography via Nervecentre will be transformational, enabling the TVN to better support teams across the organisation in their assessments.
- Eliminated double counting and recording of a pressure ulcer has continued to be achieved this month.

What are the current challenges?

- Ongoing issues with inaccurate validation and categorisation of Pressure ulcers within clinical areas.
- Appropriate Seating equipment to support patients.
- Our figures currently include pressure ulcers from local authority care/nursing homes, which has increased both workload and reported numbers.
- The rate of mattress failure due to cell twisting has continued, impacting equipment reliability and requiring targeted corrective action.

What are we doing about them?

- Deputy Chief Nurse in further discussion with the ICB regarding reporting of community pressure damage, occurring outside of our care.
- Funding released from charitable funds to purchase a small number of high-risk bedside chairs.
- Completed retrofitting of SGH mattresses in May.
- NerveCentre launched including access to wound photography, new assessments and care plans.
- TVN delivering virtual sessions to support accurate identification of PUs and engagement with Skin champions.
- Stretch target of 20% reduction in Category 2 PU agreed for 26/27 as part of TPR.

True North Report

Objective Status Down Is Good

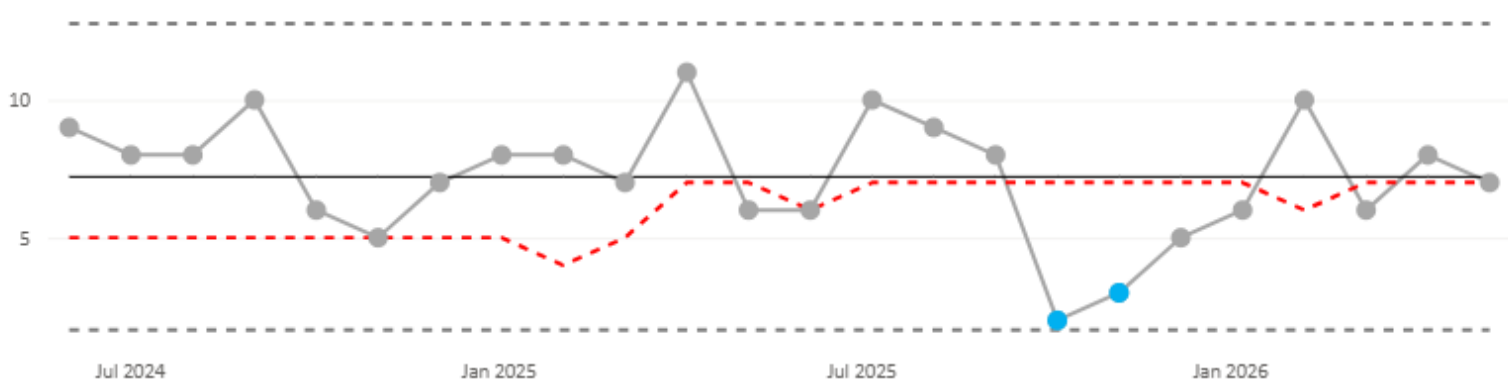
Q&S: Reduce the number of Trust Onset MSSA Bacteremia

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

Lead Director: Joe Hague

Operational Lead: Susan Peckitt

Committee: Quality



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

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

What are the organisational risks?

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

How are we managing them?

- All cases are reported by the IPC team on Datix to the relevant Care Group Handler.
- Cases are managed locally however we are now moving towards a standardised process.
- The IPC team support the care groups to investigate/manage the patients appropriately.
- MSSA 5% reduction on 2025/26 is an agreed Trust prriority.
- A Trust strategic reduction plan is in place.

What are the current challenges?

- Cases are not consistently reviewed.
- Learning not shared widely across the organisation, limiting overall improvement.
- VIP score compliance remains below the compliance threshold and further further improvement is required.

What are we doing about them?

- Care group reduction action plans in place and monitored via IPSAG.
- A Trust wide improvement plan has been developed and approved at IPSAG.
- A standardised Care Group Dashboard and PSIRF/AAR process has been developed with the Care Groups
- Line management, VIP scoring and ANTT education has been refreshed and re-launched.
- MSSA case review has commenced via the Datix process.

True North Report

Objective Status

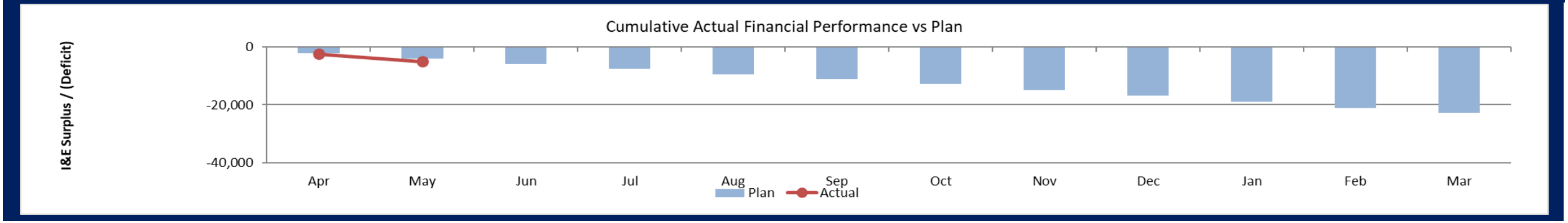
Finance: Achieve Financial Balance

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

Lead Director: Andrew Bertram

Operational Lead: Sarah Barrow

Committee: Resources



Indicator	Target £'000	Apr-26 £'000	May-26 £'000	Jun-26 £'000	Jul-26 25 £'000	Aug-26 £'000	Sep-26 £'000	Oct-26 £'000	Nov-26 £'000	Dec-26 £'000	Jan-27 26 £'000	Feb-27 £'000	Mar-27 £'000
Meet our obligation to deliver the financial plan for26/27	-22,646	-2,087	-4,068	-5,950	-7,685	-9,443	-11,170	-12,884	-14,881	-16,885	-18,956	-21,014	-22,646
Actual Position		-2,470	-5,031										
Variance		-383	-962										

What are the organisational risks?

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

How are we managing them?

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

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

What are the current challenges?

- In May WRAP delivery falls £2.7m short of the YTD target.
- There is currently a planning gap of £3m (4.8% of overall target)
- £4.2m WRAP plans are High-Risk and £18.9m Amber

What are we doing about them?

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

1. EPR Update: Nervecentre Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- The first tranche of our EPR programme was successfully implemented over a two-week period in May 2026.
- The scope of this initial phase includes observations, clinical documentation for inpatients, urgent & emergency care, electronic prescribing & medicine administration, bed management and read-only diagnostic results.
- The programme provided hyper care support throughout the go-live period, and continues to support as staff get used to the new system and processes are embedded.
- Planning for Tranche 2, which will implement Nervecentre order comms for use by UEC and inpatient staff, is progressing at pace and is expected to go live in August 2026.
- Planning for Tranche 3, which is expected to go live in June 2027, is being progressed in parallel.

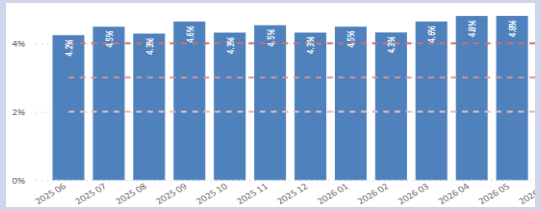
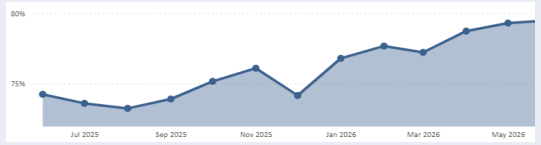
2. Continuous Improvement Update Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Following approval of our consultancy application to NHS England, we went ahead to open tender on 30th March 2026.
- The request for tender submissions closed on 30th April 2026. Application review, moderation and presentation processes will be completed by 8th June. We will then inform the successful partner and enter the next phase of the procurement process and should be able to make a formal announcement to the Trust week beginning 22nd June 2026. We are continuing to pursue a start on site in early July 2026.
- In the meantime, we continue with the delivery of quality improvement training and where targeted, the Improvement Team are supporting priority areas with an improvement approach. This includes supporting the eradication of corridor care and achieving a reduction in long lengths of stay.

3. Productivity and Efficiency Group Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Project	Current position	Actions completed	Actions for next month
004 PIFU Utilisation – achieve 6.6%	4.8% in May 2026 against a plan of 6.6% in 26/27 plan. Sustained improvement from April. 	• Delivery of speciality workshops commenced • Pain management actions identified • Reporting to productivity delivery group against programme commenced	• Gap analysis against GIRFT and all specialties to be completed
003 Outpatient Utilisation – achieve 90%	79.3% in May 2026, a 0.6% improvement from April 	• Detailed speciality level action plans developed • All clinics with 0-20% utilisation review and actions taken • Root cause analysis of specialities reporting <65% • Report on KPI's for specialties commenced, with reporting to delivery group.	• Gap analysis being completed for all specialties • All clinics from 20-60% utilisation to be reviewed. For root cause and actions
009 Referral pathways – reduce referral demand (10% reduction in consultant to consultant and maintain no more than 2% increase in GP referral demand)	Development of an approach to roll out of single point of access (SPoA). Consultant to consultant referral rates	• Specialities for roll out confirmed • Established project group and primary / secondary care interface. • Commence engagement with clinical teams • C2C referrals in Pain reviewed and reduction in demand of over 10%	• Clinical design workshops being developed for roll out specialties • Technical discussions with ICB on roll out of gateway
006 Diagnostic Pathways – Increased diagnostic activity	Being scoped in June 26	• Reviewed current actions • Gap analysis against national recovery plan completed • Manual text reminders in imaging commenced	• Reviewing national productivity information • Identify baseline and improvement metrics for modalities • External review of endoscopy commences
008 One stop clinics – reduced new:FU ratio (TBC)	Being scoped in June 26	• Initial engagement with ACOO's commenced • Review of current service delivery plan for identification of opportunities complete	• Identification of actions against opportunities and being developed into project plan.

4. Efficiency Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Trust Waste Reduction and Productivity Programme

Executive Summary

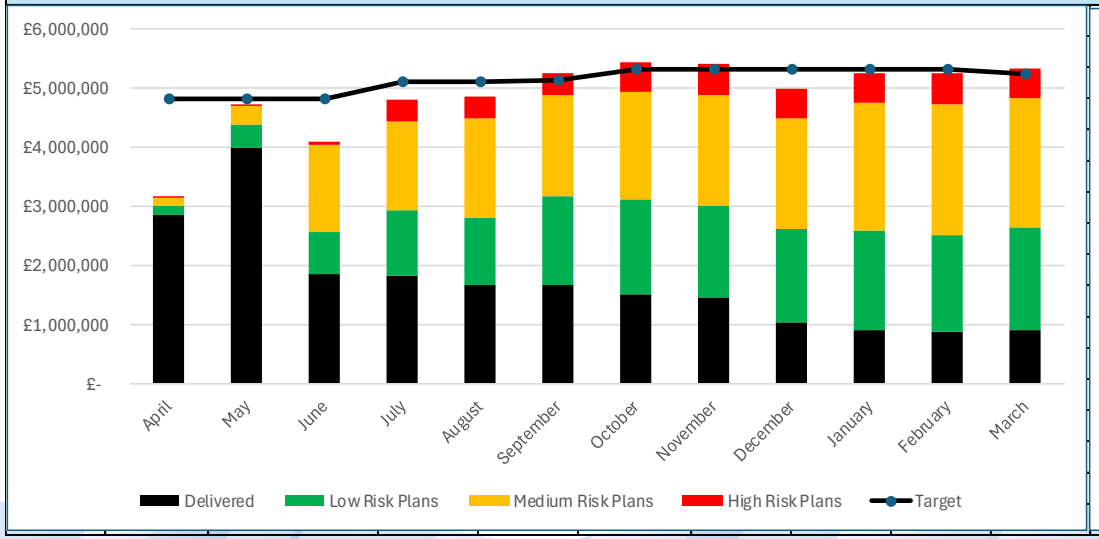
Programme Summary Position	Full Year	YTD Position
Target	£ 61,639,999	£ 9,615,844
Delivered	£ 20,592,477	£ 6,865,506
Variance	**-£ 41,047,522**	**-£ 2,750,338**
Addititional Plans to be delivered		
Planned Low Risk	£ 14,758,157	£ 525,135
Planned Medium Risk	£ 18,973,325	£ 448,078
Planned High Risk	£ 4,233,623	£ 16,008
Total Additional Plans	**£ 37,965,106**	**£ 989,221**
(Planning Gap)/Over delivery	**-£ 3,082,416**	**-£ 1,761,117**

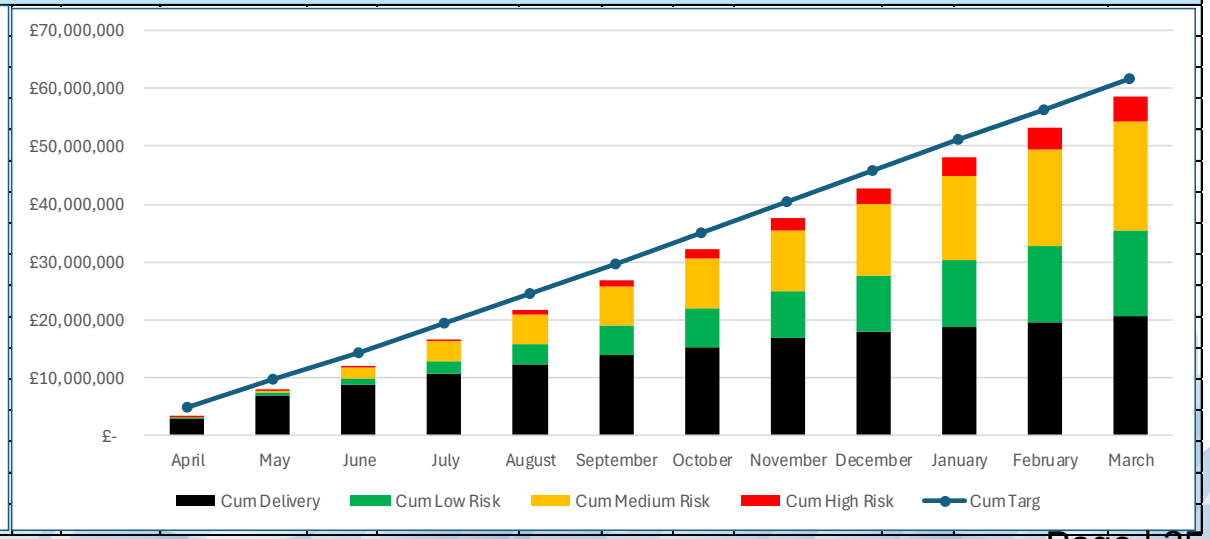
WTE Plan	179.06	**WTE Delivered**	11.69

Scheme Governance											
Total Number of Live Schemes							**144**				
EQIA Outstanding							48	33%			
Pre-Pipeline							49	34%			
Opportunity							5	3%			
Plan in Progress							13	9%			
Fully Developed							77	53%			
	Plans	**%**	**Delivered**	**%**				**Plans**	**%**	**Delivered**	**%**
Recurrent	£ 39,238,398	64%	£ 15,880,846	26%			**Pay**	£ 26,288,070	43%	£ 6,557,273	11%
Non Recurrent	£ 19,319,185	31%	£ 4,711,631	8%			**Non Pay**	£ 31,954,150	52%	£ 13,815,841	22%
Total	**£ 58,557,583**	95%	**£ 20,592,477**	33%			**Income**	£ 315,363	1%	£ 219,363	0%
							Total	**£ 58,557,583**		**£ 20,592,477**	

YTD Period Name	May 2026

In Year Plan Profile





Report to:	Board of Directors
Date of Meeting:	24 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 ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

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

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

No ☒ Yes ☐

Report History
Board of Directors only

Chair's Report to the Board – June 2026

1. I have continued to visit various wards and services at Scarborough and York Hospitals. Through conversations with colleagues during these visits, I pick up valuable insight and issues which I share with the Chief Executive as appropriate.

2. Since the previous Board meeting, I have Chaired meetings of the Digital Sub-Committee, Charity Governance Committee and the Council of Governors.

3. I am pleased to report that the Council of Governors have agreed to give me a second and final 3 year term of office from 1st November 2026.

4. Also agreed by the Council of Governors was a decision to postpone Elections to Vacancies on the Council until April 2027. If Parliament passes the legislation that removes Councils of Governors and instead require Trusts to establish new "dynamic" arrangements for patients and public involvement, the elections will not go ahead. In the meantime, Governors whose term of office would have expired on 30th September 2026 will continue to 31st March 2027.

5. An excellent Member/Governor Constituency meeting for the Hambleton & Ryedale Constituency took place on 10th June. There was almost 2 hours of high quality questioning by Members – a great example of accountability and transparency conducted with great respect and politeness. I am very grateful to Sandra Fox, an elected locality Governor for attending the meeting with me. This was the first of this year's Constituency meetings. The next one is York on 16th July.

6. With Linda Wild, Lead Governor, I have carried out the annual appraisal of our Non-Executive Directors. My thanks go to them and Linda for their terrific work and support.

7. Recently I had the great pleasure of attending the Long Service Awards presentations which took place at Scarborough. The equivalent will shortly take place at York. It was a joyous occasion giving the Trust to thank and celebrate colleagues for their long dedicated service in the NHS (both 25 and 40 years).

8. Last but by no means least, with our Finance Director and Chief Executive I attended a meeting with our national counterparts, NHSE regional Finance Director and Chair as well as the ICB Chair and Chief Executive. Clare Smith gave an excellent 5

minute introduction / scene setting and all three of us contributed to responding to the questions. But there is still no agreement to our financial plan. Further information has been sought by NHSE.

Martin Barkley
Trust Chair
15.06.2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 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.
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☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
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Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides an update from the Chief Executive to the Board of Directors in relation to the Trust's priorities. Topics covered this month include: Listening to colleagues and stakeholders, Planning update, Resident Doctors' Industrial Action, Bridlington Care Unit, Bridlington Surgical Hub Optimisation Week, Lord Mann Review, Recognising our long serving colleagues, and May's Star Award nominations.

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

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting) No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

Chief Executive's Report

1. Listening to colleagues and stakeholders

I have now been with the Trust for more than six months and it is hard to believe how quickly that time has passed.

Looking back on those first six months, I feel incredibly fortunate and thankful for the welcome I have received. Everywhere I have gone, colleagues have been generous with their time, honest in their feedback and passionate about the care they provide. Every week I continue to learn something new about our Trust, the communities we serve and, most importantly, the talented and committed people who work here. It has been a real privilege.

A particular highlight since my last update was welcoming His Majesty The King to York Hospital during his visit to the new Sir Robert Ogden Macmillan Cancer Support Centre. It was a proud moment for our Trust and for everyone who has worked so hard to bring this important project to life. As Patron of Macmillan Cancer Support, The King was visiting to celebrate a facility that will make a genuine difference to patients and families across our communities.

It is a wonderful example of what can be achieved when charities, partners and NHS organisations work together with a shared purpose.

I have continued to spend time with colleagues across a range of services and sites. During a visit to theatres in Bridlington, I had the opportunity to observe colleagues preparing for a shoulder replacement procedure. What stood out to me was the mutual respect and professionalism within the team. There was a real sense of people valuing one another's expertise and working together to deliver the best possible care for patients.

I have also spent time with a number of clinical teams, including colleagues working in hepatology, radiology, pharmacy, palliative care and our Parkinson's service. These visits reinforced the depth of expertise we have across the organisation, and the commitment colleagues bring every day to improving pathways, access and outcomes for patients. The willingness to innovate, adapt and continuously improve was evident in every team I visited.

This month also provided opportunities to spend time with colleagues who are supporting leadership development across the organisation.

I was delighted to attend the Scarborough Leadership and Management programme dinner and to join colleagues from Estates and Facilities at the conclusion of their 'One Team' leadership development session. In very different ways, both experiences reinforced the importance of leadership at every level of the organisation.

I also hosted another Senior Leadership Forum, bringing together more than 200 clinical and operational leaders from across the organisation. I always value these opportunities because they allow us to step back from the day-to-day pressures and focus on the bigger picture. I was particularly pleased that Sir Jim Mackey, Chief Executive of NHS England, joined us to discuss the opportunities and challenges facing the NHS nationally and to answer questions from colleagues. The discussion was open, honest and thoughtful, reflecting both the realities we face and the determination of colleagues to continue improving care for our patients and communities.

2. Planning update

We continue to meet with national and regional NHS England colleagues to discuss our financial plan. The message remains clear that we should work to deliver the current plan approved by the Board of Directors, given we are yet to reach a conclusion on the planning conversations.

Since our last Board meeting, Martin Barkley, Chair, Andrew Bertram, Finance Director, and I attended a national plan escalation meeting in London with Sir Jim Mackey, Penny Dash, NHS England's Regional Director and Regional Chair, along with other NHS England colleagues.

At the meeting, we discussed the action we are taking and the decisions we will need to make to ensure delivery of our financial plan and achieve plan compliance.

It is essential that we continue to focus our attention on the delivery of our Waste Reduction and Productivity (WRAP) programme, and deliver the plans we have committed to. We are continuing to work closely with Care Groups and Corporate teams to maintain a strong focus on WRAP delivery and expenditure, and we are being clear that we cannot overspend and must live within the resources available to us.

3. Resident Doctors' Industrial Action

Resident Doctors had planned a period of industrial action from 15 to 19 June. This was called off following further negotiations, and a new offer has been made, which the BMA has put to its members for a vote. We await the outcome and hope this may provide a route towards resolving the ongoing national dispute.

4. Bridlington Care Unit

As outlined in my report last month, The East Riding Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee convened an extraordinary meeting on 11 May where a number of concerns were raised regarding plans to close the Bridlington Care Unit. The Committee made a number of recommendations, and these were considered by the Board along with feedback from patients, colleagues, local residents and stakeholders, and has agreed to review the planned closure while further work is undertaken.

Over the summer, we will continue to 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 to provide safe, sustainable and high-quality care for local people, both now and in the future.

5. Bridlington Surgical Hub Optimisation Week

The Surgical Team at Bridlington Hospital joined more than 100 elective surgical hubs across England last month 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. Lord Mann Review

Earlier this month the Lord Mann Review into tackling racism and antisemitism within the NHS was published.

The report makes clear recommendations aimed at strengthening accountability, improving reporting and investigation processes, and embedding an anti-racist culture across the health system to ensure that patients and staff are better protected from discrimination and abuse.

We are reviewing the report and its detailed recommendations carefully and considering them alongside the work already underway through our Equality, Diversity and Inclusion action plans. Our response will then be considered by the Executive Committee and Board.

Creating a culture where everyone feels valued, respected, and able to be themselves at work is incredibly important, and must be a priority for us in ensuring the experience for all colleagues is a safe and positive one. This review provides a further opportunity for us to learn, reflect and continue building a Trust where everyone is treated with dignity and respect.

7. Recognising our long serving colleagues

This month we held our annual Long Service celebration events for both East Coast colleagues and those in York. The events celebrate colleagues with 25 or 40 years of service, and it is incredible to think of the many thousands of years of experience and dedication that these colleagues represent.

These events give us the opportunity to pause and recognise the extraordinary commitment, loyalty and contribution of colleagues who have dedicated so many years of service to our patients and communities. It was a real privilege to celebrate with these colleagues, hear their stories and say thank you in person.

Whilst the day-to-day issues we face can sometimes feel challenging, it is inspiring to see so many people who have chosen to dedicate their careers to meeting and overcoming these challenges for the benefit of our patients. Moments like these remind us of the depth of experience, commitment and values that exist across our Trust, and why it is so important that we take the time to recognise and celebrate them.

8. Star Award nominations

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

Date: 24 June 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

May 2026

Monika Wilamowska, Assistant Secretary **York** **Nominated by colleague**

Monika has always been supportive, polite, and friendly. I have been contacting Monika regularly with different requests, and she has always been amazing. Monika, thank you for your help and support. I love working with you.

Procurement Department **York** **Nominated by colleague**

During the last three months, there have been two significant nationwide procurement supply issues that could have caused significant challenges for the Trust. First, a supply interruption for bone cement, used for trauma and elective orthopaedic surgery and second, a Stryker Cyber Attack, which affected Stryker consumables, impacting several specialties, specifically in theatres and trauma and orthopaedic surgery.

The Trust set up a Trust Resilience Group (TRG) to oversee these business continuity issues, and the support provided by the procurement team has been invaluable. They have had to attend national meetings, change ordering practices, and support clinical teams in managing stock and ordering, identifying alternative products. They have attended all the meetings and provided information and expertise to guide decision-making. They have stepped in and supported clinical teams working closely with them to ensure we can maintain services.

These incidents affected all Trusts in the country, so this team have also had to support all providers across Humber and North Yorkshire during this period. I wanted to acknowledge their huge efforts and support. They have embodied the Trust values and have led with compassion, good humour, and a will to support colleagues in the best interests of patients. A specific shout-out to Jay and Nic, who have led a lot of the work and have had to attend multiple meetings on a weekly basis to support our teams. A huge thank you.

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

Throughout my time at the Trust, the Medical Illustration team has been an invaluable source of expertise, consistently supporting key clinical developments. The team has always demonstrated openness, a willingness to listen, and a collaborative approach in helping to develop high-quality clinical documentation.

More recently, I have worked closely with Robyn, who has consistently gone above and beyond to support the clinical team. She produces exceptional work, often within very tight timeframes, and her dedication has been instrumental in the success of several key transformational changes. This includes the recent update to the Deteriorating Paediatric Patients Monitoring and Escalation Policy. Without Robyn's contributions, particularly the development of the Deteriorating Paediatric Patient Escalation Pathway and pocket reference cards, these changes would not have been successfully implemented.

The team is a true asset to the Trust, and their expertise, professionalism, and commitment continue to make a significant impact on clinical practice.

Stores Team	**York**	**Nominated by colleague (1) and colleague (2)**

Nomination 1

I'd like to recognise the outstanding dedication and commitment shown by our store colleagues, especially during times when supply chain challenges have made their work more difficult. Despite delays, stock issues, and the frustrations caused when the supply chain has not delivered at the level needed, store teams have continued to show resilience, professionalism, and a strong focus on serving customers. They have adapted quickly, worked with what was available, and gone above and beyond to maintain standards in often difficult circumstances.

Their ability to stay positive, support one another, and keep the store running smoothly deserves real appreciation. While operational setbacks can create pressure at the store level, our colleagues' hard work and determination have helped protect patients' experiences and reflect the true strength of the team. This kind of dedication should not go unnoticed. Store colleagues are often the ones carrying the impact of wider business issues, and their effort, patience, and consistency make a real difference every day.

Nomination 2

The York Stores Team work incredibly hard in supporting York Hospital. They consistently go above and beyond to ensure that CG1 receives deliveries on time, which is a tremendous help and removes the need to chase urgent items. Nothing is ever too much trouble, and the team are always willing to assist whenever support is required.

Brian Pumfleet, Domestic Assistant	**York**	**Nominated by colleague**

I am nominating Brian for a Star Award because he consistently goes above and beyond his job role, and I hope he knows how appreciated he is by the colleagues on G1. Despite having his own tasks to do, he always tries to make other people's days a lot smoother, even if he is busy. Brian shows high levels of genuine care, teamwork, and pride in maintaining a safe, clean, and welcoming environment for patients and colleagues.

Although it is usually patient service assistants and healthcare support workers who clean beds when a patient is discharged, Brian never hesitates to step in before we get a chance to clean a bed. This is never an expectation from us, as he is also busy, and he does it for us so thoroughly, which is helpful during busy and demanding shifts, as it eases the pressure on us. His kind nature goes a long way, and he deserves true recognition for his hard work.

Bryony Alexander, Nursing Associate **Selby** **Nominated by colleague**

Following a phone call from an anxious patient on our caseload, Bryony calmly spoke with the patient to understand the symptoms they were experiencing. She actively listened and guided the patient to seek the correct support needed, reducing their anxiety. The patient trusted Bryony and responded positively to her advice, feeling comfortable sharing their symptoms. The patient made four telephone calls to Bryony, seeking reassurance at each stage.

The final phone call and information relayed to Bryony led her to advise the patient to escalate the 999 call to ensure a more rapid response. This ensured the patient was attended to by the right people at the right time and could be transported to the Emergency Department for the urgent care they required. Well done, Bryony, for supporting this patient on our caseload in such a calm, professional, and measured manner. You are a credit to your profession and our team. Thank you.

Ward 34 **York** **Nominated by colleague**

The entire multidisciplinary team on Ward 34 needs to be recognised for the incredible effort everyone made whilst caring for eight end-of-life patients over seven days. Despite the acuity of the other patients on the ward and continued operational pressures, the team provided kindness, compassion, and clinical knowledge to give the best care to these patients, advocating for their wishes and supporting their families.

The team showed incredible resilience and commitment and supported each other throughout a challenging week.

Sheena Campbell, Senior Healthcare Assistant **Bridlington** **Nominated by colleague**

Sheena was a lone passenger on a long-haul flight to visit family in Australia. She noticed at take-off that another lone passenger was looking confused, and she brought this to the attention of the air stewardess. The flight took off, but the other passenger's condition worsened, and they became agitated with confusion. Another passenger, an off-duty pilot, was alerted to the situation by Sheena and assisted Sheena in reassuring the passenger.

Sheena moved seats to try to contain the passenger, as they wanted to wander around the plane. She encouraged food and fluids after explaining to the staff that she worked as a healthcare assistant. She spent the whole flight looking after this passenger, who repetitively showed signs of confusion. At one point, they tried climbing over the seats to escape from her and the pilot, at which point Sheena and the pilot had to restrain them to prevent injury to the passenger, themselves, and other passengers. The passenger sustained a minor injury, and Sheena obtained a first-aid kit from the airline crew to clean and dress the wound.

I understand this incident was away from the workplace and that I don't have all the facts, but I feel Sheena should have some recognition for her actions over several hours, thousands of miles in the air. The airline spoke to Sheena on landing, and she had to make a statement to them. This behaviour is typical of the Sheena we all know and love in our outpatient department. She is like a mother hen to everyone and always goes the extra mile, but this was exceptional.

Jenifer Simpson, Healthcare Assistant | **Scarborough** | **Nominated by colleague**

Our team has noticed Jen's amazing attitude towards our patients on multiple occasions. Big, bright smiles, kindness, jokes, and just taking that extra couple of minutes to make our patients feel seen and cared for. Keep doing what you're doing, Jen, you're fabulous!

Ann Rose Sony, Staff Nurse | **York** | **Nominated by colleague**

Ann Rose is a kind and caring person on Ward 36. She is always happy to help and asks colleagues and patients if they're OK. I was a domestic on Ward 36, and it was a pleasure to meet such a nice and caring person. Thank you, Ann Rose, for all you do.

Beech Ward | **Scarborough** | **Nominated by colleague**

I am nominating Beech Ward for the outstanding care they have recently provided to one of our respiratory patients. This patient had complex communication needs and exhibited challenging behaviour at times. The entire ward staff cared for them with kindness and empathy. They went the extra mile in every way possible to ensure the patient felt comfortable and safe in an unfamiliar environment. Highly sensitive to the patient’s needs, the staff constantly adapted the care they provided to ensure the patient was expertly looked after. They looked after them so well that we no longer need to refer the patient onwards for any further respiratory care! This is a hard-working team that proudly displays the Trust values in everything they do and is highly deserving of this award. We are grateful for the exceptional care they provide for all our patients. Thank you!

Lyn Clegg, Ward Clerk and Digital Champion | **Scarborough** | **Nominated by colleague**

I am nominating Lyn for a Star Award in recognition of her outstanding contribution as a Digital Champion. Lyn has fully embraced the role, consistently going above and beyond to support the successful adoption of Nervecentre EPR. She has been a visible and enthusiastic advocate, proudly wearing her Digital Champion t-shirt and inspiring others to get involved. Her energy and positivity have helped build momentum across teams during a critical period of change. She has played a key role in rallying colleagues to register as floorwalkers, ensuring strong support is in place for go-live.

Lyn has actively shared updates and important information, helping to keep everyone informed and engaged. She has also provided hands-on support to colleagues, guiding them through helping colleagues on the system and building confidence in using Nervecentre EPR in practice. Lyn has demonstrated a strong commitment to learning and improvement by attending all briefings, actively participating, and asking insightful questions that benefit the wider team. Her proactive approach has helped identify and address potential challenges early.

In addition, Lyn brought creativity and team spirit by creating a countdown to go-live in MS Teams chats, helping to generate excitement and maintain focus as the milestone approached. Lyn’s dedication, enthusiasm, and willingness to support others have made a significant impact on the success of the digital programme. She truly embodies the values of a star performer and is highly deserving of this recognition.

Ruth Rodgers, Specialist Midwife – Antenatal **York** **Nominated by colleague**

I am nominating Ruth Rodgers, a midwife whose compassion, commitment, and determination have fundamentally shaped Rainbow services for those patients who experienced a previous pregnancy loss across York and Scarborough hospitals. Ruth has a deep passion for bereavement care and for improving the experience of women who become pregnant following previous loss. This is not just an area of interest for her; it is something she has actively transformed through sustained personal commitment, often in her own time and beyond her role.

In 2023, we jointly founded the Rainbow Clinic with no dedicated funding, driven entirely by goodwill and a shared recognition that families needed more structured, compassionate, and consistent support. Ruth's contribution went far beyond clinical input. She proactively visited the Manchester Rainbow Clinic with me to understand established models of care and then used her own time to explore, develop, and secure the necessary management pathways to make the service viable in our own trust. Through her persistence and belief in this service, we were able to establish the Rainbow Clinic locally across York and Scarborough hospitals, ensuring that patients can now access specialist support closer to home at a time when travel and uncertainty can feel overwhelming.

The impact of this work has been profound. Patient feedback consistently highlights not only the value of having a dedicated Rainbow Clinic, but also the difference Ruth herself makes. Families repeatedly describe her care as reassuring, compassionate, and unwaveringly supportive during a deeply vulnerable stage of pregnancy. Her presence brings calm and confidence where there is often anxiety and fear.

What stands out most is Ruth's dedication of time and emotional energy without expectation of recognition. She has helped build something from nothing, translating an idea into a sustainable, meaningful service that continues to grow and support families in need. Ruth exemplifies what it means to be an outstanding midwife: clinically capable, emotionally intelligent, and relentlessly committed to improving care for women and families. She is thoroughly deserving of this Star Award.

Selby Inpatient Unit **Selby** **Nominated by colleague**

I am nominating Selby IPU for a Star Award in recognition of the consistently outstanding care that they give patients during end-of-life care. Colleagues demonstrate exceptional kindness and compassion at every stage. They always go above and beyond to ensure that patients are comfortable and treated with dignity and that families feel supported during a difficult time.

The impact of this care was reflected in an email that we received from a patient's son, who wrote to say: "My mother was admitted to your ward, and from the moment she arrived, her care has been nothing short of outstanding. As a family, we will never be able to thank you all for what you did for her. Every member of your team has shown nothing but kindness and compassion. On behalf of our whole family, please pass on our immense gratitude to your entire team".

This feedback highlights not only the clinical excellence provided but also the genuine compassion provided by the whole team. This level of care embodies the values of our Trust, and I believe it fully deserves recognition with a Star Award.

Robert Hitchman, Patient Admin Officer **York** **Nominated by colleague**

Robert is an outstanding member of the Ophthalmology Admin Team. He is approachable, friendly, knowledgeable, and always happy to help with booking complex appointments. I have seen him communicating with patients attending the Ophthalmology clinic, and he goes above what is expected of his role, putting patients at ease and giving them clear, concise information. He is a perfect example of demonstrating the Trust values consistently and shows excellence in his work. I have seen Robert confronted with a challenging situation, which he approached with a calm, polite manner. It is always a pleasure to approach Robert; what an outstanding colleague.

Shane Tyssen, Materials Management Officer **York** **Nominated by colleague**

Shane stocks up our ward with all our supplies. He does a great job. We hardly ever run out of anything. And if we have, he normally already has it ordered before we ask. He is always helpful. If I email him, he will always respond. If there is something the ward needs, he will try to source it for us. I want to tell him that what he does is appreciated. There are jobs in the Trust where colleagues often go unnoticed, and this is one of those jobs. Thank you, Shane, for keeping our wards running smoothly.

Saira Waheed, Trust Doctor O&G **York** **Nominated by colleague**

A vulnerable young teenager presented acutely with their mother to the Paediatric Emergency Department. They were new to the country, seeking asylum, and although they had recently located to York, they were expecting to move to a new city again in a few days. Being able to speak the family's first language fluently, Saira kindly reviewed her.

Although attending with an acute problem, the child and their mother became illuminated while speaking with Saira, and it was clear that they developed a strong rapport. Saira was able to reduce some of the barriers this mother faced in seeking care for her child and reassure her. She gave them an ongoing plan and copies of relevant information to take with them to facilitate further care in their new city. I do not doubt that Saira's warmth and kindness made an enormous positive difference to this child and her mother navigating their new life in the UK.

Maria Liversidge, Parkinson's Disease Physiotherapist Clinical Lead **York** **Nominated by colleague**

Maria is an integral part of the elderly Parkinson's multidisciplinary service. We receive constant positive feedback from our patients who want to show their gratitude for the support and care they have received from Maria. She uses her clinical knowledge and experience to support people with Parkinson's to gain a level of independence and take ownership of their condition.

Maria's invaluable work also keeps people out of hospital due to her ongoing intervention. She was pivotal in setting up links with various community services that highlight patients at risk of admission. Her expertise also supports patients in a hospital setting to push towards a timely discharge.

Maria is always considering innovation in her daily practice and strives to support the improvement of the Parkinson's service. She takes the time to listen to the patient voice by attending stakeholder meetings to find out what works for them. Maria is a source of encouragement to her colleagues and always makes time for the people around her. She's a star!

Joseph Nash, Consultant **York** **Nominated by colleague**

We brought a patient with Creutzfeldt-Jakob Disease to the Emergency Department. The patient had a sudden deterioration at home and attended the department with their partner. Joe came to take our handover and showed outstanding compassion towards the patient's partner, who was suffering from carer's burnout and understandably concerned for their partner. The empathy shown by Joe and his courtesy and professionalism towards us as a crew were exceptional and should be applauded. Thank you!

Sophie Ruszczynski, Cancer Pathway Coordinator **York** **Nominated by colleague**

Sophie runs the head and neck (H&N) and thyroid multidisciplinary teams. She works under continuous high pressure, never makes any mistakes, and tracks patients in a way that is indispensable to the H&N team. She proactively tracks referrals via the fast-track system, rearranges appointments and generally acts in a way that considerably improves the fast-track service and progression of patients rapidly through the system.

I nominate Sophie every year because she does her job in an incredibly diligent way, and patients are never aware of just how much she does for them. She goes far above the usual level of service in this role, with big benefits to our patients.

Martin Cook, PACS Support Officer | **York** | **Nominated by colleague**

Martin is brilliant and is just on it! I send him image requests, and he gets back to me in minutes, even providing updates on the delivery of images. The PACS team does not receive enough credit for the essential work they do and how efficiently this work is done. However, it is Martin who stands out to me. He's always cheery and happy to help, and his emails always entertain me with his mention of what national day it is, a welcome difference to the usual formal types of emails I receive. Martin's energy and effort are appreciated. The work that the PACS team do cannot be disputed as anything less than essential for ensuring sufficient patient care.

Samantha Jennings, Staff Nurse | **Scarborough** | **Nominated by colleague**

I have worked with Sam on a few occasions, and she is a wonderful nurse, even under pressure. She speaks to her patients with kindness and empathy, with a soft manner. She explains to the patient exactly what she is doing before she does anything. I have witnessed Sam working under extreme pressure with three poorly patients and having to put a crash call out, but she remained calm and professional.

Healthcare Academy Facilitators | **York** | **Nominated by colleague**

This team has been kind and caring during training. Not only have they delivered great training, but they have also made some of the practical training fun for all the healthcare support workers. They have had other colleagues doing some training at the academy who have given their training to all healthcare support workers, making sure we all follow the training correctly.

I've done different training in different roles before. This academy has been different, interesting, and one I've enjoyed the most. If I were to meet any new healthcare starters, I would tell them to enjoy their training. Thank you to the academy team for delivering all the training you gave me and the rest of the healthcare support workers during the three weeks at the academy. I will be taking my new skills and knowledge to the ward I’m based in.

Rabia Ilyas Gill, Healthcare Assistant | **York** | **Nominated by colleague**

I am nominating Rabia in recognition of the outstanding dedication and commitment she consistently demonstrates. All her hard work, professionalism, and positive attitude make a meaningful impact on our department every day.

Rabia not only delivers high-quality results, but she also embodies the core values we strive to uphold: collaboration, integrity, and a strong work ethic. She always goes above and beyond to support her colleagues, contributes to a positive team environment, and approaches every challenge with determination and care. Her contributions do not go unnoticed, and she is truly deserving of this recognition.

Sharon Wardle, Advanced Nurse Practitioner | **Malton** | **Nominated by colleague**

Sharon’s actions with a young patient went above and beyond.

Jonathan Dilly, Consultant in Anaesthetics **York** **Nominated by colleague**

As part of a broad sustainability initiative to tackle the environmental and cost issues of using piped medical gases, I am nominating those involved with the project to decommission piped nitrous from the Trust. This initiative has not only brought tens of thousands of pounds in savings but also saved hundreds of thousands of litres of nitrous oxide from leaking into the atmosphere. Working to find a portable cylinder solution, all users of piped nitrous, suppliers, and funding to take this initiative forward are examples of the work required to deliver this initiative.

The drive, determination, and positivity of colleagues who were key to delivering this initiative are exemplary examples of Trust employees and a wonderful example of cross-departmental working between the Anaesthetics, Estates, Medical Engineering, Pharmacy, and Sustainability teams. Their work and support, and for seeing this over the line, make them more than deserving of a Star Award, in addition to my grateful thanks. Now starting to work on piped Entonox!

Richard Exelby, Senior Medical Engineer **York** **Nominated by colleague**

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Daniel Wise, Consultant in Anaesthetics **York** **Nominated by colleague**

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Darren Carmichael, Equipment Library Team Leader **York** **Nominated by colleague**

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

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

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Nihal Abdu, Consultant in Obstetrics and Gynaecology | **Scarborough** | **Nominated by colleagues**

We are nominating Ms Abdu for a Star Award in recognition of her exceptional dedication and consistently going above and beyond for both her colleagues and the wider team. Ms Abdu embodies the true spirit of teamwork and professionalism. She is always the first to step forward when support is needed, willingly volunteering to cover shifts, often at short notice, and even coming in on her days off to ensure the team continues to run smoothly. Her reliability and selflessness make a tangible difference to everyone around her.

What truly sets her apart is not what she does, but how she does it. No matter how busy or challenging the situation, she approaches every task with a positive attitude and a genuine smile. She never complains and consistently maintains a calm, supportive presence that boosts team morale. Her willingness to help others, combined with her upbeat attitude, creates a culture of trust, collaboration, and positivity. She is a role model within the team and someone others naturally look to for support and inspiration. For her unwavering commitment, positive outlook, and exceptional teamwork, we strongly believe Ms Abdu is a truly deserving recipient of this award.

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

Beth is an exceptional Healthcare Assistant who consistently goes above and beyond her role. She demonstrates genuine compassion in every interaction, always treating patients with dignity, kindness, and respect.

In emergencies, Beth remains calm and focused under pressure. She supports doctors efficiently by preparing and managing equipment, while also providing comfort and reassurance to both the child and their parents. Her ability to care for not just the patient, but the whole family during distressing moments, makes a profound difference.

Beth is always willing to step in wherever needed, supporting her colleagues without hesitation and helping the team run smoothly, even during the busiest shifts. Her positive attitude, reliability, and dedication make her an invaluable member of the team. Beth truly embodies compassionate care and professionalism, and she is highly deserving of this Star Award.

Nick Doughty, Operating Department Practitioner | **York** | **Nominated by colleague**

Every day, Nick demonstrates the core values of our Trust to the highest standard. He is a credit to the department with how he cares for his patients with kindness, patience, and reassurance. For the most anxious patients, especially those having procedures done under local anaesthetic, he is always there to offer a hand to hold, a chatty conversation, and dedicated care that puts patients at ease and helps them through their experience of surgery.

Nick is knowledgeable and is often around to help and support junior colleagues with a friendly smile and non-judgmental attitude. He has supported many students on their journeys to becoming ODPs.

Lyn Hughes, Catering Supervisor | **York** | **Nominated by colleague**

I have lactose Intolerance, and cannot have milk, cream, or cheese. I must be careful when I eat at Ellerby's, as if I eat something with lactose in it, I am very unwell afterwards. Lyn kindly answers any questions I have about whether milk has been added, such as in the scrambled eggs and soups. If she does not know she always goes and asks her colleagues, which I appreciate greatly. Last week, I was about to take a serving of vegetable soup when she came over and told me that the soup contained cream, as she had remembered that I cannot have dairy. She saved me from several days of very unpleasant symptoms and pain, for which I am grateful!

Ross Morton, Outpatient Co-ordinator | **Scarborough** | **Nominated by colleague**

Ross went above and beyond for a patient who had attended a clinic at Scarborough Outpatients Department. They had unfortunately left home early in the morning without breakfast or their morning insulin. The patient also needed to wait until late in the afternoon for transportation home via Medibus. Ross was contacted by the team to support them with the situation. He facilitated alternative transportation with Patient Transport Service and worked with colleagues in Outpatients to support the patient until they could be transported back home safely. Ross demonstrated the highest Trust values of kindness and excellence.

Sallie Whitson, Personal Assistant | **York** | **Nominated by colleague**

Sallie is a warm-hearted, kind, and supportive colleague who has been committed to the NHS for several years! She works tirelessly to ensure the smooth running of the Executive functions, always going above and beyond for the Trust. Sallie has been particularly helpful and supportive to me, and for that, I am forever grateful.

Daniel Lopez Ortega, Deputy Team Leader | **York** | **Nominated by colleague**

Daniel continually goes above and beyond for members of his department and workplace. He is always approachable and is an asset to the Trust.

Karolina Basan, End User Platform (365) Administrator | **York** | **Nominated by colleague**

Karolina went above and beyond to support me at short notice during a fast-moving situation where support and information needed to be shared with colleagues quickly. I was struggling to implement a solution and reached out to her for advice. Karolina responded promptly, and we arranged a call at the earliest opportunity. She put aside her own work to support me, introducing an AI tool and communication solution that enabled me to manage a pressured situation effectively.

She approached this with exceptional speed, friendliness, and genuine support, which made a real difference. Karolina's actions demonstrated true collaboration and commitment, and her support had a significant positive impact at a critical moment.

Sarah Waites, Deputy Team Leader, Nicola Fox, Theatre Support Worker, Alison Frobisher, Staff Nurse, Megan Ahulia, Operating Department Practitioner, Dare Oloadokun, Consultant in ENT, Olorunleke Arokoyo, Trust Grade Doctor, Andrew Horne, Consultant in Anaesthetics, and Alexander Dunn-Roberts, Specialty Registrar	**York**	**Nominated by colleague**

The Theatre 5 ENT team on 8 May worked extremely hard to facilitate not only the surgery and care of their elective patients but also two additional acute cases, including staying after their shifts had ended to ensure the patients were all safe. Together they worked amazingly to ensure that the theatre ran efficiently so all patient surgeries were carried out safely and promptly. As a team, they demonstrated excellent communication throughout the day, ensured each other felt supported, and helped each other constantly.

Not only that, but even in the more challenging moments, they all continued to smile and find time for a laugh to keep up the motivation and positive working environment. Their dedication and hard work were clear throughout the day and can be seen in everything they achieved, especially those who were also on-call and had to coordinate patient care across the hospital at the same time. Well done team, another super star effort by all!

Thomas Lang, Pathology Information and Systems Manager	**Hull Royal Infirmary**	**Nominated by colleague**

Tom's assistance in supporting St Leonard’s Hospice with its new SystmOne ICE interoperability has been greatly appreciated. He consistently made time to provide clear guidance and instruction, ensuring the setup process was smooth and liaising with additional parties went well.

His approachable manner, patience, and willingness to provide help for our small organisation created real confidence within my team that we were being looked after, making a complex implementation feel manageable and well supported. His support will make a real, tangible difference to our clinical users on the inpatient unit and our delivery of patient care. Thanks, Tom!

Barbara Mansfield, Radiology Service Administrator	**Scarborough**	**Nominated by colleague**

Barbara supported me while I was going through a tough time at the beginning of this year. Her care and support helped me immensely. Barbara upholds the Trust values, and I thank her for her support.

Michelle Hepples, Radiology Service Administrator | **Scarborough** | **Nominated by colleague**

Michelle supported me when I was going through a hard time at the beginning of the year. She demonstrated the Trust values.

Sue Smith, Volunteer | **York** | **Nominated by colleague**

Sue was quick and efficient when reporting the emergency to Main Reception (crash call) and stayed with the patient until the crash team arrived. Sue was volunteering at the Main Reception at the time. Truly a wonderful individual to work with.

Michal Sladkowski, Advanced Pharmacist - Oncology | **York** | **Nominated by colleague**

The Breast Care Nursing Team are nominating Michal because he is a fantastic clinician who strives to ensure all patients get the best possible information and support while undergoing systemic anti-cancer treatment. He is always willing to go the extra mile to ensure patients feel supported and can access care when they need it.

For example, he recently travelled to Scarborough Hospital to review a patient face-to-face who could not travel to York for a review. This was hugely appreciated by the patient and the nursing team supporting them. He is keen to speak at patient support groups, and they always benefit from his knowledge and enthusiasm. He is a great asset to the team, and we (in the CNS team) value his tolerance of our repeated questions, his quick responses when we are looking for drug information, and his willingness to share his amazing knowledge. He is an all-around amazing person, and we feel lucky to work alongside him. Thank you, Michal.

Kate Adamson, Assistant Admin Coordinator | **York** | **Nominated by colleague**

Kate is the admin support to child health, and to us, senior nurses, she is invaluable. From HR processes to support for clinical presentations and room bookings, Kate is there and gets it done. She excels in her work and does it quietly and efficiently, often behind the scenes. Always so positive and smiling, she is a pleasure to work with. She is the definition of a star and deserves to be recognised.

Joan Clancy, Consultant in Emergency Medicine | **Scarborough** | **Nominated by colleague**

Dr Clancy, as well as being a busy Consultant in Emergency Medicine, is one of our medical appraisers. Joan is one of the first to volunteer when the Medical Director's Team need to arrange an appraisal at short notice. This is greatly appreciated and demonstrates the Trust values.

Amanda Burchett, Ward Sister **Scarborough** **Nominated by colleague**

Amanda Burchett always goes the extra mile. She has been covering another colleague's role on top of her own roles. She has supported and advised the NICOR coordinator and me, despite being busy. She leads by example, and we are fortunate to have her as a team member at the Trust.

Amy Stones, AHP Clinical Educator **York** **Nominated by colleague**

I am nominating Amy Stones for a Star Award because she is quite simply a fantastic person to work for. Amy is incredibly kind and patient, and she always takes the time to be supportive and understanding, no matter how busy things get. Her professional approach and genuine nature make a huge difference to our daily work. The PDET team and the NHS are lucky to have her, and I'd love to see her recognised for the lovely person she is.

Pema Dema, Domestic Assistant **York** **Nominated by colleague**

Pema cleans the Paediatric ED and is an amazing colleague. Nothing is too much trouble for her when the department is busy. Pema demonstrates the Trust values when working with colleagues and patients in this area and is always smiling. She is quick to act when cleaning is needed and makes sure the areas are cleaned to high standards. I would like Pemma to know this award is to show appreciation for the hard work she does and a way to say thank you.

Katharine Bowden, Senior Administrator **York** **Nominated by colleagues**

Where do we start? Kate has worked within Outpatient Services for over seven years. Just a little over three years ago, Kate stepped up to be one of our Office Seniors. She has shown such kindness and support to every member of the team and to our new starters.

Kate doesn't mind getting her hands dirty, too! Kate's often found on the floor under desks, working out where computer cables go, trying to help all of us fix monitors, keyboards, etc., and is always willing to try and solve any IT issues that arise within the office. Kate has supported the deputy service managers and service managers daily, also stepping into these two roles within the office when needed to help the office run smoothly, constantly helping with staff rotas and putting together a SOP for our IPT role within the office. She problem-solves daily. When we are short on staff, Kate has juggled the office tasks, making sure that all the important tasks are covered.

Kate encourages every individual within Outpatient Services, constantly building the confidence of colleagues by training and helping them wherever she can, dropping her own duties and tasks to help others. Kate is a person who gets on with the job quietly behind the scenes, without fuss or taking credit. You will find her on her days off, jumping in to volunteer wherever possible to work overtime.

Kate will continue to be a valuable member of the team at York Hospital as she moves forward in her new role and new department. She demonstrates the Trust values of kindness, openness, and excellence through every task and every support of confidence that Kate delivers. This is why we feel this Star Award is very much deserved. Thank you!

Lucy Wood, Specialist Occupational Therapist | **Scarborough** | **Nominated by colleague**

A patient recently presented to the Emergency Department in Scarborough because of a major incident involving a gas explosion. The patient had a learning disability, was profoundly deaf, and only communicated via British Sign Language (BSL). The patient's brother, who was her main carer, was seriously injured in the incident. I attended as an Autism Liaison Practitioner (covering the on-site Learning Disability Service on this day) to offer support to the patient and family and set up a hospital passport. Unfortunately, the family members present had little knowledge of BSL, so communication was difficult. I had previously worked with Lucy and knew she had worked with people who were deaf and could communicate via BSL, so I enlisted her help. This was initially only to establish consent, with the intention of working with the family to complete the hospital passport.

Lucy was keen to help, and from the moment she introduced herself in BSL, the patient's face lit up. A full conversation then took place, and with Lucy's help, we completed the hospital passport, establishing that the patient was craving a chocolate biscuit and a Diet Coke, which we sourced for her. Lucy's interaction did not stop there. The fire brigade arrived, and Lucy worked with them to communicate with the patient. Thankfully, the patient was not seriously injured and was medically fit for discharge. Lucy helped with the discharge planning, utilising both her sign language skills and her knowledge of complex discharges as an OT to help plan for the patient to go back to one of her family's homes to be supported. Finally, just as the patient was about to leave, the police arrived, and Lucy came back to help communicate between the police and the patient.

Overall, this was a wonderful example of how making reasonable adjustments and good, clear communication can make a world of difference to a patient's experience of the ED, especially after such a traumatic incident. Both the patient and her family were incredibly appreciative, as was I, for all her help and support.

Nicola Lloyd-Jones, Lead Diabetes Nurse | **York** | **Nominated by colleagues**

We are nominating our unit lead for a Star Award in recognition of her outstanding support and leadership. Nic has supported the healthcare team through a difficult period, despite the pressures she faces daily. Not only has she gone above and beyond to solve the issues the healthcare team were facing, but she has also created a positive and supportive work environment for us where we felt listened to and encouraged. She has gone above and beyond when dealing with our recent challenges, and we feel her hard work and commitment deserve to be recognised.

Deborah Barrett, Community Directorate Secretary | **Selby** | **Nominated by colleagues**

Deb is our Team Leader, and she needs recognition for being a fantastic person and manager. Deb is always ready to listen and to support us with our daily work. Deb currently manages 20 colleagues across two teams and is never too busy to help and guide her colleagues. Deb is naturally kind and caring and will always find a way to support colleagues' wellbeing. We have worked for Deb for at least 10 years and have experienced difficult transitions within this period, while Deb has been consistently supportive and committed to her Team.

Mark Sellars, Scanning Services Administrator | **York** | **Nominated by colleague**

Mark is an amazing person who has been an absolute star. I have a few personal problems, and Mark has been so supportive and is always on hand if I need help. Coming to work knowing Mark is here to help and support me is such a relief. We work well as a team, and I would be lost without his kindness and support.

Kieran Duncan, Staff Nurse | **Scarborough** | **Nominated by colleague (1) and colleagues (2)**

Nomination 1

I am nominating Kieran for the incredible support he has provided throughout the implementation of Nervecentre. Kieran has consistently gone above and beyond, even coming in on his days off to ensure colleagues received the teaching and support needed during this period of change. He has always been patient, approachable, and kind while sharing his knowledge and helping colleagues build confidence in using the system. His dedication and commitment have had a huge positive impact on the team.

I genuinely feel that without Kieran's support, we would not have been able to implement the changes as effectively and smoothly as we have. Kieran's willingness to help others and his positive attitude throughout have been greatly appreciated by the whole team.

Nomination 2

We are nominating Kieran for a Star Award in recognition of his outstanding support and patience during the rollout of the new Nervecentre system. Throughout the transition, he has consistently gone above and beyond to help all colleagues understand and use the new system confidently. No matter how busy things became, he remained approachable, calm, and patient, always taking the time to explain processes clearly and give reassurance where needed.

What stood out most was his willingness to support others, even volunteering to come in on his days off (one of which was his birthday) to help new colleagues who hadn't used the system before. His commitment ensured colleagues felt supported and confident, making a real difference to both colleagues and patient care. His positive attitude, professionalism, and teamwork have been greatly appreciated by everyone he has supported. Kieran has truly demonstrated exceptional dedication and is highly deserving of this recognition.

Breast Screening Admin Team | **York** | **Nominated by colleague**

I am nominating the Breast Imaging Administration Team for this Star Award due to their outstanding commitment over the past few weeks. Despite vacancies and staff sickness, the team has worked hard, remained flexible, and ensured the service continued to run smoothly. Their dedication has been exemplary, with Alison even coming in on her day off to provide additional support.

Casey Arnott, Senior Sister **Scarborough** **Nominated by colleague**

I am nominating Sister Casey for a Star award in recognition of her outstanding quick thinking, leadership, and professionalism during a medical emergency in the ED car park. When a patient collapsed in a car, she responded immediately, assessed the situation calmly, and promptly commenced CPR. She gave clear, confident instructions to those around her, ensuring effective teamwork and rapid escalation of care. Her quick decision-making and ability to remain composed under pressure demonstrated exceptional clinical skills and compassion, giving the patient the best possible chance of recovery.

Imola Bargaoanu, Consultant in Elderly Medicine **Scarborough** **Nominated by colleague**

I am nominating Dr Bargaoanu for a Star Award for her exceptional dedication and advocacy for patients. She consistently goes above and beyond to ensure patients receive the best possible care, working tirelessly to remove barriers and coordinate support across teams. I have witnessed multiple occasions where she has stepped in to problem-solve difficult situations, always putting the patient first and advocating strongly on their behalf. Nothing is ever too much trouble for her, and her compassion, professionalism, and determination are admirable.

Practice Development and Education Team (PDET) **York** **Nominated by colleague**

Since PDET was established on 1 April 2025, the team has come together to build strong working relationships and make a meaningful difference across the Trust. They bring a huge amount of skill, knowledge, and experience, all focused on supporting our workforce through education, building competence, and, importantly, building confidence.

They play a key role in welcoming new colleagues into the organisation through well-structured induction programmes for both registered and unregistered colleagues. The team ensures people feel prepared for their roles and supported from day one, helping them to deliver safe, high-quality care. PDET also delivers a wide range of clinical skills education, including in-situ training and hands-on support in clinical areas. They are visible, approachable, and always willing to help. Their work in developing and embedding the Professional Nurse Advocate (PNA) role has given colleagues valuable opportunities to access restorative supervision, as well as career support and guidance.

The team also supports the large number of students on placement within the Trust, helping them develop the skills and confidence they need as they begin their journey into clinical practice. This continues through the Trust-wide Preceptorship Programme, where newly qualified colleagues are supported as they transition into their roles, both clinically and personally. They contribute to the safer staffing agenda by providing oversight and support to teams, helping to maintain safe and effective staffing levels. More recently, they have supported international nurses joining the organisation, while also strengthening support networks and development opportunities for global majority colleagues. PDET also delivers important training around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), supporting clinical teams to care safely for some of our most vulnerable patients. Over the past six months alone, the team has delivered training to more than 3,000 colleagues.

However, this only tells part of the story. In day-to-day practice, they are responsive, flexible, and always willing to adapt to meet the needs of the Trust. Behind the scenes, their work is supported by a dedicated administrative team, who are essential in keeping everything organised and running smoothly. Overall, the PDET team consistently supports staff development and helps maintain high standards of care across the organisation. Their contribution is wide-reaching and makes a real difference, making them very deserving of this recognition.

Gayle Desa, Sister - Orthopaedics **Bridlington** **Nominated by colleague**

Gayle is an exceptional manager. I appreciate her outstanding support and leadership. She is always approachable, helpful, and genuinely willing to listen whenever support or guidance is needed. I admire her positive attitude and open communication. She consistently goes above and beyond to support her colleagues, making everyone feel valued and heard. Her dedication, professionalism, and caring nature truly make a difference, and she is highly deserving of this recognition.

Eve Bannister, Midwife **Malton** **Nominated by colleagues**

We are nominating Eve for a Star Award in recognition of the outstanding contribution she has made to our team and the wider maternity service. Eve is an early-career midwife currently working as a rotational midwife during her preceptorship period. Since joining our Malton-based community team earlier this year, she has quickly become a valued and respected member of the team.

Eve consistently demonstrates professionalism in her work, showing kindness, respect, and compassion in her interactions with both colleagues and service users. Eve is proactive in her approach, always willing to learn and develop, and regularly offers support wherever it is needed. Her positive attitude and strong work ethic make her a pleasure to work alongside, and she embodies the Trust values of kindness, openness, and excellence in everything she does.

We would particularly like to highlight how Eve has gone the extra mile over the past few weeks. Due to staffing pressures and increased demand across services, our team has been required to support other community teams across the organisation. During this time, Eve has shown exceptional commitment and flexibility, travelling across Scarborough, Whitby, and Bridlington without hesitation to ensure that service users continued to receive high-quality care. Despite the additional travel and demands, Eve has remained positive, professional, and dedicated, consistently prioritising the needs of women and families. Her willingness to step in and support wherever required has made a real difference to both patients and colleagues during a challenging period.

Eve is an asset to our organisation, our team, and the maternity service users across our region. We have thoroughly enjoyed having her as part of the Malton Community Team and wish her every success as she moves on to her next rotational placement. Well done, Eve, and thank you!

Adam Brook, Consultant in Gynaecology **Scarborough** **Nominated by patient**

I first met Mr Brook a few years ago after having issues after having my son. I have suffered badly with pelvic pain, prolapses, and nerve pain. Mr Brook has performed surgery on me twice now and is still helping to get me referred to the physio and communicating with my GP surgery to advise on what may help me, such as medication, creams, and exercises. I have had a tough few years and have felt like I have been understood and supported by My Brook. He is a great doctor, and even though he is busy around the hospital, he still finds the time to follow up with his patients.

Kimberley Fernandez, Midwife, and Zoe Jack, Student Midwife **York** **Nominated by patient**

After having a previous shoulder dystocia birth, which caused so much anxiety around birth, Zoe and Kim were absolute angels sent from heaven. They didn't leave my side for my whole labour and successfully helped me have the birth I'd always wanted! They listened to my wishes, and we had a lovely chat, including explaining everything in major detail so I could make the right informed choices. They made my birthing experience amazing. Such caring, compassionate human beings, thank you!

Josie Mewburn, Midwife **Scarborough** **Nominated by patient (1) and patient (2)**

Nomination 1

Josie saw me multiple times when I came to triage due to reduced movements, and each time she reassured me. Due to having so many different issues throughout my pregnancy, it was a stressful time. After seeing a consultant, they said I'd need a C-section at 39 weeks due to the baby being breech, but when I came in for my 15th episode of reduced movements, Josie spoke to a doctor, and they agreed that my baby should be delivered at around 37 weeks. Josie got it booked and sorted that day, so the following week, my little girl was born healthy and tiny. She was small, but she was here safe!

Thanks to Josie, my baby was here, happy and healthy. Josie advocated for me when I felt like no one was listening.

Nomination 2

Josie came on shift around an hour or so before I gave birth, and she was amazing. She was so attentive and listened to me when I expressed concerns or had questions. She delivered my baby boy, and her care after the birth was impeccable. She took care of my stitches, helped my partner dress our son, and made the experience calm.

She noticed our boy had a tongue tie and went out of her way to get this sorted before we left the hospital, updating us when we were on the regular ward. When I think about my birth story, Josie is a massive part of it for me, and I hope I'm lucky enough to cross paths with her if I ever have any other children.

Megan McCarthy, Midwife **York** **Nominated by patient**

Megan was one of the midwives who looked after me recently during the birth of my daughter. Unfortunately, the birth was difficult, but Megan supported me throughout. I had to go for an emergency C-section, and even though Megan's shift had ended, she stayed with me. As someone who is very anxious, her kindness to stay and support me didn't go unnoticed.

Abigail Bell, Healthcare Assistant **York** **Nominated by patient**

I wanted to say thank you to Abi on the Day Ward who looked after me after my procedure. She made such a huge difference to me at a time when I really needed it. I was anxious, my heart rate was high, and I felt like I was going to have a breakdown. I was scared, overwhelmed, and not coping well at all. On top of that, I was dealing with bleeding and just felt completely out of control. Abi was so calm, kind, and reassuring. She spoke to me in a gentle way and stayed with me while I was panicking. I could feel my heart rate coming down just from her talking to me and helping me feel safe again.

At the time, I genuinely thought something awful was happening to me, and she didn't dismiss that; she just supported me through it in such a caring and understanding way. I honestly feel like without her, I would have spiralled so much more after everything that day. She grounded me and helped me through a moment where I felt desperate.

I'm so grateful to her. She is exactly the kind of nurse you hope to have when you're at your most vulnerable, and I hope she knows how much of a difference she made to me. I will remember her forever for the kindness she showed me. Thank you for everything.

Chris Ruddock, Staff Nurse **York** **Nominated by patient**

I had surgery, and Chris was the nurse who looked after me when I woke up. We had a bit of an emergency because when I woke up, I was having a hypo, and my blood sugars were low. The way Chris handled the situation was amazing, trying to keep me awake to get glucose into me, physically feeding me, and helping me drink as I couldn't coordinate my arms properly and because I was shaking so much. He always had his eyes on me and made sure I was okay. He was reassuring and so kind in what was a scary situation. I was in huge amounts of pain, and he ensured I had all the pain relief medication I could.

What should have been a quick 30 minutes in recovery ended up well over two hours, and the whole time, Chris was making sure I was stable and well enough to go back to the Day Unit. The care Chris gave me was the best I have ever received. This was my sixth general anaesthetic, so I have encountered lots of wonderful members of staff over the years, but Chris was outstanding, and I am so grateful for how kind he was. I feel fortunate that I got to be looked after by Chris. Chris is wonderful at his job and a lovely human. He is an asset to the NHS.

Michelle Wright, Midwife **Scarborough** **Nominated by patient**

Michelle is truly exceptional. She cared for my son and me on Hawthorn Ward during the most vulnerable time of our journey when I was unable to move due to having a severe post-dural headache. Michelle took the time all day to help me feed my son, especially as he had a severe tongue tie. Michelle went above and beyond all day to help me achieve my breastfeeding goal. She advocated for me when I needed her and when I needed pain relief.

Michelle is truly an amazing midwife, and I honestly couldn't have got through that dreaded day without her, so thank you, Michelle. She is and always will be our little earth angel.

G1 **York** **Nominated by patient**

I am nominating the entire team on G1 for a Star Award. After two recent admissions following major surgery for endometriosis and a hysterectomy at just 36, I can honestly say that the care I received on G1 changed one of the darkest periods of my life into something I could face with hope, dignity, and strength. From the moment I arrived, every member of staff treated me with kindness, patience, and genuine compassion. I was frightened, in pain, and struggling with the emotional weight of losing so much at a young age. Yet the team on G1 made me feel safe, understood, and never alone.

The treatment I needed was always fully explained, and every question I asked, no matter how anxious or emotional, was answered with respect and clarity. When I lost my independence and needed help with personal hygiene, nobody ever made me feel embarrassed or like a burden. Their kindness in those moments is something I will never forget. Food and drinks always arrived hot and nutritious, and the ward was spotless. The cleaners worked tirelessly throughout the day, and their presence brought comfort and reassurance. The whole environment felt calm, secure, and cared for. Every healthcare assistant and nurse I met was outstanding. The doctors and consultants were equally exceptional - polite, gentle, and incredibly patient. They took the time to understand not just my medical situation, but me as a person. After major surgery and then a readmission due to infection, their reassurance helped me stay grounded when everything felt overwhelming.

Being on G1 felt like being wrapped in a blanket of safety. Whether I was in a bay or a side room, I felt protected, valued, and able to rest. In some of my darkest days, the G1 team were the light that helped me through. I would love to recognise some of the individuals who stood out as truly exceptional: Judy, Kaz, Sonja, Jake, Brian (Cleaner), Sharon, Lorraine (Patient Services), Chrissie, Joshi, Michaela, Nicky, Miss Sanaullah, Dr Meerek, and Mr Bandy. There were many more whose names I sadly cannot remember because I was so unwell, but every single person played a part in my recovery. If I could give the entire team a Star Award, I absolutely would. Thank you, G1, for your compassion, your humanity, and your unwavering care. You didn't just look after my body; you helped heal me at a time when I felt broken. I will carry your kindness with me for the rest of my life.

Mujtaba Bukhari, Specialty Registrar **York** **Nominated by patient**

Mujtaba was brilliant. They were caring, patient, understanding, warm, and friendly. They were also attentive and full of kindness. Mujtaba is a star.

Nicola Wilson, Outpatients Administrator, Nicola Dean, Consultant in Obstetrics and Gynaecology, Gillian Featherstone-Todd, Staff Nurse, and Sarah Hill, Theatre Support Worker **York** **Nominated by patient**

I was called and offered an appointment for the following day for a hysteroscopy, biopsy, and polyp removal. I was nervous, but Miss Wilson (who called) was good at explaining what would happen and put me at ease. When I arrived for the appointment, my nerves had returned. I was afraid of the procedure, pain/discomfort, and the overall “what does this mean for my future?”.

Miss Dean was incredibly kind and patient in explaining everything to me beforehand. Once we were all in the procedure room, Lisa and Gillian were fantastic with making sure I was comfortable (and distracted) while all three kept me informed with everything that was going on. They even let me watch on the screen and answered all my questions!

In the past, I have often felt ignored or overlooked while trying to get answers or treatment for my ‘female complaints’. These four women have changed my perspective for the better. I felt heard and cared for and not like I was just a name with symptoms to be checked off a list. I felt like a person. I am grateful for their high level of empathy and professionalism.

Emergency Eye Clinic **York** **Nominated by patient**

I attended the urgent eye clinic today after receiving a worrying referral from my optician. I am 17 weeks pregnant and was feeling incredibly anxious about what the appointment might mean for my health. Throughout the whole experience, I was so pleased with the efficiency of the whole appointment flow, the level of assessment I received and the compassion and care I was met with.

I had two nurses assess me; one called Rachel and one called Amanda. They were both so kind, professional, and caring, which made me feel so at ease. The imaging staff were helpful and kind, and throughout the whole appointment, I was kept informed on what the next steps would be with excellent communication. I was then seen by a wonderful consultant, who was kind, caring, and informative. I am so grateful to have received such wonderful care and have been able to experience such a wonderful department (in which I was seen from start to finish in two hours!). I am so grateful for the care I received today and the relief that I now feel.

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

I recently attended York Hospital Day Unit post-surgery and have never felt so at ease and well looked after as I did on that ward. The level of care and reassurance shown to me by the nurses, healthcare assistants, and patient service officers is something I’ll never forget. I am 61 years of age, and although I’ve had surgery in the past, I was extremely anxious about going into the hospital again. From the minute I was wheeled from recovery onto the day unit, I felt like I was in the best care.

The NHS gets its fair share of negativity thrown its way, but this couldn’t be further from what I experienced. The department/team were all incredible, and I would especially like to thank Jennifer Eiles, Stacey Scrivener, and Liv Goodwin. Thank you.

Peter Coleman, Waiting List Co-ordinator **York** **Nominated by patient**

I am nominating Peter for a Star Award in recognition of his outstanding care and dedication while working within the surgical waiting list team. While I was awaiting surgery, Peter was consistently polite, friendly, and reassuring. He took the time to clearly explain timescales and processes, always making me feel at ease during a stressful period.

What truly stood out was his compassion and commitment. On one occasion, when I was unwell and attending the ED, Peter contacted me regarding my surgery. After I explained my situation, he went out of his way to come and see me in person and provide the relevant paperwork. This level of care and initiative was completely unexpected and greatly appreciated. Peter went above and beyond his role, demonstrating genuine kindness and professionalism. His actions made a significant difference to my experience as a patient.

I would also like to extend a heartfelt thank you to Peter for his support, care, and dedication. His kindness did not go unnoticed and made a difficult time much easier to manage. I believe Peter should be recognised for his hard work and dedication, especially as he works behind the scenes in a role that is often unseen but vital.

Kymberly Wilford, Midwife **Scarborough** **Nominated by patient**

Kim is the most amazing midwife. After having two traumatic births, I was scared for my third. She made me feel so relaxed and at ease. I enjoyed every second of it, and that's because of her. What a kind and special person she is.

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

Honey got me through the hardest part of labour and delivery. She was the support I needed, and it felt like I'd known her a lifetime, not that I had met her a few hours prior. She was beyond kind, caring, and comforting. She supported me at times when my husband couldn't, as he was prepping for an emergency C-section, and explained everything amazingly. She turned what should've been a stressful and scary situation with the potential to cause PTSD into a calming and relaxed experience.

I've gone away from the birth thankful that Honey was allocated to me on that day. Without her, I don't think I could've done it. It truly is hard to put into words how much she did for us that day. Anyone would be lucky to experience such a kind and caring soul like Honey!

Alex Senior, Midwife **Scarborough** **Nominated by patient**

When I gave birth to my daughter. I was in for a week after a not-so-straightforward birth. Everyone was amazing, but every time Alex was on shift, I felt a sigh of relief. She made me feel relaxed and at home. She was so easy to talk to and did such an amazing job! She never got stressed, took everything in her stride, and if I needed her, she was there for both my baby and me.

Bethan Herridge, Midwife, and Isabel Preece, Student Midwife **Scarborough** **Nominated by patient**

I recently gave birth to my beautiful little boy at Scarborough Hospital, and I just wanted to publicly thank the incredible midwife and student midwife who cared for me during my labour and delivery. Their kindness, compassion, reassurance, and professionalism were amazing from start to finish. They made my husband and me feel supported, safe, and truly cared for during such an important and emotional experience, and I honestly couldn't have asked for better care.

A special mention to the student midwife. This was her very first delivery, but you would never have known. The level of care, confidence, and support she gave was outstanding, and she should be incredibly proud of herself. They are both a real credit to the maternity team and to the Trust. Thank you both so much for helping bring my little boy safely into the world. We'll never forget your support.

Peritoneal Dialysis Nurses **York** **Nominated by patient**

I'm writing this both as a York Hospital employee and as someone who has been a patient of the Peritoneal Dialysis unit since my kidney failure began in 2014. For over a decade now, Geraldine, Sarah, and Iona have been my absolute rocks. We all know how busy the hospital gets and how much pressure our teams are under, but you would never know it when you talk to them. No matter how much they have on their plates, they have never once made me feel like I was a bother or 'just another patient' to tick off a list.

The thing I appreciate most is their 'open door' approach. There have been so many times over the last ten years when I've been worried or unsure, and whether I'm knocking on their door in person or calling them on the phone, they are always there for me. That direct line of support has been my safety net. It isn't always easy being a patient in the same place where you work, but they have made that balance feel completely seamless. They have always treated me with the perfect blend of professional respect as a colleague and genuine, tender care as a patient. They've protected my dignity every step of the way.

As a colleague, I'm so proud to work in the same Trust as them. As a patient, I honestly don't know how I would have managed this journey without them. They don't just 'do their jobs', they genuinely care. They've seen me through the ups and downs since 2014 with the same kindness and patience they had on day one. They are a fantastic team, and, to me, they are exactly what the Star Award is all about. I really hope they get the recognition they deserve.

Ward 31 **York** **Nominated by patient**

All the staff on day and night shifts on Ward 31 made me feel secure and safe after being admitted to the ward. The nurses were friendly and sympathetic to our needs, during what is a rollercoaster for cancer patients. They always had a friendly smile whenever they saw us.

This ward is specialised, and I have experienced true nursing from every single member of the team who are all dedicated to their role of helping cancer patients. It is managed by Ian, who has the department running like clockwork. I would also like to thank the housekeepers, Eddie, Hollie, and Olivier, who made sure we were looked after with food and drinks, and the cleaning team, who did a fantastic job. Please, recognise this ward with a Star Award.

Endoscopy **York** **Nominated by patient**

Nobody looks forward to or enjoys an endoscopy or colonoscopy (I had both yesterday), but the whole team, from reception to discharge, were pleasant, understanding, patient, and efficient. I have had similar procedures in various hospitals, and York was outstanding. I was put at ease and treated like an individual rather than a job to be processed. I have to return for another procedure, but I am not dreading it. Thank you.

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

Ailsa was knowledgeable and patient when explaining my options, the procedure, and my condition. She allowed me to be in full control, yet sensitively got the procedure done, which I was anxious about due to bad previous experiences. Lexy and Jayne were equally patient, caring, and understanding, calming me, not rushing me, being empathetic, and making me feel in safe hands. Together, the team were efficient, skilled, and knowledgeable yet compassionate, kind, and patient. They made me feel like I mattered in a situation where I felt anxious and vulnerable.

Emily Warren, Trust Doctor Medicine **Scarborough** **Nominated by relative**

My dad attended the Emergency Department with high blood pressure and some minor neurological symptoms. Dr Emily oversaw his care while he was in the SDEC unit. Dr Emily displayed a constant professional and friendly manner towards my dad. She listened to his concerns and worries and explained everything to him in a manner which he was able to understand.

I feel Dr Emily went above and beyond to arrange an out-of-hours scan for my dad over a busy weekend period as opposed to sending him home with an outpatient appointment later in the week. Her professionalism and kind nature helped put my dad at ease when he was anxious and worried. Dr Emily displayed what I believe to be the true ethos of a doctor, and I am grateful for the support she offered my dad.

Alison Kearney, Parkinsons Specialist Nurse | **Scarborough** | **Nominated by relative**

My father attended Scarborough, York, and Bridlington hospitals with a host of long-term issues, with the team at Scarborough quickly diagnosing Parkinson's. Due to my father's comorbidities and fluctuating condition, as a healthcare professional, I had many questions and concerns.

Alison demonstrated such empathy, understood my concerns, and acted as my advocate and, more importantly, for my father. Alison led and liaised with all relevant practitioners to ensure all my questions were thoroughly explored and answered, providing the reassurances my family and I needed, knowing everything that could be done had been done. I have no doubt, as a healthcare professional and as a daughter, that this helped us to accept the situation and aided the grieving process.

I am in no doubt Alison went above and beyond her role (and working hours!). Her knowledge, standards of care, and communication skills with other healthcare professionals and me are of the highest level and reassuring, particularly in this current resource-constrained environment. Alison removed my 'what if?' thoughts, and without her, my situation would have been very different. I'm not in the habit of writing emails regarding staff members, but the impact Alison has had is profound, and with all the negative feedback surrounding the NHS, I thought some positivity should be shared.

Aspen Ward | **Bridlington** | **Nominated by relative (1) and colleague (2)**

Nomination 1

The team on Aspen Ward cared for my aunt recently, who, very sadly, was at the end of her life. The care and love shown to my aunt, her daughter, and my family was exceptional, and Nicky, the Ward Sister, went above and beyond to ensure my aunt was always comfortable. As a nurse and a staff member myself, I feel that this is the kind of care we all strive to give to our patients. Nicky and her team ensured that every aspect of my dear aunt's care, and towards us all as a family, was of the highest standard.

Nicky and the team enabled a very sad situation to seem lighter, and it was very comforting to know that my aunt was peaceful at the end. I cannot thank Nicky and the Aspen team enough for giving us a lovely lasting memory of my aunt's last days. You are all amazing and are a credit to the profession.

Nomination 2

The team on Aspen Ward is always welcoming on the ward. They all worked together through COVID and often have end-of-life patients. They treat family members of the patients with comfort and respect. The team always refers to using the NHS values with professional assistance to anyone who enters the ward.

The staff are supportive of each other and always go the extra mile to ensure the team are working together, from the domestics on the team (always friendly with the patients and ready to assist when needed) to the healthcare assistants working hard alongside the nurses and sister. I worked on this ward for four years, and they are truly underrated as a small ward. I believe the Aspen team deserve to be nominated for a star award.

Macmillan Specialist Palliative Care Nurses | **Scarborough** | **Nominated by relative**

The Macmillan Specialist Palliative Care Nurses recently cared for my aunt on Aspen Ward, who was sadly at the end of her life. The care she received from the hospital's Macmillan team was attentive and comforting to her and our family. Many thanks to a great team who contributed to my aunt's end-of-life care, ensuring she died peacefully and with dignity.

Charlotte Taylor, Play Leader | **York** | **Nominated by relative**

We nominated Charlotte last year after she went above and beyond to help my 14-year-old autistic daughter cope with an operation. We are nominating her again because my daughter, unfortunately, needed another operation only a few months later, and she needed Charlotte's support to get through it. We made a specific request for Charlotte because we weren't sure how my daughter would cope with another operation only a few months after the first one.

Arrangements were kindly made to ensure that Charlotte would be there on the day. The only thing that would cheer my daughter up in the run-up to the operation, when she was worrying about it, was reminding her that Charlotte would be there to help her. On the day, Charlotte again went above expectations and came in earlier than scheduled that morning so that she could be there with plenty of time to help my daughter. She was there every step of the way, knowing exactly what to say during very anxious moments in the run-up to going to sleep. She was also there again for me afterwards when my daughter was having her operation.

Charlotte is a lovely and kind person and is so good at her job. The hospital and the families she helps are so lucky to have her working there. She also made sure to come and see my daughter after the operation. We can't thank her enough for her help, support, and kindness.

Gaynor Hall, Nursing Band 7 **York** **Nominated by relative**

I visited the Emergency Department with my daughter, who competes at a high level in trampolining. She was due to take part in the British Qualifiers that weekend, but unfortunately landed awkwardly from a twisting somersault, hyperextending her leg. After a long wait in a very busy department, we were seen by Gaynor.

From the outset, Gaynor demonstrated a strong understanding of the type of injury my daughter had sustained. She took the time to ask detailed questions about how the injury occurred and showed genuine interest in my daughter's sporting background. She immediately recognised how important trampolining is to her, and approached the situation with both professionalism and empathy, which helped to put us at ease. Gaynor carried out a thorough and careful examination of my daughter's leg, explaining what she was doing and why at each stage. She ensured my daughter was as comfortable as possible, providing appropriate pain relief promptly. She then arranged for an X-ray to rule out any more serious damage.

What stood out most was the way Gaynor communicated with us throughout. After the X-ray, she returned and clearly explained the findings in a way that was easy to understand, taking the time to answer our questions without making us feel rushed. She also outlined the next steps in my daughter's care, ensuring we knew what to expect and how best to support her recovery, particularly in relation to her sport.

In a busy and pressured ED environment, it would have been easy for us to feel like just another case. However, Gaynor's approach meant we felt genuinely cared for as individuals. Her kindness, patience, and professionalism were evident throughout, and she is a real credit to the NHS. Her compassion and professionalism truly reflect the very best of the NHS, and I wanted to take the time to recognise the outstanding care she provided.

Abie Blades, Midwife **York** **Nominated by relative**

My daughter went into labour, and it went smoothly right up to the end, where she needed a forceps delivery. Abie was with us the whole time and coordinated the team. The baby ended up needing resus, and this is something Abie noticed immediately and so whisked her off. She then sorted the baby and came back to my daughter, who was haemorrhaging. The rest of the team was working hard, but it seemed so stressful. Watching your daughter go through that was the most horrific experience, and it was Abie who took control and calmed the situation. She seemed aware of all the things that nobody else was considering.

At one point, I asked Abie if I might lose my daughter, but she knew how to deal with such an intense situation, calmly reassure and support the family, and focus on the patient. I've had four babies and never experienced anything like it in my life. Abie is a total superhero in my eyes. I live an hour away from York, and when the chaos had stopped, I asked Abie if she felt it was OK for me to leave. I left knowing that my daughter was in her care for the night and that I 100% trusted her. I genuinely feel I owe her my life. She is a credit to midwifery and a credit to the NHS! Thank you, Abie. I will never forget what you did for me, my daughter, and my beautiful granddaughter.

Lauren Hall, Specialist Respiratory Physiotherapist **Scarborough** **Nominated by relative**

My mother is very elderly and frail with advanced dementia. Her pacemaker battery recently reached the end of its useful life, and Lauren was helpful when she communicated with me as my mother's next of kin and holder of the Health and Welfare LPA. Lauren contacted me and kept in touch to facilitate my understanding of the situation. She also proactively gathered additional information from the pacemaker unit manufacturer and agreed to visit my mother in her care home to assess her heart function.

Lauren behaved in a highly professional manner throughout, while also demonstrating compassion and understanding with respect to my mother's extremely fragile physical and mental state and the stressful and upsetting situation in which my family and I found ourselves. Thank you so much, Lauren. Your thoughtfulness and care made a positive difference in a difficult situation and are very much appreciated.

Christopher Swain, Healthcare Support Worker **Scarborough** **Nominated by relative**

Sadly, my grandad recently passed away on Chestnut Ward following a short illness. For two days, he received end-of-life care from the team on Chestnut Ward. While all the team were kind and caring during this time, Chris went above and beyond when supporting my family and me.

He checked in on us regularly and made sure that we took breaks. He ensured that we ate and drank even though we did not feel like doing so. He also ensured we were informed of what was happening and made us feel at ease during a very difficult time. He was kind and compassionate to my grandad too, making sure he was comfortable in his final hours, which meant so much to us.

Hawthorn Ward **Scarborough** **Nominated by relative**

I want to say a massive thank you to the team on Hawthorn Ward for delivering my twin girls safely. My partner was in for a week, she was comfortable around everyone, and everyone made her welcome.

Ward 26, Christine Ross, Operating Department Orderly, and Victoria Rodriguez Jerez, Deputy Sister **York** **Nominated by relative**

A couple of weeks after the birth of our daughter, my wife was rushed into hospital, suffering from gallstones and requiring same-day surgery to remove her gallbladder. During that time, she stayed with our child on Ward 26.

I wish to nominate the team on Ward 26, along with Christine Ross (a theatre orderly) and Victoria Rodriguez Jerez (a recovery nurse), due to the exemplary care and incredible support they provided while my wife was there with our child. This included a separate side room and finding a cot for my daughter, a camp bed for my sister-in-law to stay the night and help my wife with the baby, a breast pump to help my wife express before surgery, formula milk when we ran out of time to express, and extra food when required. They also allowed me to come and go when needed for baby supplies and many other little things that helped us care for a newborn child and her mother while her mother was recovering from surgery.

While it wasn't the easiest period of our daughter's life, having all these things around us allowed our daughter to keep developing during the first few weeks of her life.

Ellie Mosey, Staff Nurse **York** **Nominated by relative**

We recently had a traumatic experience, and my son was extremely unwell and had suffered a traumatic brain injury (TBI). Ellie was supportive and caring and went above and beyond to support not just my son but the whole family. Her experience, commitment to the job, and passion for nursing were clear to see. She made me feel seen and supported and listened to my concerns during the scariest time we have experienced as a family. She was checking on his medications and how he was doing regularly, as well as explaining steps and just being an amazing nurse.

I wanted to pass on my heartfelt thanks to her and to let her know how much it meant to my son and his family. Ellie, we really appreciated you and your kindness. We are so thankful to all the staff who were fabulous, but you were just amazing, and we wanted to thank you as a family.

Paediatric Day Unit Team and Ophthalmology Theatres **York** **Nominated by relative**

I want to pass on a huge thanks to the York Theatre Eye Team and the Paediatric Day Unit. I was there yesterday with my daughter for her double eye surgery. They were all brilliant with her from the moment we arrived. She was made to feel so special by the wonderful surgical team and happily walked with them to the 'sleep room', laughing and chatting with them and the fantastic play team right until she fell asleep.

Needless to say, I found her being put under very tough, but they took amazing care of her and supported me too. They all went above and beyond. I can't say a big enough thank you to everyone for the positive experience we both had. Thank you, York Hospital.

Pauline Matlock, Medical Secretary **York** **Nominated by visitor**

I am putting Pauline forward for a Star Award because she is the kindest person I have ever spoken to over the phone. She is an amazing secretary to speak to, and she is always able to help when needed. I am thankful to her; she really deserves a Star Award.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

TRUST PRIORITIES REPORT

June 2026

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NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Summary
Narrative

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

TPR metric performance to note:

Special Cause Improvement – Pass (defined by NHSE Make Data Count methodology as "improving nature where the measure is significantly higher. The process is capable and will consistently pass the target"):
Workforce - Overall Corporate Induction Compliance.
Workforce - A4C Staff Corporate Induction Compliance.

Special Cause Concern – Fail (defined by NHSE Make Data Count methodology as "concerning nature where the measure is significantly lower. The process is not capable and will fail the target without process design"):
Operational Activity & Performance – Inpatients – Proportion of patients discharged before 5pm.
Workforce – Annual absence rate.

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

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

True North (TRUN)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Inpatients - Lost bed days for patients with no criteria to reside	2026-05	H		1754		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-05		F	70.1%	67.7%	82%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-05		F	12%	17.1%	5%
Cancer - Faster Diagnosis Standard - Declared Position	2026-04		F	71.6%	72.5%	84.3%
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-05		F	58.1%	56.9%	67.5%
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-05	L	F	2%	1.7%	0%
Total Number of Trust Onset MSSA Bacteraemias	2026-05		?	7	7	7
Inpatient Acquired Pressure Ulcers - Category 2	2026-05	L	?	61	60	60

National Operational Framework

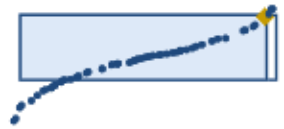
Rank Oversight

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Description	Latest Reporting Date	Previous Score	Latest Score	Score Difference	Rank
Percentage of patients waiting over 52 weeks for elective treatment	Mar-26	3.12	3.07	-0.05	102
Percentage of patients waiting over 52 weeks for community services	Mar-26	3.79	3.72	-0.07	70
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q4 2025/26	3.92	3.51	-0.41	101
Percentage of patients treated for cancer within 62 days of referral	Q4 2025/26	3.38	2.61	-0.77	61
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q4 2025/26	3.18	3.41	0.23	97
Percentage of emergency department attendances spending over 12 hours in the department	Q4 2025/26	2.87	2.74	-0.13	71
Number of MRSA bacteraemia cases (12 months)	Mar-26	3.60	3.51	-0.09	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Mar-26	3.61	3.88	0.27	125
Average number of days from discharge ready date to actual discharge date (including zero days)	Mar-26	1.98	1.76	-0.22	33
Summary Hospital-level Mortality Indicator	Jan 24 - Dec 25	2.00	2.00	0.00	
Proportion of E. coli bacteraemia	Mar-26	2.26	2.32	0.06	
Urgent Community Response 2-hour performance	Q4 2025/26	4.00	2.95	-1.05	48
NHS Staff survey - raising concerns sub-score	2025	3.95	3.68	-0.27	120
CQC inpatient survey satisfaction rate	2024	2.00	2.00	0.00	
Planned surplus/deficit	2025/26 plan	3.00	3.00	0.00	76
Combined finance	Q4 2025/26	4.00	4.00	0.00	
Variance year-to-date to financial plan	Month 12 2025/26	4.00	4.00	0.00	120
Sickness absence rate	Q3 2025/26	2.16	2.53	0.37	81
NHS staff survey engagement theme sub-score	2025	3.98	3.35	-0.63	105
Implied productivity level	Q3 2025/26 vs Q3 2024/25	2.85	3.62	0.77	117
Proportion of C. difficile infections	Mar-26	1.00	1.00	0.00	
Difference between planned and actual 18 week performance	Mar-26	3.17	3.33	0.16	115
Access to services domain score	Q4 2025/26	3.38	3.28	-0.10	126
Patient safety domain score	Q4 2025/26	3.12	2.98	-0.14	107
Finance and productivity domain score	Q4 2025/26	3.42	3.81	0.39	129
People and workforce domain score	Q4 2025/26	3.07	2.94	-0.13	99
Effectiveness and experience domain score	Q4 2025/26	2.49	2.18	-0.31	65

129 out of 134

Latest Rank



Latest Average Metric Score

Latest Average Segment Score

Latest Adjusted Segment Score

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

June 2026

Executive Owner: Claire Hansen

Summary Position

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

ECS performance was 70.1% (includes Trust share of Bridlington and Whitby UTCs) achieving the Trust's improvement trajectory. 12-hour in department performance also achieved trajectory in May 2026 with performance of 12%.

Cancer performance for FDS and 62-day standards continue to improve achieving the 62 Day Treatment Standard but remaining off trajectory in April 2026 for FDS. The drivers include diagnostic delays, dermatology referral surges, FIT compliance issues, and pathway bottlenecks. Recovery actions continue across colorectal, urology, gynaecology and skin, including expanded proformas, haematuria STT and GP engagement. High referral volumes and diagnostic limitations remain critical risks.

The RTT waiting list (TWL) increased, provisionally behind trajectory (1,513), challenges include significant GP referral growth with a 3% rise seen YTD compared to 2025/26 this is on top of the 5% growth the Trust saw for 2025/26 versus 2024/25. Zero RTT65 week waits was maintained.

Outpatient productivity remains strong compared with peers, PIFU rates remain below plan and further work with team to accelerate improvements being identified, the Trust DNA rate was 4.5%.

Diagnostics DM01 performance was 76%, a 3% improvement on the previous month and achieving the May trajectory of 75.8%. Long waits reducing, driven by insourcing, MRI GA lists, additional echo capacity, and backlog-focused clinics. Key risks include workforce shortages, equipment breakdowns, audiology capacity delays and continued prioritisation of cancer fast-track patients.

Executive Owner: Claire Hansen

Key Risks (Cross-cutting)

- Rising UEC demand and ambulance conveyances.
- National workforce shortages (radiographers, echocardiographers, audiologists, SLT).
- Diagnostic capacity and equipment issues.
- High referral volumes and FIT non-compliance impacting Cancer.
- Rise in GP referrals year on year has continued into 2026/27.
- Community capacity limits affecting flow and discharge.
- Capital project and estate constraints (CDC build, RAAC, MRI/CT replacement).

Strategic Priorities (Q1)

1. Reduce 12 hour stays and improve ECS and patient flow through new models of care (EEMAC and EAU) launched in March, providing new next step pathways expected to continue to deliver 4- and 12-hour performance trajectories. Nervecentre optimisation.
2. Increase Cancer and Diagnostics capacity via imaging expansion and FIT compliance improvement. Insourcing + mobiles, CDC go-live (June) and recruitment pipeline.
3. Maintain RTT recovery momentum, delivering activity plans and performance trajectories, tight grip from corporate and operational teams. Validation of 30–40 RTT week cohort and single point of access
4. Support staff safety, morale and core clinical standards with new clinical strategy. Recruitment, insourcing, wellbeing and absence plan
5. Stabilise community capacity and reduce therapy backlogs.

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

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

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

Operational Activity and Performance
Chief Operating Officer Report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Metric	Latest position vs plan	Key Mitigations – Next three months	Expected trajectory
Urgent & Emergency Care	ECS performance incl. Trust share of Bridlington and Whitby UTCs 70% vs monthly 67.7% trajectory. Average Ambulance Handover behind trajectory. Long stays reduced; 12 hr waits in department (T1) 12% (ahead of 17.1% trajectory). We launched two new pathways at each Emergency Department in March 2026. These were developed using new national guidance and we have seen significant improvements in ECS and 12-hour performance levels. Flow constrained by community and social care capacity.	A new North Yorkshire and York task and finish group has been established, which Trust representatives are attending as appropriate. This group has been set up on behalf of Sara Storey, Director for Adult Social Services at York, to develop and implement a clear and explicit plan to build sustainable community capacity, enabling patients to receive care in the right place and reducing pressure on acute services. Delivery of LoS and 12-hour performance is dependent on system discharge capacity; without improvement, gains in front door flow will not fully translate. We continue to liaise regularly with Yorkshire Ambulance Service about the alternative pathways in place and ask that they continue communications with crews to highlight these.	Full recovery dependent on wider system demand management and community discharge capacity.
Cancer FDS/62 day	February FDS 71.6% vs 72.5% monthly trajectory. February 62-day 72.3% vs 66.5% monthly trajectory. Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.	Process in place for returning referrals with no FIT to primary care. New colorectal cancer lead appointed. Ongoing discussions with endoscopy around pilots to improve TAT and provide additional capacity. Initial scoping discussions around COLOFiT. STT CT model in haematuria commenced implemented. Lower GI proforma rollout; enhanced GP comms.	Gradual improvement through 2026/27. However national targets remain high risk due to referral volume and diagnostics.
RTT TWL / %<18w/52w	TWL 56,381 provisionally against the trajectory of 54,868. Provisional <18w: 58.1% vs 56.9% trajectory; Trust was ranked 113/118 in March. 52-week waiters 1,104 (Provisional position) v trajectory of 899. GP Referral growth +3% YTD v 2025/26.	Fortnightly meetings in place from start of April 2026 with Care Groups to review activity and performance delivery at specialty level, proactive identification of issues to allow material mitigations to be made in month. The service delivery plan has a comprehensive list of actions to support the delivery of increased productivity and RTT performance improvement, these are monitored through the RTT Delivery Group.	Improvement expected in RTT under 18 week, TWL and RTT52 week waits.
Diagnostics	DM01 76%, ahead of trajectory (75.8%). Impact from MRI workforce shortages, CT3 removal, mobile breakdowns, NOUS MSK backlog, audiology staffing gaps.	Radiology: Staffing vacancies in MRI are being mitigated by use of RMS insourcing to retain core capacity until recruitment can be completed to return to full substantive establishment. Endoscopy: Centralised preassessment clinics in Bridlington expected to be in place by the end of Q2 2026/27, to release 3 RN in York to support staffing of room 7.	Improvement through quarter but recruitment and equipment risks remain.
Outpatients	PIFU 4.7% vs 5.3% trajectory. RACP 14-day performance 83.7%, below 99% target. DNA rate 4.5%% (national average 5.6%).	"PIFU as standard" rollout (Gynae, Cardiology, Gastro, ENT). Template redesign in multiple specialties to raise 1st OP capacity. ICB–GP demand management on high growth specialties.	Incremental improvement 2026/27; largest opportunity in PIFU uplift. Transformative pathway design is required over the longer term.
Children and Young people	CYP RTT52 waits 2 off trajectory of zero. CYP ECS 82.6% below trajectory of 94.1%.	The introduction of the new model of care for adults should reduce congestion in departments which may lead to more timely assessment of children Weekly RTT review; ENT/OS aiming to deliver zero 52 week waits by end of Q1 .	Improved ECS for CYP; zero RTT40 week waits across all specialties in 2026/27.
Community	SLT backlogs impacted by workforce shortages. Mitigation in plan for 2026/27 are funded. Demand–capacity mismatch persists across therapy services.	SLT; Additional WTE mitigation included in 2026/27 plan. Business Case underway. Tests underway around H@H in ED, SDEC and Selby.	Large strategic change required with confidence for 2026/27 if WTE mitigation can be recruited to.

Headlines:

- The May 2026 Emergency Care Standard (ECS) position was 70.1%, ahead of the monthly planned improvement trajectory of 67.7%. Please note, as per a national mandate for 2026/27 100% of Bridlington and 50% of Whitby UTCs are mapped to the Trust for performance purposes and are included as their performance was incorporated into the Trust's 2026/27 planning submission. **ECS performance is a True North metric.** In the latest available national data (April 2026) the Trust ranked 54th out of 118 providers and 6th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group (March performance saw the Trust at 81st and 7th respectively). ECS Performance for Trust controlled sites was 66.8% in May 2026.

- Average ambulance handover time in May 2026 was behind trajectory at 23 minutes 04 seconds against trajectory of 20 minutes 52 seconds.

- 12% of Type 1 patients spent over 12 hours in our Emergency Departments during May 2026, ahead of the monthly improvement trajectory of 17.1%. In the latest available national data (April 2026) the Trust ranked 28th out of 118 providers (March: 54th). **This is a True North Metric.**

- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 7.6 days in May 2026, behind the trajectory of 6.6 days.

- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) during May 2026 was 87.5%, against the trajectory of 88% submitted as part of the 2026/27 annual planning process. The average delay (number of days after the DRD that a patient was subsequently discharged) was 6.1 days, behind the submitted trajectory (4 days).

Factors impacting performance:

- In May, the transition to Nervecentre caused disruption to performance within both Emergency Departments. It was hoped that any decline caused would be mitigated by further development and use of the Extended Emergency Medicine Ambulatory Care (EEMAC) and Emergency Assessment Unit (EAU) pathways. This was not possible and performance at both sites deteriorated.

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

Actions planned in June 2026:

- An after-action review is concluding, looking into the way that our new pathways (EEMAC and EAU) were implemented. The final report will be ready for presentation in June and will be used to support future project work.

- Following a key stakeholder session on 2nd June a series of recovery actions have been drawn up for implementation over the next month. These include further communication to medics about real-time documentation in Nervecentre which could reduce duplication of administrative tasks by doctors, thus freeing up more time to see patients.

Summary MATRIX 1

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* ED - Proportion of Ambulance handovers waiting > 240 mins	* ED - Proportion of Ambulance handovers waiting > 45 mins * ED - Ambulance average handover time (number of minutes)
COMMON CAUSE / NATURAL VARIATION			* ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - Total waiting 12+ hours - Actual number of all Type 1 attendances * ED - 12 hour trolley waits - Declared Position * ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs) * ED - Emergency Care Standard (Type 1 level) - Declared Position * ED - Proportion of Ambulance handovers over 15 mins
SPECIAL CAUSE CONCERN		* ED - A&E attendances - Type 1 - Declared Position	

Acute Flow (1)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Proportion of all attendances having an initial assessment within 15 mins	2026-05			72.7%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-05	L		19.7%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-05		F	12%	17.1%	5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-05		F	1482	1908	558
ED - 12 hour trolley waits - Declared Position	2026-05		F	293		0
ED - Emergency Care Attendances - Declared Position	2026-05			19384		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-05		F	70.1%	67.7%	82%
ED - Emergency Care Standard (Trust level) - Declared Position	2026-05			66.8%		
ED - A&E attendances - Type 1 - Declared Position	2026-05	H	?	12406		10999
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-05		F	51%	42%	70.1%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-05			6978		
ED - Median Time to Initial Assessment (Minutes)	2026-05	L		4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-05	L		26.5%		

Summary MATRIX 2

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

MATRIX KEY

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

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

Acute Flow (2)
Scorecard

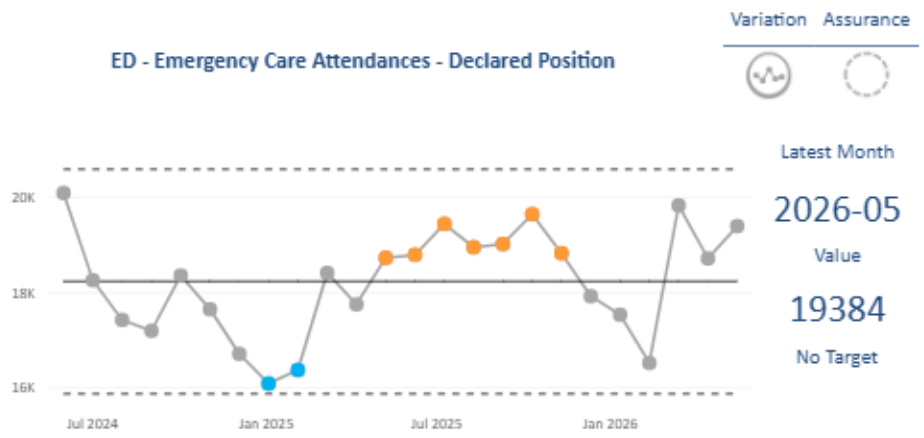
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of SDEC attendances	2026-05	H		5218		
Proportion of SDEC attendances transferred from ED	2026-05			58.2%		
Proportion of SDEC attendances transferred from GP	2026-05	L		14.7%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-05	H		77.8%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-05			24%		
Number of RAFA attendances (York Only)	2026-05	L		77		
Number of attendances at SAU (York & Scarborough)	2026-05	L		558		
ED - Proportion of Ambulance handovers within 15 mins	2026-05			29.5%		
ED - Proportion of Ambulance handovers over 15 mins	2026-05		F	70.6%	63.2%	49.6%
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-05	L		24.2%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-05	L	F	5.3%	2.9%	0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-05	L	?	0%		0%
ED - Number of ambulance arrivals	2026-05			4754		
ED - Ambulance average handover time (number of minutes)	2026-05	L	F	23	20	19

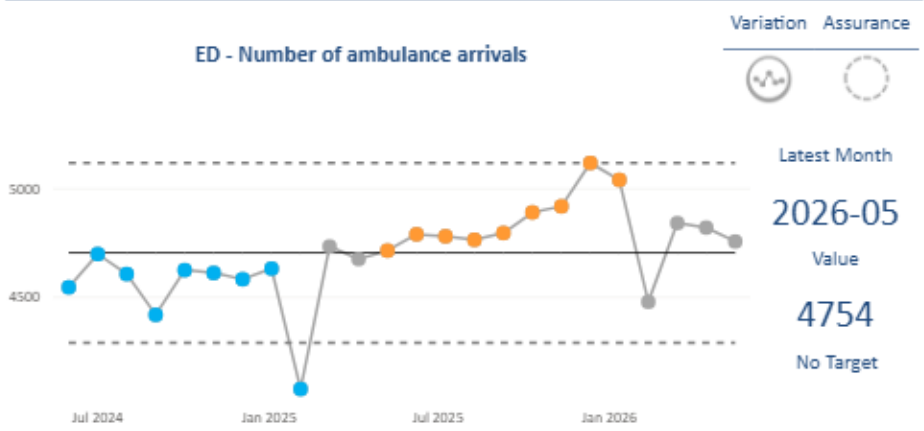
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

The latest months value has **deteriorated** from the previous month, with a difference of **679.0**.



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

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

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

What actions are planned?

A new North Yorkshire and York task and finish group has been established, which Trust representatives are attending as appropriate. This group has been set up on behalf of Sara Storey, Director for Adult Social Services at York, to develop and implement a clear and explicit plan to build sustainable community capacity, enabling patients to receive care in the right place and reducing pressure on acute services. This is the result of discussions at the NY&Y UEC Board Spring Workshops held in March 2026.

In the meantime, we continue to liaise regularly with Yorkshire Ambulance Service about the alternative pathways in place and ask that they continue communications with crews to highlight these.

What is the expected impact?

Developing more community capacity is a long-term strategic plan which will create impact in future years.

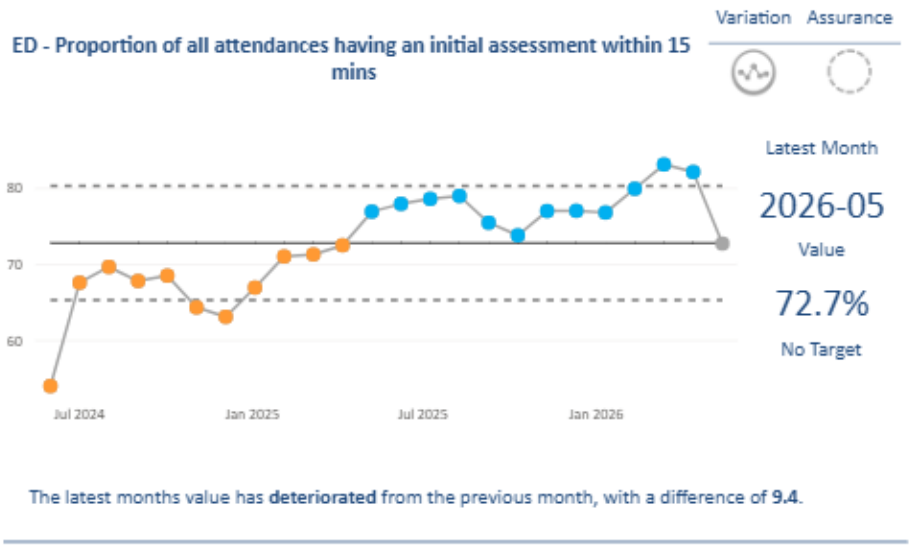
Increasing use of non-ED pathways may reduce or slow the increase of ambulance arrivals and attendances in the meantime.

Potential risks to improvement?

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

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

What actions are planned?

The proportion of patients having an initial assessment within 15 minutes has declined as expected due to the team adjusting to new ways of working with Nervecentre. Recovery is expected from June onwards.

What is the expected impact?

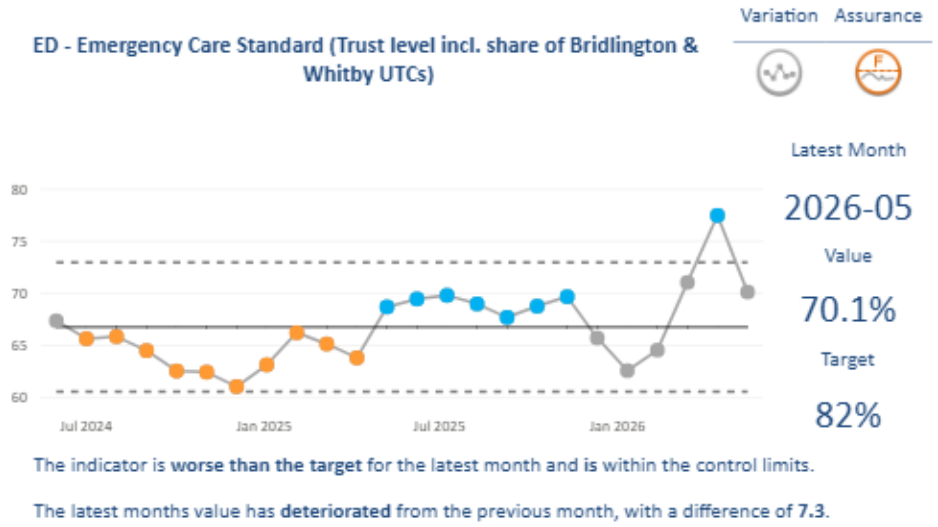
It is expected that multiple key metrics relating to our Emergency Departments start to recover in June 2026 as the new system becomes more embedded.

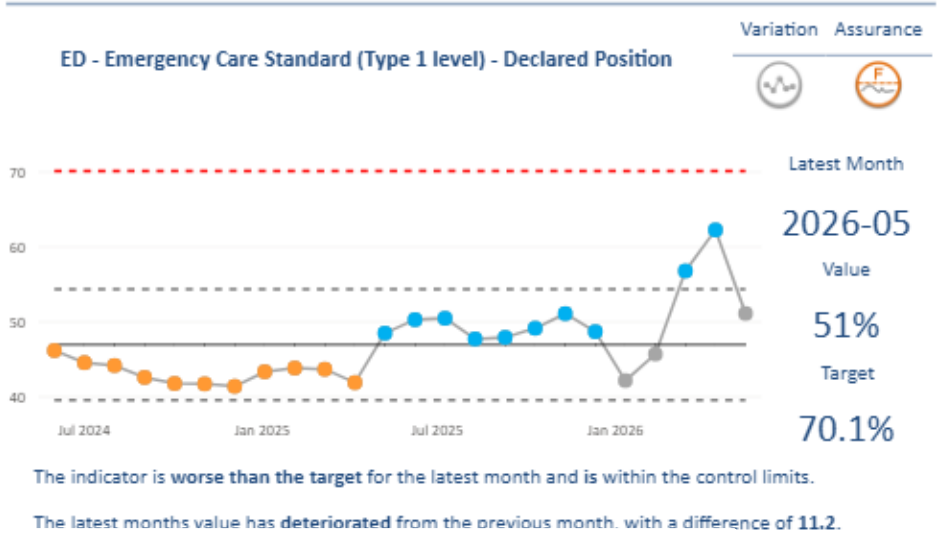
Potential risks to improvement?

- Increased support to ED withdrawn following Nervecentre launch
- Continued high attendances
- Increasing ambulance arrivals

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





Rationale: To monitor waiting times in Emergency Departments and Urgent Treatment Centres. **Target: SPC1:** NHS Objective to improve A&E waiting times so that no less than 82% of patients are seen within 4 hours by March 2027. **This is a True North Metric. SPC2:** Modelling showed that to achieve 82% as a Trust Type 1 performance needs to be at least 70%.

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

What actions are planned?

In May the transition to Nervecentre caused disruption to performance within both Emergency Departments. It was hoped that any decline caused would be mitigated by further development and use of the Extended Emergency Medicine Ambulatory Care (EEMAC) and Emergency Assessment Unit (EAU) pathways. This was not possible and performance at both sites fell.

Multiple after-action review sessions have taken place and the findings of that will be shared in June. Lessons learned can then be used in future changes.

A workshop took place on 2nd June 2026 with key stakeholders from emergency and acute medicine. The aim was to identify actions that can support performance recovery. These include further communication to medics about real-time documentation in Nervecentre which could reduce duplication of administrative tasks by doctors, thus freeing up more time to see patients.

What is the expected impact?

It is hoped that June performance increases but there is a risk that performance takes time to fully recover to April 2026 levels, as teams work through the actions agreed in the recent session.

Potential risks to improvement?

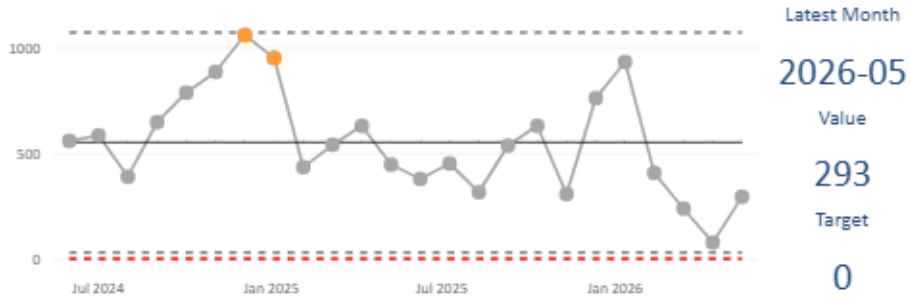
- Continued high attendance levels (Type 1) likely to continue based on trends
- Increased support to ED withdrawn following Nervecentre launch
- Financial constraints jeopardise the required workforce plan.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

ED - 12 hour trolley waits - Declared Position



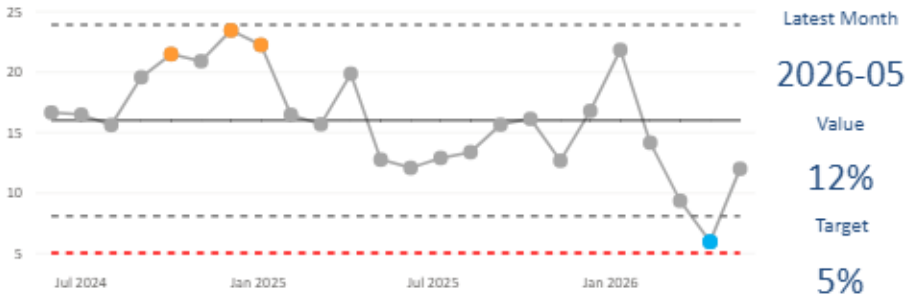
Latest Month
2026-05
Value
293
Target
0

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

The latest months value has **deteriorated** from the previous month, with a difference of **216.0**.

Variation Assurance

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



Latest Month
2026-05
Value
12%
Target
5%

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

The latest months value has **deteriorated** from the previous month, with a difference of **6.1**.

Rationale: To monitor long waits in A&E.
Target: SPC1: Zero patients to wait over 12 hours from decision to admit to being admitted. **SPC2:** Less than 5% of patients should wait more than 12 hours by end of March 2027. **This is a True North Metric.**

What actions are planned?

The Emergency Assessment Units (EAU) initially supported a reduction in patients spending over 12 hours in ED, because medical patients awaiting admission were being moved to and managed in the EAU by Acute Physicians.

In May there has been a challenge with maximising the opportunity this presents; there has been a lack of flow out of EAU due to low discharges home and high admission to the main bed base.

Work to refine these pathways continues since this is important for managing flow and eradicating corridor care.

What is the expected impact?

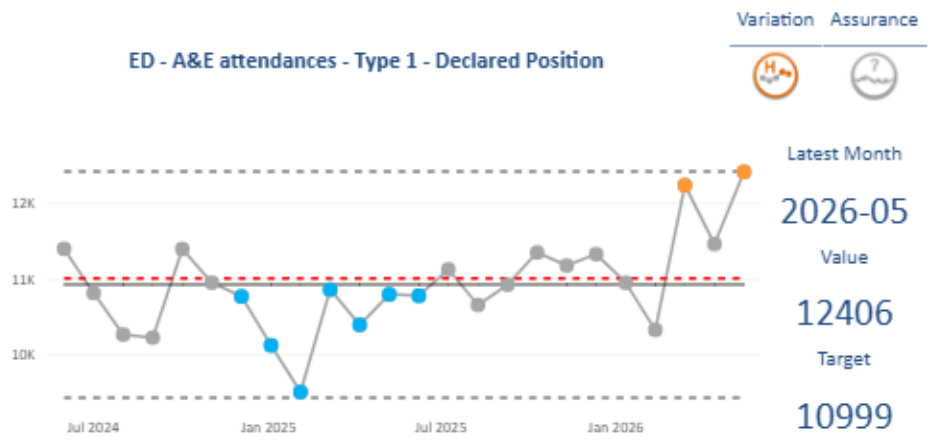
We expected the April position to hold in May 2026, however this was not possible. The change to Nervecentre both in ED and on wards has temporarily slowed processes including discharge processes. Multiple small changes to Nervecentre have been suggested to the Digital team who are supporting with ensuring the system is as efficient as it can be for staff.

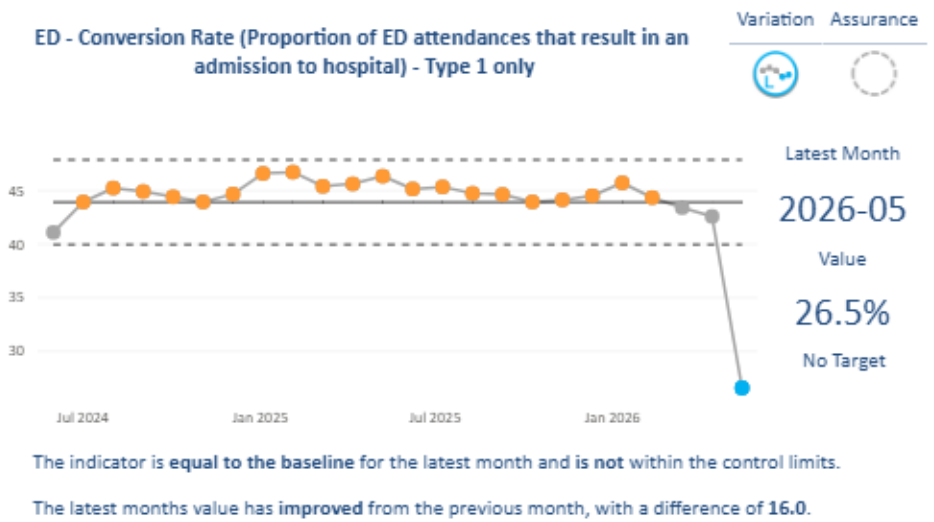
Potential risks to improvement?

- Community health and social care capacity remains challenged.
- Some patients are waiting for 12+ hours in EAU which can become full if patients are not discharged or moved to AMU and/or the main bed base.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

Note: At the launch of Nervecentre, admissions no longer includes admission to Type 5 SDEC areas. This explains the significant drop off in NEL admissions in May 2026. This is the driver for the reduction in the conversion rate as those patients are no longer counted as an admission. This is as per national guidance.

What actions are planned?

The new model of care, ie Extended Emergency Medicine Ambulatory Care (EEMAC) and Emergency Assessment Unit (EAU), brought senior decision making closer to the front door and appeared to successfully support a reduction in the proportion of patients being admitted in April 2026. Sustaining this has been difficult, particularly at Scarborough where there are insufficient senior medical staff to cover all areas every day. A business case for additional senior medics is being prepared.

What is the expected impact?

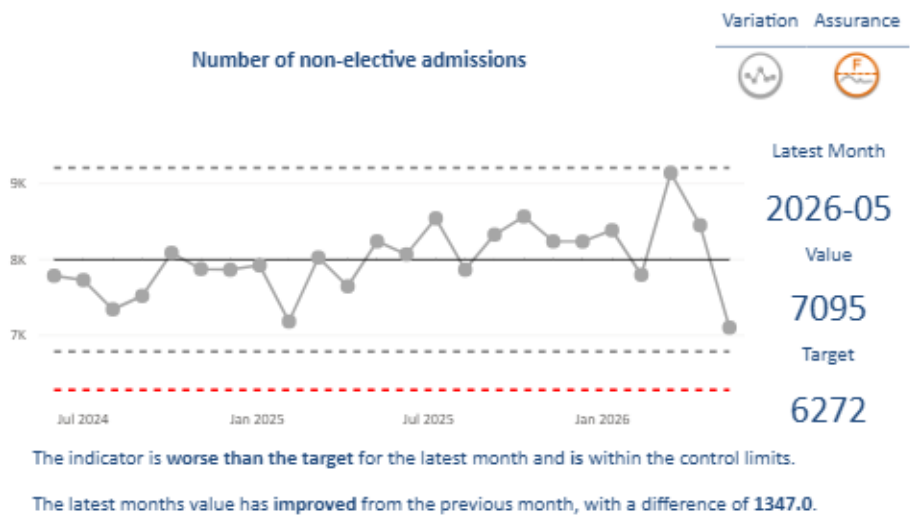
The reduction in admissions to the main bed base, ie general and acute beds, should hold.

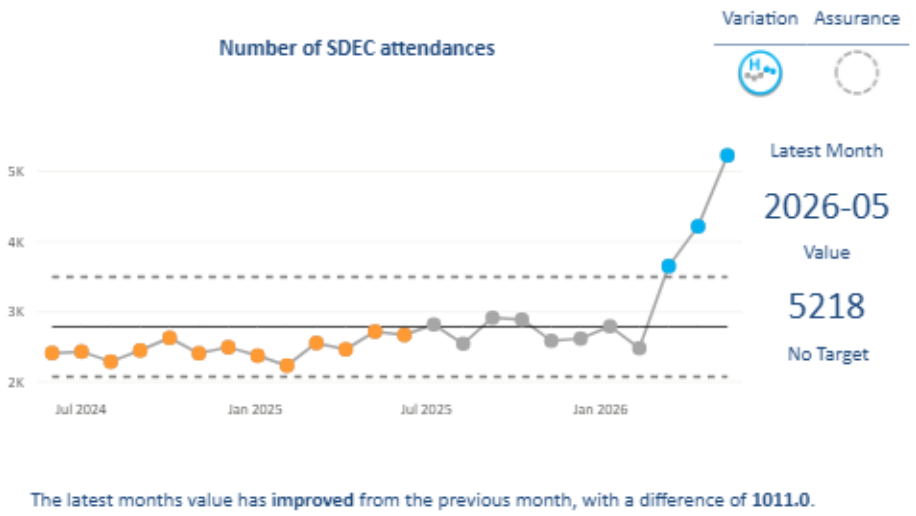
Potential risks to improvement?

There is a risk that the number of Type 1 attendances continues to rise, indicating a high volume of high acuity patients.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

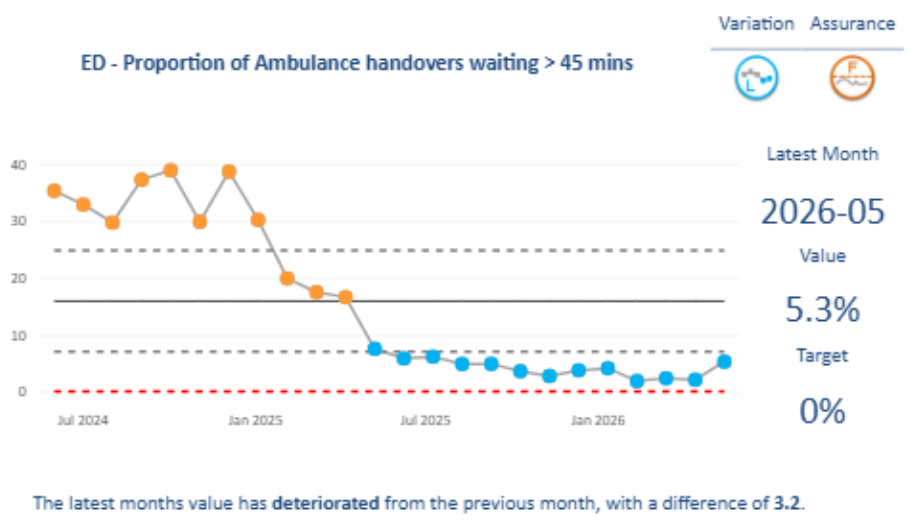
Note: At the launch of Nervecentre, admissions no longer includes admission to Type 5 SDEC areas. This explains the significant drop off in NEL admissions and the corresponding rise in SDEC attendances May 2026. This is as per national guidance.

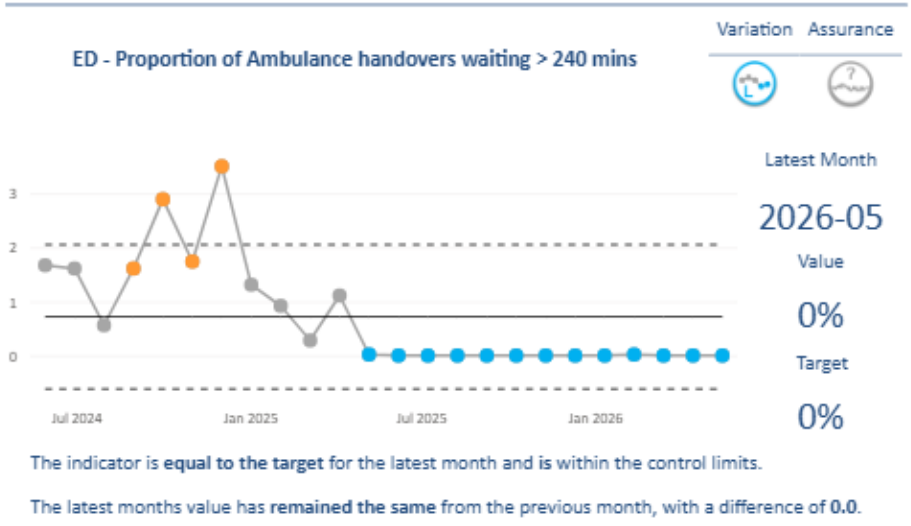
SDEC attendances includes all patients going to EEMAC and EAU, which accounts for the large increase in SDEC activity.

Plan for an Integrated Assessment Unit at York, which will encompass General Surgery, are progressing with multiple engagement sessions and conversations underway.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

As part of the recent recovery action planning session, it was agreed that regular meetings with Yorkshire Ambulance Service (YAS) team leaders for both sites will recommence from June 2026.

What is the expected impact?

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

Potential risks to improvement?

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

Acute Flow (3)
Scorecard

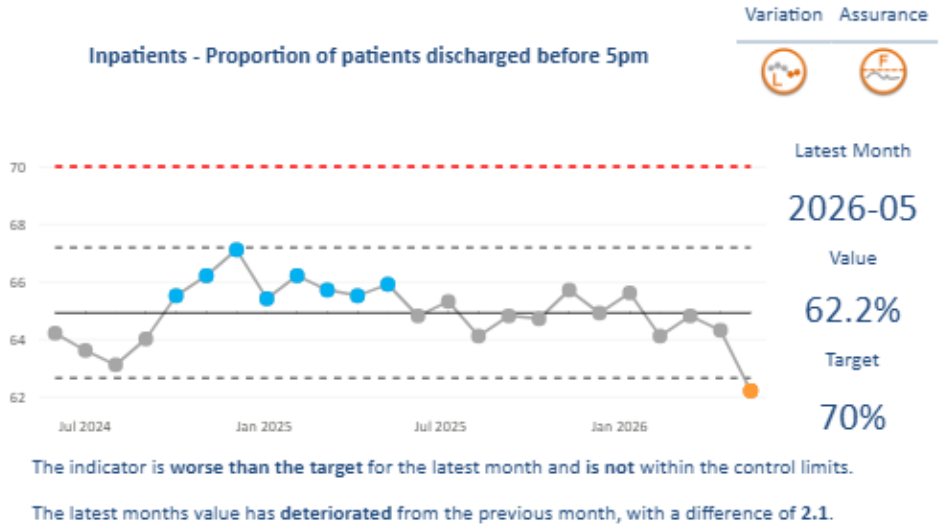
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

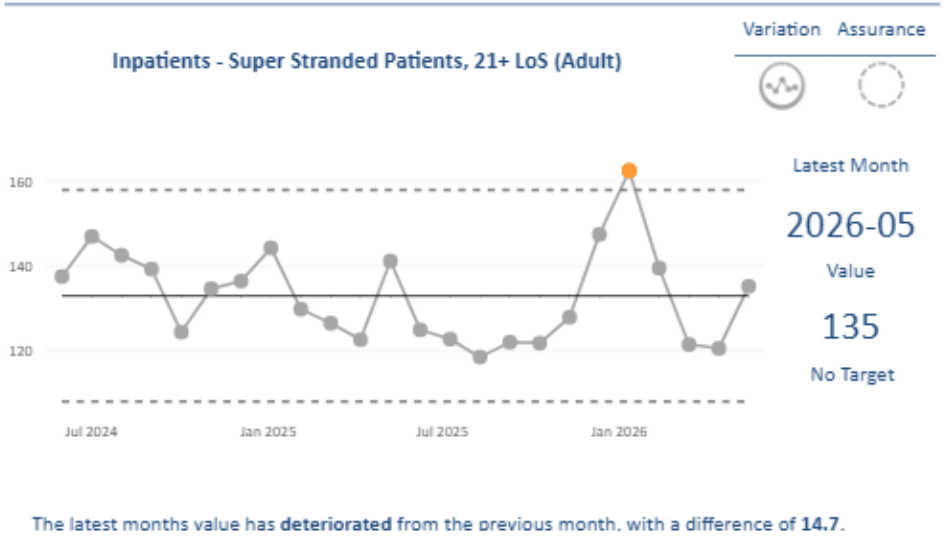
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2026-04		F	78.4%		90%
Patients with Senior Review completed at 23:59	2026-04	L		44.7%		
Inpatients - Proportion of patients discharged before 5pm	2026-05	L	F	62.2%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-05	H		1754		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-05			14.5%		
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-05	H	?	6.1	4	3.7
Number of non-elective admissions	2026-05		F	7095	8013	6272
Number of zero day length of stay non-elective admitted patients	2026-05	L		1826		
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-05			135		
Overnight general and acute beds open	2026-05		?	879	843	843
Of those overnight general and acute beds open, proportion occupied	2026-05		?	91.7%	91.9%	93.2%
Community bed occupancy/availability	2026-05		?	92.9%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

- There has been disruption to process completion on wards due to embedding the new patient database, and discharges have been later in the day. Note, the graph does not take into account that many patients move to the discharge lounge before 5pm, making beds available.
- During the new EPR rollout some staff were under the impression that patients could not be transferred to the discharge lounge prior to Electronic Discharge Notices being completed. This is not correct and communication has gone out with correct information, with Discharge Liaison Officers supporting the messaging too.
- We expected positive impact on 21+ day patients due to a new review process; however, approval of the new process has been delayed. The Coming off Corridors project will release senior medic time for reviews.
- For delayed complex discharges we are holding a process-mapping session in July to review the escalation process and ensure appropriate senior system partners support escalations.

What is the expected impact?

- Timeliness of discharges should return to normal levels next month.

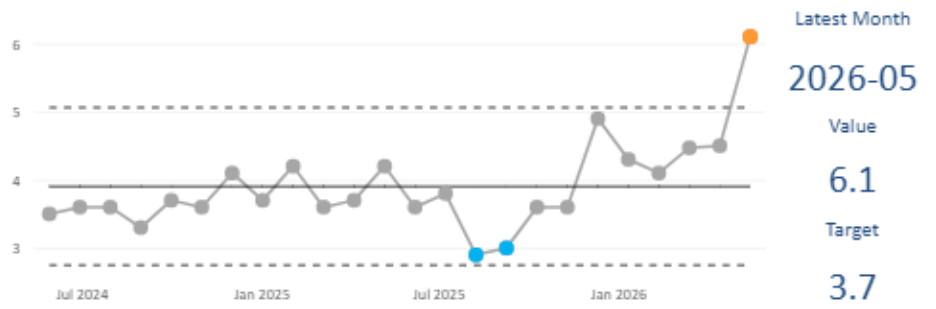
Potential risks to improvement?

- There is a critical dependency between community health and social care capacity and delivery of discharge performance.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

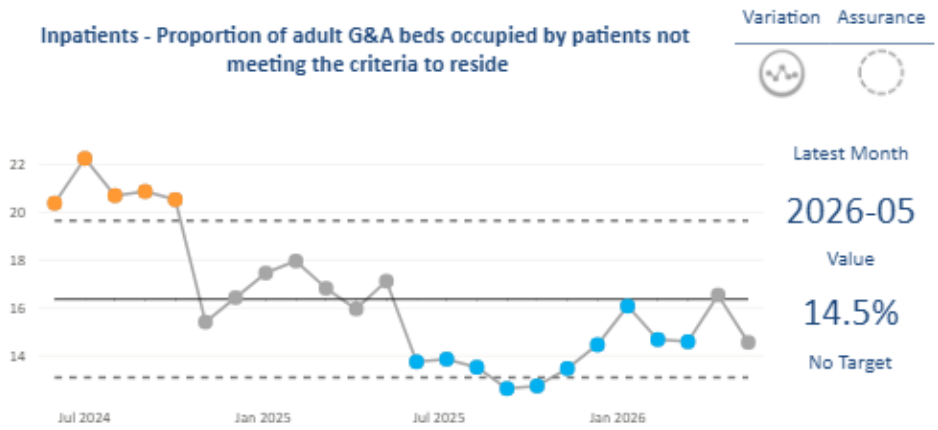
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)



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

The latest months value has **deteriorated** from the previous month, with a difference of **1.6**.

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



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

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

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: SPC1: To reduce the average number of beds days between the time a patient is assessed and fit for discharge to when a patient returns to the place they call home to less than 3.7 days by March 2027.

What actions are planned?

- The new Discharge Readiness Form went live on 7th May with Nervecentre. This has supported automation of multiple data fields and should lead to more 'describing, not prescribing' and patients moving out of acute care sooner, for onward review outside of our hospitals.
- Early feedback is that local authorities are readjusting to the different level of detail provided in this form. Conversations are ongoing, including through our Discharge to Assess task and finish group.
- Discharge Command Centre continues to receive support from the Digital team to ensure the new system is fit for purpose and as efficient as possible.

Potential risks to improvement?

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

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait from diagnosis to first treatment - Declared Position	* Cancer - Faster Diagnosis Standard - Declared Position * Cancer - 62 Day First Definitive Treatment Standard - Declared Position
SPECIAL CAUSE CONCERN			

CANCER
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard - Declared Position	2026-04		F	71.6%	72.5%	84.3%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-04		F	72.3%	66.5%	80%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-05			173		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-05			7.5%		
Cancer 31 day wait from diagnosis to first treatment - Declared Position	2026-04		?	94.9%	96.1%	96.3%
Total Cancer PTL size	2026-05			2260		

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

- The Cancer performance figures for April 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 71.6% failing to achieve the monthly improvement trajectory of 72.5%. In the latest available national data (March 2026) the Trust ranked 90th out of 119 NHS providers nationally and 7th out of 11 against our Model Hospital peer group (February: 99th and 8th respectively). **This is a True North Metric.**

- 62 Day waits for first treatment service standard in April 2026 was 72.3% , with the monthly trajectory of 66.5% achieved. In the latest available national data (March 2026) the Trust ranked 70th out of 119 providers nationally and 3rd out of 11 against our Model Hospital peer group (February: 58th and 4th respectively). This 62-day position is the highest the Trust has achieved in 12 months.

Factors impacting performance:

- The following cancer sites exceeded 80% FDS in April 2026: Breast & Non-Site Specific. Head & Neck, Colorectal, Upper GI and Urology achieved above their internal trajectories.

- The following cancer sites exceeded 75% 62-day service standard in April 2026: Breast, Gynaecology & Haematology. Head & Neck, Colorectal & Urology achieved above their internal trajectories.

- 31-day treatment standard was 94.9% overall, which was marginally below the national service standard of 96%. This was driven by Colorectal, Skin & Urology and a combination of patient-initiated delays and surgical treatments.

- At the end of April, the proportion of patients waiting over 104+ days equates to 1.6% of the PTL size, this position is stable between 2% and 2.6% over the last 6 months. Colorectal, Skin and Urology remain areas with the highest volume of patients past 62 days with/without a decision to treat but are yet to be treated or removed from the PTL, with Colorectal and Skin accounting for 60% of this patient cohort.

- Diagnostic performance, in particular pathology turnaround time, colonoscopy and fast track imaging acquisition is impacting faster diagnosis performance due to delays in diagnostic pathways.

Actions:

- Please see following pages for details.

KPIs – Operational Activity and Performance

Cancer (1)

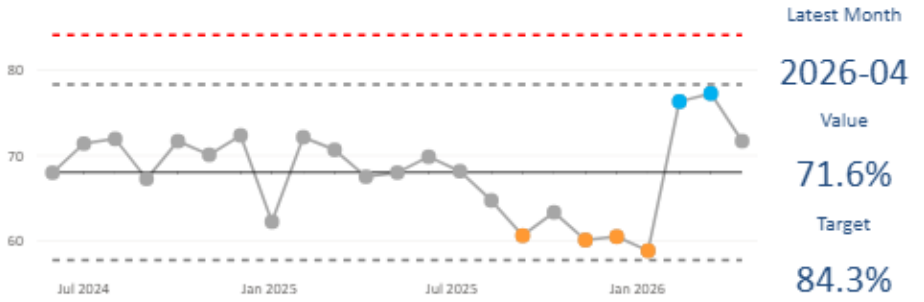
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Cancer - Faster Diagnosis Standard - Declared Position

Variation Assurance



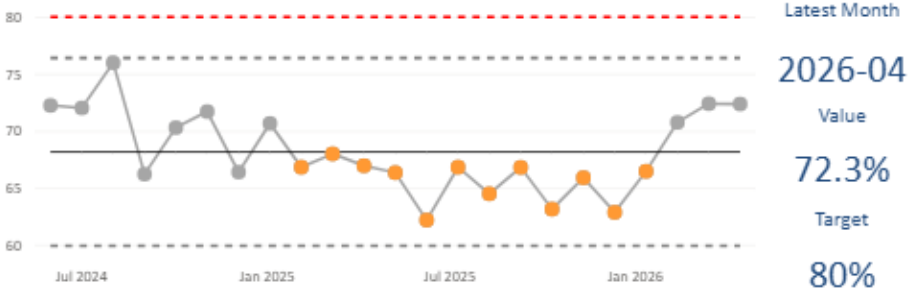
Latest Month
2026-04
Value
71.6%
Target
84.3%

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

The latest months value has **deteriorated** from the previous month, with a difference of **5.6**.

Cancer - 62 Day First Definitive Treatment Standard - Declared Position

Variation Assurance



Latest Month
2026-04
Value
72.3%
Target
80%

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

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

Rationale: SPC1: Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. **This is a True North Metric. SPC2:** National focus for 2026/27 is to continue improve performance against the headline 62-day standard**.**
Target: SPC1: 80% as an average for the whole of 2026/27. **SPC2:** 80% by March 2027.

What actions are planned?

2nd weekly Trust wide meeting remains in place to review specific FDS cohort and newly diagnosed patient. Targeted investment and transformation schemes from alliance funding
Colorectal New colorectal cancer lead appointed. Ongoing discussions with endoscopy around pilots to improve TAT through streamlining booking processes and provide additional capacity. Initial scoping discussions around COLOFiT and endoscopy pre-assessment hot clinics..
Urology STT CT model in haematuria commenced implementation. Ongoing discussions for implementing standardized discharge post Likert score and scope and consult model for TP biopsy, with target start date of March 26, however workforce rota changes required alongside clinical governance review and support. Target date for implementation end of Q1 26/27.
Gynaecology PMB pathway implementation on both sites however variability of referral compliance with new guidance around pre/post referral USS workup. East Coast lead clinician absent for extended period. Arrangements made for consultant and CNS cover at MDT to present patients, Working group to be initiated for IOTA ADNEX one stop model. Senior operational gaps mitigated in part with involvement of head of cancer running tumour site PTL meetings with ops appointments now complete.
Skin- Ongoing risk around dual running of telederm and non telederm pathways, alongside consultant sickness. Team exploring with interim clinical lead around step down options for patients on pathway, MOP's continued to be prioritised on clinical urgency. Scoping for community models pre-LES expiry in December 2026 but no definitive system plan as of yet.
Lung- internal working group setup with clinicians around lung work up process: PET CT access, EBUS capacity, IPT arrangements and MDT streamlining for SGH.

What is the expected impact?

Focus on maintaining and sustaining improved performance, whilst transformational actions also run in parallel.

Potential risks to improvement?

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

Headlines (Provisional performance):

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

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

- The Trust's **RTT Total Waiting list position** provisionally ended May 2026 behind the trajectory submitted to NHSE as part of the 2026/27 planning submission: 56,381 against the trajectory of 54,868 (+1,513).

- The Trust was provisionally ahead of the trajectory for the proportion of the **patients on an RTT waiting list under 18 weeks** at the end of May: 58.1% against 56.9%. Validation before submission is expected to deliver the trajectory. In the latest available national data (March 2026) the Trust ranked 113th worst out of 118 NHS providers and 10th worst out of 11 in our Model Hospital peer group (February: 111th and 10th respectively). **This is a True North Metric.**

- The Trust is provisionally behind the **RTT patients waiting over fifty-two weeks** trajectories submitted within the 2026/27 planning submission; 1,104 waiters and 2% of the total RTT Total Waiting list against the trajectories of 899 and 1.8%, respectively (+205 and 0.2%). Validation before submission is expected to improve performance against the trajectories. In the latest available national data (March 2026) the Trust was ranked 113th worst out of 118 NHS providers and 10th worst out of 11 in our Model Hospital peer group for the proportion of the TWL waiting over 52 weeks (February: 93rd and 8th respectively). Nationally at the end of February 2026 there were 6,573,234 patients on the national TWL, of which 90,175 (1.4%) were waiting over 52 weeks.

- The Trust was ahead of the trajectory for **RTT patients waiting no longer than 18 weeks for a first appointment** submitted to NHSE as part of the 2026/27 planning submission with performance of 63.9% against the end of May 2026 ambition to be above 61%. There is currently no nationally available comparative data for this metric.

Factors impacting performance:

- YTD for 2026/27 has seen a 3% rise in GP Referrals compared to the same period in 2025 (circa 750 additional referrals). There have been significant increases in several specialties, namely; Pain Management (+38%), Orthopaedics (+13%), Paediatrics (+34%) and Gastroenterology (+58%). The Trust continues to engage with the ICB to understand the drivers and the opportunities to mitigate.

Actions:

- Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

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

Referral to Treatment (RTT)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List - Provisional Position	2026-05	H	?	56381	54868	49360
RTT - Waits over 78 weeks for incomplete pathways - Provisional Position	2026-05	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Provisional Position	2026-05	L	?	0		0
RTT - Waits over 52 weeks for Incomplete Pathways - Provisional Position	2026-05		F	1104	899	0
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-05		F	58.1%	56.9%	67.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-05	L		17.5		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-05	L	F	2%	1.7%	0%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-05	H	F	63.9%	61%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-05	H		2%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-05	H		12.4%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-05	H		68.5%		

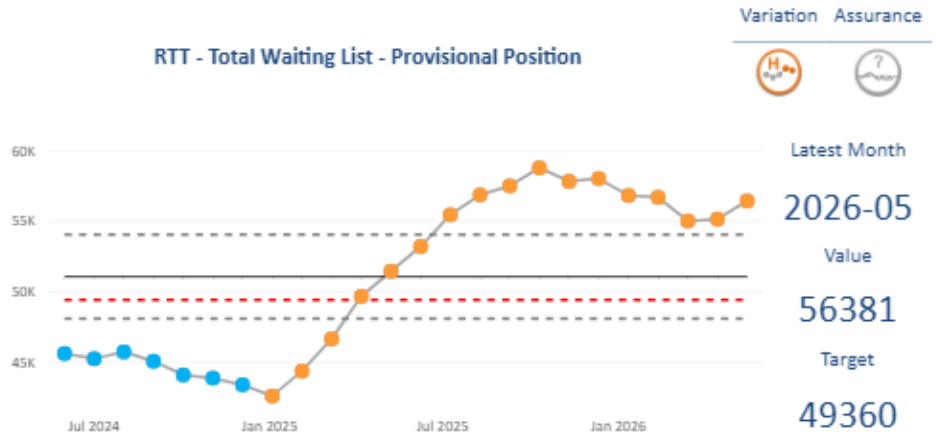
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

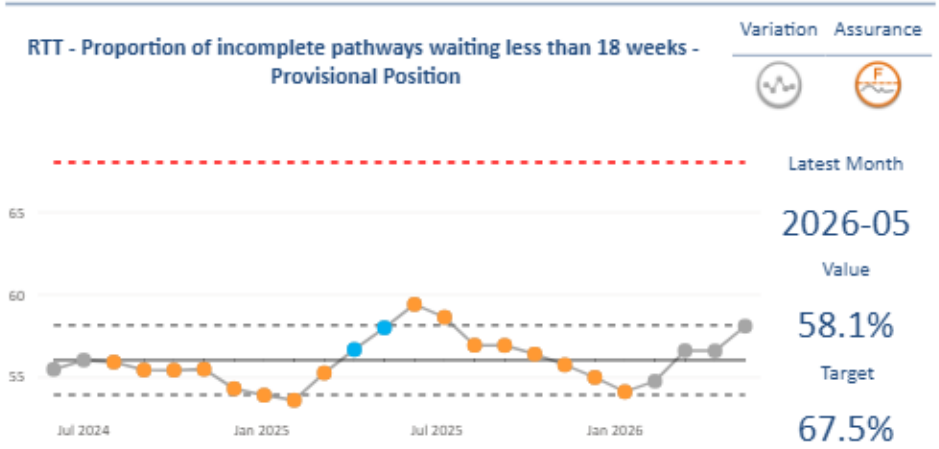
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **1283.0**.



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

The latest months value has **improved** from the previous month, with a difference of **1.5**.

Rationale: SPC1: To measure the size of the Referral to Treatment (RTT) incomplete pathways waiting list. **SPC2:** To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC1: Aim to have less than 49,360 patients waiting by March 2027 as per activity plan. **SPC2:** National constitutional target of 92% of patients should be waiting less than 18 weeks. Target for March 2027 is to be above 67.5%. **This is a True North Metric.**

What actions are planned?

- Fortnightly meetings in place from start of April 2026 with Care Groups to review activity and performance delivery at specialty level, proactive identification of issues to allow material mitigations to be made in month.
- The service delivery plan has a comprehensive list of actions to support the delivery of increased productivity and RTT performance improvement, these are monitored through the RTT Delivery Group.
- Focused regular BAU discussions to identify action to improve scheduling discipline and chronological booking ongoing with care groups and outpatient services.
- Intensive validation of patient cohort between 30-40 week continues to reduce patients breaching 52 weeks in Q1.
- Gynaecology intensive improvement week, supported with primary care physician being planned to identify further targeted improvement actions
- Delivery of single point of access in Q2/Q3 should reduce demand and support longer term reduction in TWL.

What is the expected impact?

- Reduction in the TWL.
- Reduction in the number of RTT52 week waits.
- The Trust continues to do very well on missed appointments, pre referral triage and high level of Advice and Guidance in Further faster cohort 2 and above the national provider median.

Potential risks to improvement?

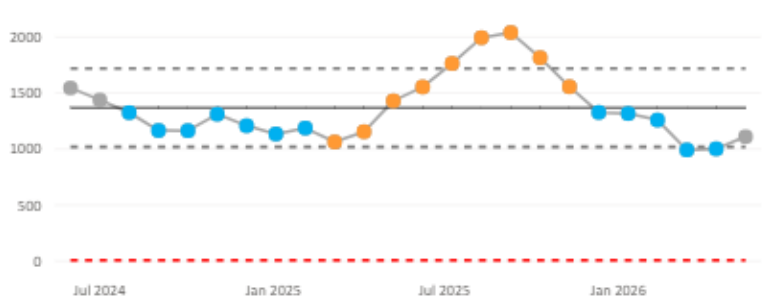
- Increase in GP referrals in YTD 2026/27 compared to 2025/26 (up 3%).
- Impact of delayed capital builds (CDC, Hybrid theatre, MRI, VIU, SGH Roof and RAAC), resulting in reduction in capacity and increasing waiting times.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

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

Variation Assurance



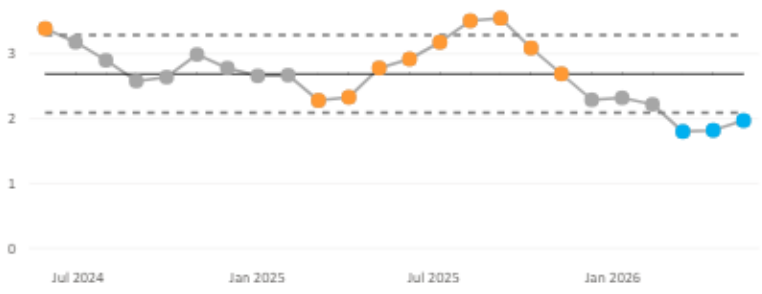
Latest Month
2026-05
Value
1104
Target
0

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

The latest months value has **deteriorated** from the previous month, with a difference of **108.0**.

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

Variation Assurance



Latest Month
2026-05
Value
2%
Target
0%

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

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

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC1 & SPC2: Aim to have zero patients waiting more than 52 weeks by March 2027 as per activity plan.

What actions are planned?

- Weekly monitoring of RTT52 week waits throughout the month with weekly trajectory in place. Scope of weekly meeting expanded in April 2026 to monitor full pathway metrics rather than focus on longest waiters. Maintaining zero RTT65 week waits remains a priority.
- Fortnightly meetings with Care Groups to review in month performance against activity and performance targets.
- Focused on improvement actions for Pain Management who are the service with most significant variance from plan. This includes funded additional capacity, commissioning discussions, review of other providers, request through NHSE tiering for external clinical review of pathways.

What is the expected impact?

- Reduced RTT long waiters.
- Activity Related Investment Panel (ARIP) to focus on requests for funding for targeted at specialties most in need.

Potential risks to improvement?

- Patient choice can lead to end of month breaches.
- Diagnostic performance.
- Capital Programme delays (RAAC replacement, CT replacement, Roof replacement, OP procedure rooms and hybrid theatres) which will impact on Diagnostic and theatre capacity at Scarborough and York through construction phases.
- Impact of diagnostic delays and prioritisation of cancer resulting in increase in 52-week waiters.
- Volume of 1st OPs on PTL, risk of breaches due to pathways of care resulting in longer waits and increase in RTT52 weeks.

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

Headlines:

- For the month of May 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 5.3% with performance of 4.7%. Y&S has three specialties in the upper quartile of Trusts within the NE&Y region (Clinical Haematology, Physiotherapy and Rheumatology).

- Rapid Access Chest Pain (RACP) seen within 14 days was at 83.7% below the target of 99% (April: 74.5%).

Factors impacting performance:

- In the latest North East & Yorkshire Region provided Outpatient data the Trust is above the national provider median for Pre-Referral Specialist Advice Utilisation and Diversion Rate (highest quartile for dermatology, gynaecology, paediatrics and urology) and DNA rate (lowest in NEY). Further internal opportunities identified to delivery productivity in plan and being supported and monitored through productivity programme.

- The Trust's DNA rate was 4.5% in May 2026. The Trust has one of the lowest DNA rates in the country, the national average is 5.6% (NHSE).

- Digital letters for Radiology – we have now reached 58% of letters via Synertec. The roll out has been delayed slightly due to the workflow for the safety questionnaire in MRI but this is being worked through.

- The Clinical letters pilot is being completed by the Ophthalmology Team. We are putting through 50-75 letters per day which is helping us refine the technical configuration with Synertec. Once we have updated some parts of the configuration, we will extend the pilot within Ophthalmology and to Rheumatology. This is planned by the end of June.

Actions:

- Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

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

Outpatients & Elective Care
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2026-05	H	F	22%		25%
Outpatients - DNA rates	2026-05		?	4.5%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-05		?	19172	22634	23266
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-05		P	40695	55654	55935
Outpatient procedures	2026-05			11646		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-05		F	27725		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-05	H	F	4.7%	5.3%	6.6%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-05	H	F	83.7%		99%
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days*	2026-05		?	2		0
Day Cases (based on Activity v Plan)	2026-05		?	6832	7313	7781
Electives (based on Activity v Plan)	2026-05		?	657	702	660
Proportion of elective admissions which are day case	2026-05		P	91.2%		85%
Outpatients: All Referral Types	2026-05			24429		
Outpatients: Consultant to Consultant Referrals	2026-05			2521		
Outpatients: GP Referrals	2026-05			11210		

KPIs – Operational Activity and Performance

Outpatients (1)

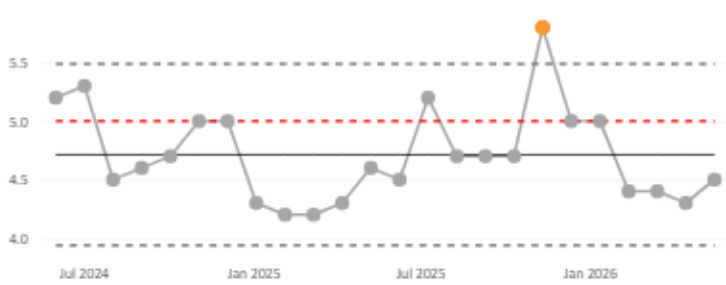
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Outpatients - DNA rates

Variation Assurance



Latest Month

2026-05

Value

4.5%

Target

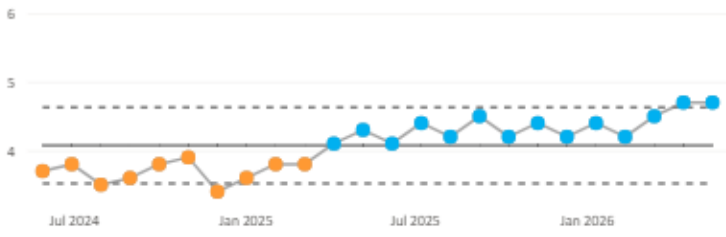
5%

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

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

Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)

Variation Assurance



Latest Month

2026-05

Value

4.7%

Target

6.6%

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

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

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

What actions are planned?

- A PIFU rate of 6.6% by March 2027 was included in the submitted plan. Specialties identified for rapid improvement work using the GIRFT pathways for implementation. These are Cardiology, Dermatology, ENT, Gynaecology, Neurology, Respiratory medicine, Trauma and Orthopaedics. This is supported by the Project Management Office team.

- GIRFT clinic template standards audit completed. Specialties have amended templates to reflect improvements, with further actions identified. Service reviews will continue in Q1 with endocrinology planned next and gap analysis being completed against full service delivery plan.

- Outpatient utilisation project commenced to increase utilisation to 90% and has seen steady improvement with 0.6improvement from April to May.

- DNA reduction project also commenced with targeted specialities with higher DNA rate. Focused analysis on new v follow up DNA to target interventions.

What is the expected impact?

- PIFU improvement to 6.6% (March 2027).
- Delivery of 1st Outpatient plan and reduction in new to follow up ratios.
- Reduced demand for high cost additional capacity.

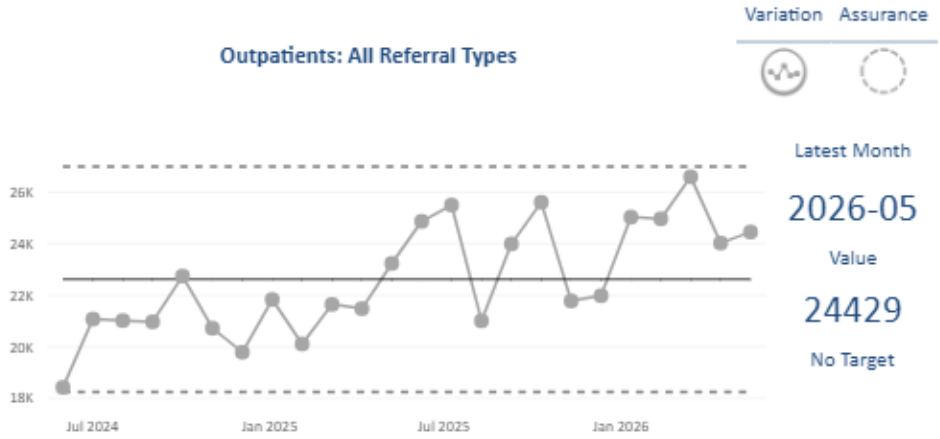
Potential risks to improvement?

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

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

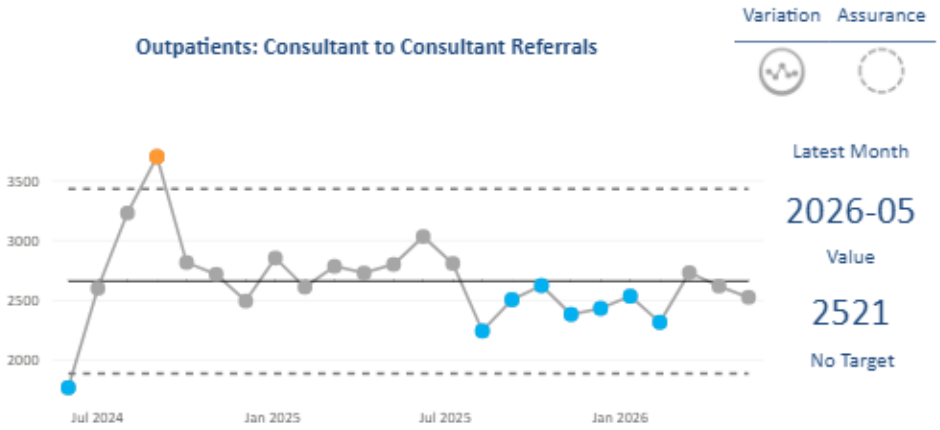
Outpatients: All Referral Types



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

The latest months value has **deteriorated** from the previous month, with a difference of **429.0**.

Outpatients: Consultant to Consultant Referrals



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

The latest months value has **improved** from the previous month, with a difference of **93.0**.

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

What actions are planned?

- Commenced with scoping project to reduce consultant to consultant referrals (C2C) by 10% from April 2026 (compared to 2025/26). Focus area in May will be pain referrals. YTD C2C are down by 14% compared to the same period in 2025/26.
- ICB undertaking review of GP referrals to identify outlying practices for further discussion and education.
- Single point of access proposal to be presented at Executive Committee in June. Plan required to deliver in 10 specialties by October 2026 in line with NHSE roadmap, these have been identified through review of impact on RTT performance. The Trust currently has 4 specialties with single point of access via gateway (REI); Clinical Haematology, Dermatology, Rheumatology and Neurology.

What is the expected impact?

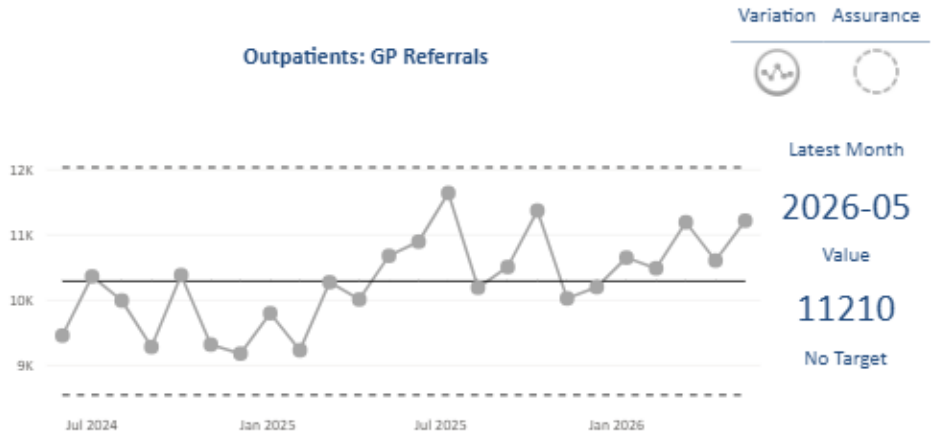
- Reduction in internal demand and reduction in open referrals**.**
- Reduction in GP demand.
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

Potential risks to improvement?

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

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **611.0**.

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

Please see previous page

Headlines:

- Trust DM01 performance at end May 2026 was 76%, a 3% improvement on the previous month and achieving the May trajectory of 75.8%.
- There was a reduction of just over 5% in total waiting list from 12,702 in April to 11,981 in May, as well as reduction in overall number of 6-week and 13-week breaches. 6-week breaches reduced by 16% month on month, and 13-week breaches reduced by 27% compared to the end of the previous month. In the latest available national data (March 2026) the Trust ranked 81st worst out of 118 NHS providers and 8th worst out of 11 in our Model Hospital peer group (February: 80th and 8th respectively).

Factors impacting performance:

- CT was the largest driver of deterioration in April performance but has seen a 13% improvement from 55% in April to 68% in May through use of staffed mobiles and waiting list initiatives. While still significantly under trajectory of 87.7%, due to the volume of waiters in this modality the improvement has impacted positively on overall DM01 performance and allowed recovery to overall Trust DM01 trajectory in May.

- Some deterioration in Non-Obstetric Ultrasound (NOUS) 6-week performance during May due to Yorkshire Health Solutions being unable to deliver sufficient activity due to their own staffing issues, however long wait patients have been prioritised into available capacity so 13-week waits continue to reduce despite increase in 6-week breaches.

- Delays in implementation of additional Audiology booths to allow extra clinical space to deliver activity. While the Malton and Bridlington booths are now in use, the site identified for the York booths is unsuitable due to noise levels, so these are not yet able to be used. Scoping around alternative space ongoing first week of June.

- While the outpatient element of Cystoscopy is performing well, there is a cohort of patients requiring inpatient procedures due to clinical or anaesthetic requirements and there has been insufficient theatre and related staffing availability to maintain performance in this pathway which brings overall performance down.

- Further delay in opening of Scarborough CDC. Operational go live scheduled for w/c 29 June 2026.

- Delay in installation dates for new equipment in both MRI and CT. Ongoing intermittent equipment breakdown impacts on ability to deliver planned activity.

- Workforce challenges in multiple modalities due to staff shortages caused by vacancies, sickness, and maternity leave. Recruitment is challenging in many areas, particularly imaging and physiological modalities, due to a national shortage of trained staff.

Summary MATRIX

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

MATRIX KEY

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

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

DIAGNOSTICS – National Target: 95%

Scorecard

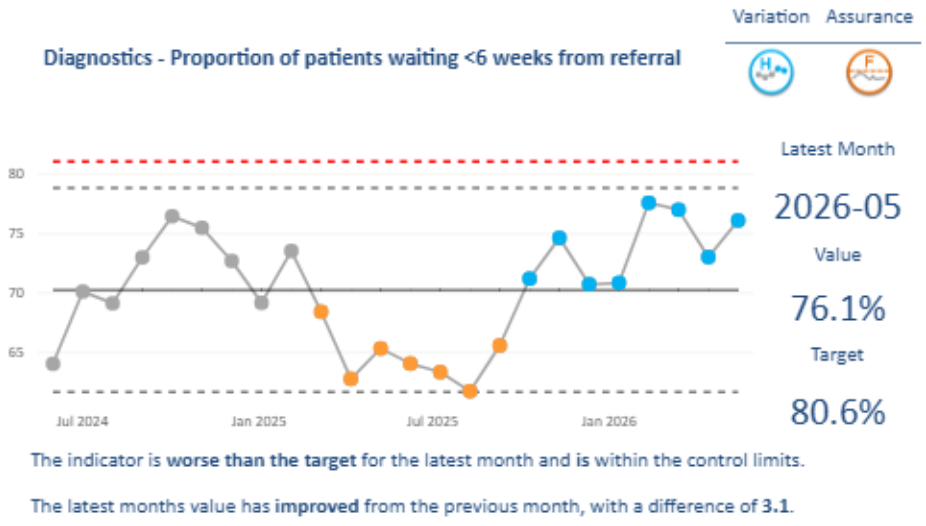
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Diagnostics - Proportion of patients waiting <6 weeks from referral	2026-05	H	F	76.1%	75.8%	80.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-05	H	F	93.9%	81.5%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-05		F	68.1%	87.7%	91.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-05		?	72.3%	75.9%	77.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-05	H	F	97.1%	80.8%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-05		?	84.2%	90.3%	86.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-05	H	F	81.5%	74.9%	80%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-05	L	?	24.6%	72.8%	79.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-05	L	?	74.1%	95.7%	95.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-05		?	91.4%	94.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-05	H	F	69.3%	70.7%	84.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-05	H	F	91.7%	80.5%	86%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-05	H	?	92.5%	82.5%	85.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-05		?	81.5%	65%	69.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-05	H	?	90.5%	83.2%	86%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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Rationale: Maximise diagnostic activity focused on patients of highest clinical priority.
Target: Increase the percentage of patients that receive a diagnostic test within 6 weeks to above 80.6% by end of March 2027.

What actions are planned?

Endoscopy: Recruitment continues with the aim to staff room 7, Monday to Friday by December 2026. Centralised preassessment clinics in Bridlington expected to be in place by the end of Q2 2026/27, to release 3 RN in York to support staffing of room 7. Cystoscopy service are working with the inpatient waiting list team to identify opportunities to clear the backlog, consultant availability dates identified up to July so potential for dates to be added pending theatre availability and related staffing.

Imaging: Staffing vacancies in MRI are being mitigated by use of RMS insourcing to retain core capacity until recruitment can be completed to return to full substantive establishment. YSJ scanner increased from 2 days to 4 days per week from end April. CT service leads developing plans for what capacity would be required to staff all scanners 7 days per week, 12 hours per day to allow recovery. Majority of 13+ week CT waits are cardiac scans; mobile being brought in mid June to clear this cohort. We are anticipating RMS beginning to deliver some NOUS capacity this month so it is expected that performance will recover by the end of June 2026. Scarborough CDC opening is anticipated by the end of June so this should help maintain performance. A solution to resolve the national field safety notice for DEXA was successfully installed on 18th of May 2026, resolving the issue of being unable to scan patients with implantable devices.

Physiological: WLIs have been planned to target long Urodynamics (UDS) waiters with two additional lists completed in May which have already led to an improvement in performance, and five further lists planned in June. Bank post advertising imminently for 2 days of an echocardiographer resulting in 20 additional slots per week at York. Utilising additional outpatient room wherever possible to increase echo capacity. Plan in place to increase Stress Echo and Echo capacity when new VIU opens - through physiologist led Stress Echo with Rapid Access Chest Pain nurse support. Respiratory pathways are being redesigned to include pre-appointment diagnostics where appropriate for patients on an open RTT pathway.

What is the expected impact?

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

Potential risks to improvement?

Ongoing issues with equipment breakdown and recruitment challenges.

Summary MATRIX

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

MATRIX KEY

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

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

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

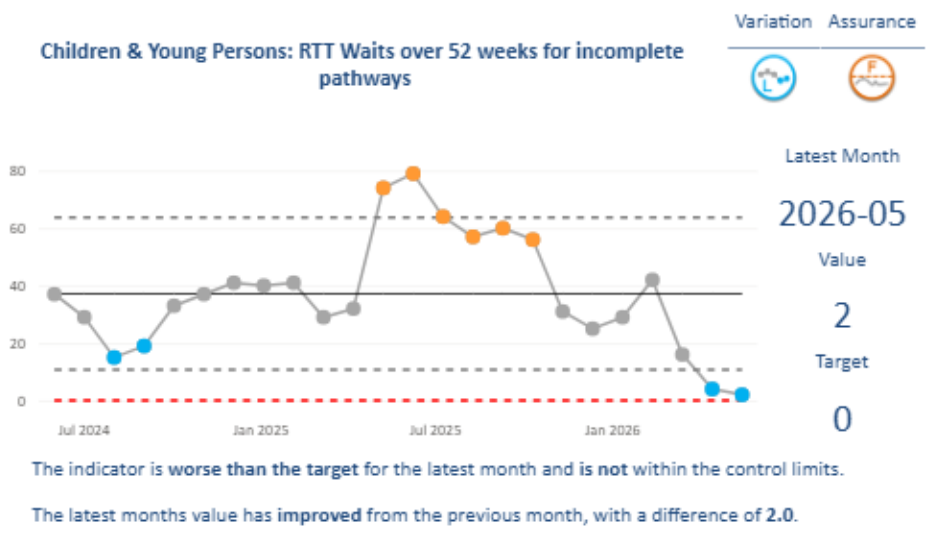
Executive Owner: Claire Hansen

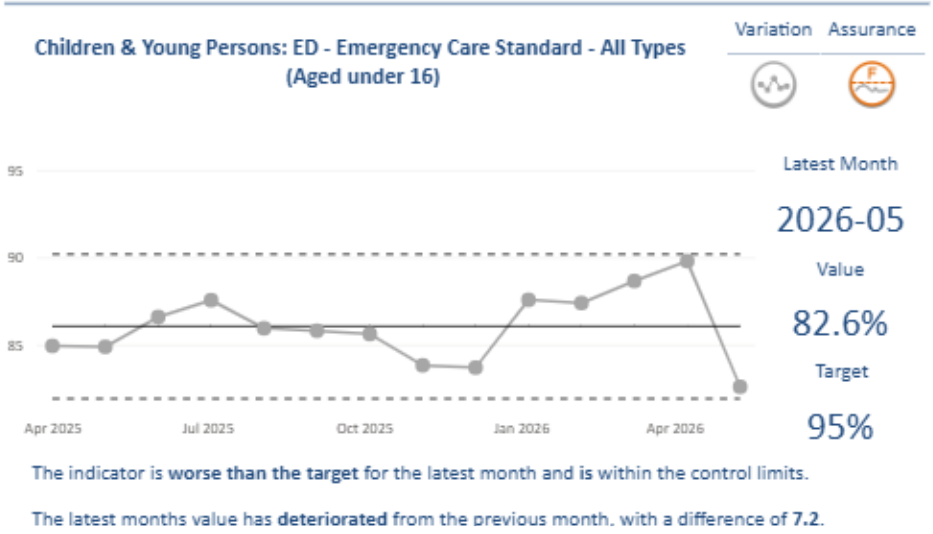
Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2026-05	H	?	63		0
Children & Young Persons: ED - Emergency Care Standard - All Types (Aged under 16)	2026-05		F	82.6%	94.1%	95%
Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Aged under 16)	2026-05			78.6%	94.1%	
Children & Young Persons: ED Attendances - Type 1 only (Aged under 16)	2026-05	H		1975		
Children & Young Persons: RTT - Total Waiting List	2026-05	H		4308		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-05	H	F	67.4%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-05	L	F	2	0	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi





Rationale: SPC1: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients. **SPC2:** To monitor waiting times in A&E and Urgent Care Centres.

Target: SPC1: Internal aim to have zero patients waiting more than 52 weeks by end of quarter one 2026/27. **SPC2:** Internal objective to improve A&E waiting times so that no less than 95% of CYP patients are seen within 4 hours by March 2027.

What actions are planned?

SPC1:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 weeks wait for patients aged under eighteen. Zero RTT40 week waits by the end of Q4 2025/26 except ENT and Oral Surgery was not delivered (provisionally fourteen at the end of May), Care Groups have refocused on delivering by the end of Q1.

- ENT and Oral Surgery were planning to deliver zero RTT52 week waiters by the end of May 2026, this was not achieved with two complex Oral Surgery patients waiting at month end. Both were treated in early June, and the services are confident of delivering zero for the end of June 2026.

SPC2:

- The team are closely monitoring paediatric time to initial assessment, triage and clinician review separately by site.

What is the expected impact?

- Improved ECS and 'wait to be seen' for CYP patients.
- Delivery of zero Paediatric RTT40 week waiters.

Potential risks to improvement?

- Impact of treating potential RTT52 week waits continues to take priority particularly in Head and Neck.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Total Urgent Community Response (UCR) referrals * Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	* Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list * Percentage of people on waiting lists for Children's Community Services per system who are waiting 18 weeks or less as proportion of entire Children's waiting list * Number of people on waiting lists for CYP services per system who are waiting over 52 weeks
COMMON CAUSE / NATURAL VARIATION	* Attended Community Care Contacts	* Proportion of intermediate care beds occupied by people with no criteria to reside * Proportion of Virtual Ward beds occupied	
SPECIAL CAUSE CONCERN		* Number of open Virtual Ward beds	

COMMUNITY
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Proportion of intermediate care beds occupied by people with no criteria to reside	2026-05		?	14.4%	25%	20%
Number of open Virtual Ward beds	2026-05	L	?	33	33	33
Proportion of Virtual Ward beds occupied	2026-05		?	45.5%	82%	82%
Community Response Team (CRT) Referrals	2026-05	H		567		
Total Urgent Community Response (UCR) referrals	2026-05	H	?	563	519	514
2-hour Urgent Community Response (UCR) care Referrals	2026-05	H		222		
2-hour Urgent Community Response (UCR) Compliancy %	2026-05			84.2%		
Attended Community Care Contacts	2026-05		P	37376	39126	41283
Number of District Nursing Contacts	2026-05			21099		
Number of Selby CRT Contacts	2026-05			2638		
Number of York CRT Contacts	2026-05			3413		
Referrals to District Nursing Team	2026-05			2078		

COMMUNITY
Scorecard (2)

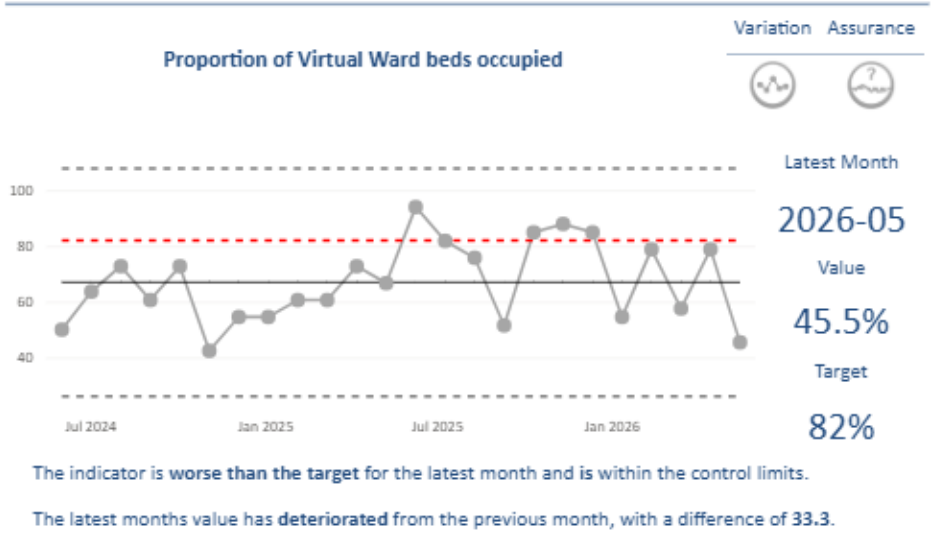
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of Adults (18+ years) on community waiting lists per system	2026-05	L		707		
Number of CYP (0-17 years) on community waiting lists per system	2026-05	L		1592		
Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list	2026-05	H	F	59.6%	60.3%	78%
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	2026-05	H	?	99.6%	99.6%	99.6%
Percentage of people on waiting lists for Children's Community Services per system who are waiting 18 weeks or less as proportion of entire Children's waiting list	2026-05	H	F	41.8%	42.9%	63.7%
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-05	L	F	539	562	0

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

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

What actions are planned?

The Frailty Virtual Ward / Hospital at Home model remains keen to expand to Selby following a successful test. To meet GIRFT requirements and further expansion, investment is required. The care group is looking into options of funding.

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

Potential risks to improvement?

- Challenges regarding the medical cover can sometimes cause instability of the service. This is the driver for the reduced occupancy in May; there is no provision for clinician cover for periods of leave.

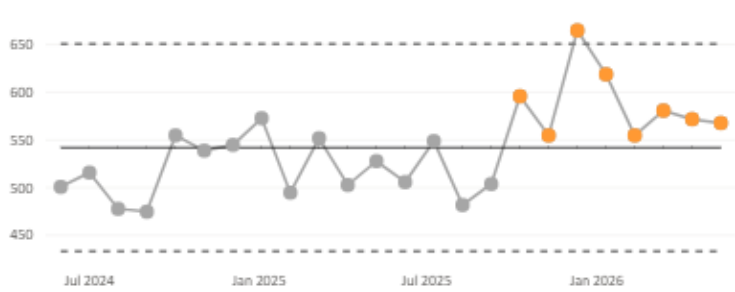
- There remains no service for Selby; funding for additional senior nurse to establish a 5 bedded Selby H@H service is not available. The team is working to establish source of funding. The system partners are supportive of this approach as part of the Selby neighbourhood model.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton

Variation Assurance

Community Response Team (CRT) Referrals

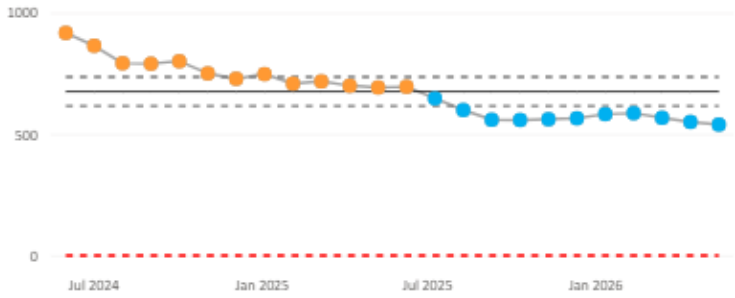


Latest Month
2026-05
Value
567
No Target

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

Variation Assurance

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



Latest Month
2026-05
Value
539
Target
0

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

The latest months value has **improved** from the previous month, with a difference of **11.0**.

Rationale: To monitor demand on Community services.
Target: SPC1: No target. **SPC2:** zero waiting over 52 weeks by end of March 2027 as per activity planning submission.

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

What actions are planned?

SPC1: Referrals for UCR and home-based intermediate care at home remain high. Workforce challenges remain with high sickness actively managed. Selby UCR continues to work well with the additional medic cover (1WTE).

SPC2: Speech and Language Therapy: the Trust is involved in regional and national work. Additional WTE mitigation included in 2026/27 plan, Care Group working through Business Case for implementation by end of Q2. Service delivered the trajectory for the end of May (539 against end of month ambition to be at or below 562).

What is the expected impact?

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

SLT – the service is exploring all options to reduce the long waiting patients. The Request for Help phone line and resources available through the Trust's website have been well received by patients and their families.

Potential risks to improvement?

- Capacity challenges and balancing step down and step up activity on a day-to-day basis.
- National shortage of SLT therapists.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

June 2026

Executive Owner: Karen Stone and Joe Hague

Highlights: IPC

- C.difficile **6 cases under** the year-to-date threshold.
- The IPC Hierarchy of Control Audits for all in-patient wards commenced in April 2026
- Band 7 Specialist IPC Nurse recruited, based at Scarborough

Concerns / Risks :

- E.coli bacteraemia **3 cases over** the year-to-date threshold
- MSSA bacteraemia **1 case over** year-to-date threshold.
- Pseudomonas bacteraemia - **4 cases over** the year-to-date threshold.

Next Steps:

- The IPC improvement plan has been refreshed for 2026/27 in recognition of the further stretch improvements required and delivery is being driven with the care groups.
- The priority improvement objective around the management of both urinary and venous catheters is continuing, with task and finish groups set up. This is based around the findings of a local audit undertaken in Q3 2025/26 with an agreed Care Group improvement objective of achieving 90% of all care delivery outcomes for invasive devices.

Highlights: Pressure ulcers

In May, 61 Category 2 pressure ulcers were reported, above the monthly target of 60. 20% stretch target agreed for 2026/27 to be reported in TPR.
Pressure ulcer rate (all categories) = 4 per 1000 bed days, against a target of 4.

Concerns / Risks:

- Appropriate seating equipment to support patients is not consistently available in all ward areas.
- An increase in mattress failure due to cell twisting has continued to be an issue, impacting equipment reliability and requiring targeted remedial action.

Next Steps:

- The Tissue Viability Nurse (TVN) team has continued virtual sessions to support accurate identification and categorisation of pressure ulcers.
- Funding has been released through charitable sources for the purchase of high-risk specialist chairs (91).
- Retrofitting of mattresses at SGH has been completed in May, with completion of other sites planned for June/July.
- NerveCentre launched providing strengthened referral pathways including access to photographic evidence to support assessment and escalation.

Summary MATRIX 1

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Total Number of Trust Onset MSSA Bacteraemias * Total Number of Trust Onset MRSA Bacteraemias * Total Number of Trust Onset C. difficile Infections * Total Number of Trust Onset E. coli Bacteraemias * Total Number of Trust Onset Klebsiella Bacteraemias * Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias * Pressure Ulcers per thousand Bed Days * Patient Falls per thousand Bed Days * Medication incidents per thousand bed days * Patient Safety Incidents per thousand Bed Days * Harmful Incidents per thousand bed days * Total Number of Never Events Reported * Monthly SHMI * Monthly HSMR	
SPECIAL CAUSE CONCERN			

Quality & Safety
Scorecard (1)

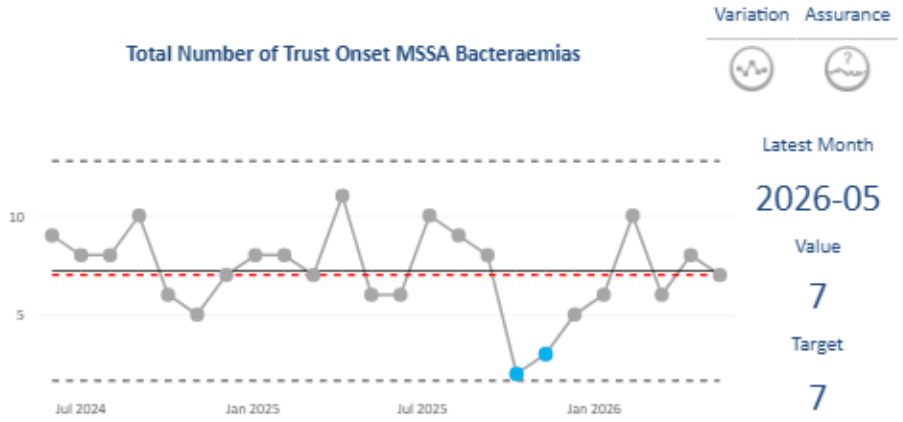
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Joe Hague **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2026-05			7	7	7
Total Number of Trust Onset MRSA Bacteraemias	2026-05			0		0
Total Number of Trust Onset C. difficile Infections	2026-05			4	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-05			20	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-05			4	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-05			5	2	2
Pressure Ulcers per thousand Bed Days	2026-05			3.5		4
Patient Falls per thousand Bed Days	2026-05			7.1		8.7
Medication incidents per thousand bed days	2026-05			4.3		6

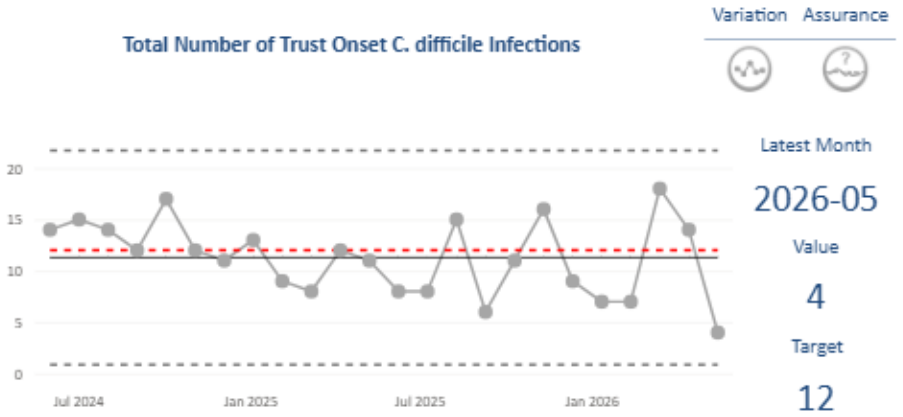
Executive Owner: Joe Hague

Operational Lead: Sue Peckitt



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

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



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

The latest months value has **improved** from the previous month, with a difference of **10.0**.

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

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

Key Risks:

- MSSA bacteraemia **1 case over** year-to-date threshold but a decrease on previous month
- E.coli bacteraemia - **3 cases over** the year-to-date threshold
- Pseudomonas bacteraemia - **4 cases over** the year-to-date threshold.

Key assurances/brilliances

- C.difficile **6 cases under** the year-to-date threshold
- Klebsiella bacteraemia **1 case under** the year-to-date threshold
- There is a Hospital Acquired Infection review process in place led by the Corporate IPC lead nurses and the Care Group senior team to identify key learning opportunities and key actions.
- The Deputy Director of Infection Prevention & Control (DIPC) reports against the agreed strategic IPC improvement plan to the Infection Prevention Strategic Advisory Group and to Quality Committee.
- The IPC Hierarchy of Control Audits for all in-patient wards commenced in April 2026
- Band 7 IPC specialist nurse recruited and based at Scarborough
- The IPC improvement plan has been refreshed for 2026/27 in recognition of the further stretch improvements required.

Next Key Improvements:

- The priority improvement objective around the management of both urinary and venous catheters is continuing. This is based around the findings of a local audit undertaken in Q3 with an agreed Care Group improvement objective of achieving 90% of all care delivery outcomes for invasive devices.
- Focused work continues with improving hand hygiene and the Gloves Off Campaign, as agreed with the Care Group Senior Nursing Teams.
- Clinical review of E.coli Bacteraemia and Klebsiella Bacteraemia cases to determine themes has continued with support of Microbiology Registrars.

Quality & Safety
Scorecard (2)

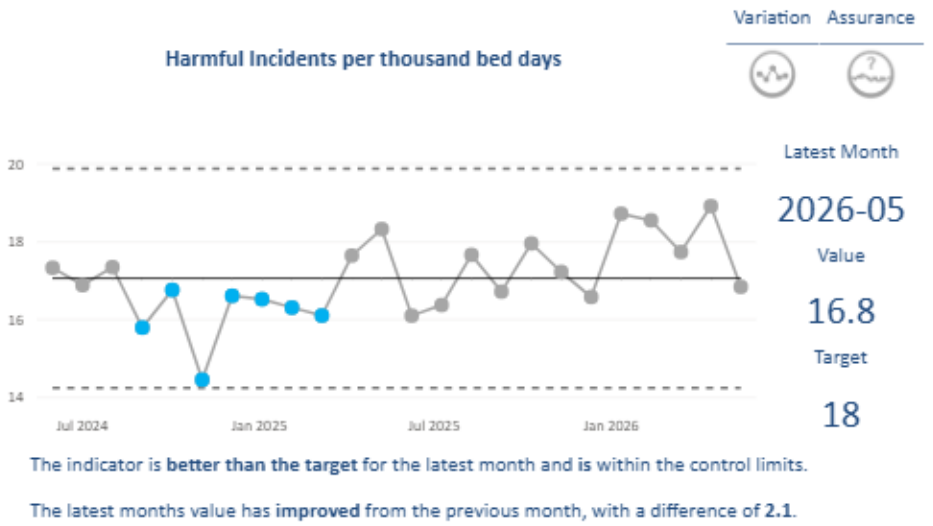
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Adele Coulthard/Joe Hague **Operational Lead:** Dan Palmer/Alice Hunter/Tara Filby/Sacha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patient Safety Incidents per thousand Bed Days	2026-05			51.7		56
Harmful Incidents per thousand bed days	2026-05			16.8		18
Total Number of Never Events Reported	2026-05			0		0
In-Hospital Deaths	2026-05			249		
Quarterly SHMI	2025-12			87.9		100
Monthly SHMI	2025-08			77.3		100
Quarterly HSMR	2025-09			105.7		100
Monthly HSMR	2025-09			108.9		100
Trust Complaints	2026-05			118		
Antepartum Stillbirths	2026-04			0		
Intrapartum Stillbirths	2026-04			0		
Early neonatal deaths (0-7 days)	2026-04			0		
PPH > 1.5L as % of all women - York	2026-04			6%		
PPH > 1.5L as % of all women - Scarborough	2026-04			0%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-04			71.4%		

Executive Owner: Adele Coulthard/ Joe Hague /Karen Stone

Operational Lead: /Alice Hunter



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

Target: No target identified as the reporting of incidents is an indicator of an open reporting culture

Incident reporting levels remain within the expected range, indicating normal variation.

Medication Safety Update

Assure

- 140 medication incidents reported; all reviewed, triaged and trended.
- 7 low harm and 3 moderate harm incidents were reported.
- Missed doses of insulin and Parkinson's medicines have reduced over five consecutive months following redefinition of time-critical medicines and a safety bulletin.
- Reported insulin administration errors have reduced for four consecutive months.

Advise

- A Patient Safety Incident Investigation is underway into care associated with severe dehydration, hypernatremia, acute respiratory failure requiring non-invasive ventilation, cardiac arrest and death.
- A Patient Safety Incident Investigation is underway into delays in escalation, senior and specialty review, and delivery of time-critical sepsis and operative interventions.
- The insulin administration quality improvement project has been completed, showing better prioritisation, no missed doses due to insulin unavailability, fewer avoidable missed doses and fewer hypoglycaemic events. Further work is needed on timely administration and responding to hypoglycaemia.

Next Steps

- Revised potassium guideline to go to the Medicines Optimisation Group for approval (June 2026).
- Hydrocortisone emergency injection kits have been sourced for roll-out, supported by a Medicines Matters briefing (June 2026).
- Medicines Matters bulletins on methotrexate and adrenaline auto-injectors to be issued (May 2026).
- The insulin quality improvement project will be presented at CLIC and the Diabetes and Endocrine Clinical Governance Meeting (July 2026), with learning shared in the incidents bulletin (June 2026).
- Medication safety functions within Nervecentre will be reviewed and recommendations developed (June 2026).
- GIRFT guidance on insulin storage in neonatal areas will be addressed with pharmacy clinical governance, quality assurance and the neonatal specialty (June 2026).
- MHRA drug safety updates on nasal decongestant sprays and finasteride/dutasteride will be included in the learning bulletin (May 2026).
- Updated NICE guidance on isotretinoin prescribing in under-18s will be shared via the learning bulletin (May 2026).

Executive Owner: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy

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

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

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

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

Complaints

Factors impacting performance:

The SPC chart continues to show common cause variation in relation to the number of complaints received. There are a similar number of complaints in the month of May with 118 new complaints across the Trust received in the month of May 2026 (in contrast to 119 in April 2026).

57% of complaints were closed in 30 days (compared to 71% in April 2026) and 50% of complex complaints were closed in 45 days (compared to 47% in April 2026) showing decline in complaint response times. Performance remains below the expected compliance rate of 90% that was to be achieved by the end of April 2026.

Key risks and emerging risks

- 208 cases (82%) of the backlog of concerns have been closed. Of the 46 cases that remain open, 41 relate to surgery.
- Recruitment of the new Concern and Complaints Officer has been delayed as the advert had to be withdrawn and candidates stood down for interview due to the late notification of someone to be considered for the role from the redeployment register. This will mean there is a risk that the position currently being filled by a secondment will be vacant for some weeks if the redeployment candidate is unsuitable.

Key assurances

- PALS are supporting with closing the backlog open concerns for surgery.
- The corporate patient experience team continue to support Care Groups with a number of complex complaints to reduce the burden on Care Group leadership teams.
- Care Groups will be working towards achieving the 90% target for complaints/complex complaints responses by the end of August 2026
- Over the forthcoming financial year there will be an expansion of the "What Matters to You" training, the launch of an internally delivered customer-support skills programme to equip staff with the confidence and capability to communicate effectively and help improve patient and carer communication
- Trust wide patient experience priorities and KPI's have been proposed and will be finalised through the Chief Nurse Team in June.

Next key improvement actions

The following priorities have been identified to improve complaints performance alongside continuing to provide timely resolution of complaints within policy timescales:

- June - education for Investigating Officers to equip them with the confidence and capability to deliver against their responsibilities - this has been delayed from June due to other Trust activities in relation to eliminating corridor care
- June onwards - culture and communication, promoting a Trust-wider shift to addressing concerns in the moment, prevent escalation of complaints and improve patient experience
- June/July onwards - triangulation of complaint themes and insights to drive patient-centred improvements.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

June 2026

Executive Owner: Karen Stone and Sascha Wells-Munro

Please note that Maternity Services provide a dedicated report to Trust Board against a range of quality and safety metrics. The metrics in this TPR are currently under review.
Highlights:
Special Care Baby Unit.
Concerns / Risks :
Special Care Baby Unit had a period of reaching full capacity in December 2025. This has now resolved and is managed through the business continuity plan in place to support that pathway of care.
Next Steps:.
Maternity and Neonatal services are working with the local Operational Delivery Network (ODN) to review the current service delivery pathway for SCBU in Scarborough.

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

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

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

Summary MATRIX
Maternity Scarborough

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

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

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2026-04		P	120		169	Target
No. of women delivered - Scarborough	2026-04			95		112	Target
Births - Scarborough	2026-04			96		113	Target
Induction of labour - Scarborough	2026-04			44.7%		43.9%	Baseline
Elective caesarean - Scarborough	2026-04			20.2%		16%	Baseline
Emergency caesarean - Scarborough	2026-04			27.6%		28.3%	Baseline
BBA - Scarborough	2026-04			1		2	Target
Total number of Stillbirths - Scarborough	2026-04			0			No Target
Neonatal Death - Scarborough	2026-04			0		0	Target
Number of maternity diverts/unit closures - Scarborough	2026-04			0			No Target
Homebirth service suspended - Scarborough	2026-04		F	30		3	Target
SCBU at capacity - Scarborough	2026-02			0		0	Baseline
% of 3rd and 4th degree tears - Scarborough	2026-04			0%			No Target
L/W Co-ordinator supernumerary % - Scarborough	2026-04	H		100%		100%	Target
Breastfeeding Initiation rate - Scarborough	2026-04			58.3%		75%	Target

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	2026-03			0		0	Target
% of women seen within 15 minutes in triage - Scarborough	2026-04			91.2%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - Scarborough	2026-04			0			No Target
Number of babies transferred out for cooling - Scarborough	2026-04			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - Scarborough	2026-04			6			No Target
Number of babies born with an Apgar of 7 at 5 mins - Scarborough	2026-04			5			No Target
Number of maternal deaths - Scarborough	2026-03			0			No Target
Number of midwifery red flags - Scarborough	2026-04			1			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - Scarborough	2026-04			0			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - Scarborough	2026-04			0			No Target
Number of planned caesarean sections > 24 hours - Scarborough	2026-04			2			No Target

Summary MATRIX
Maternity York

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

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

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - York	2026-04			287		295	Target
No. of women delivered - York	2026-04			219		242	Target
Births - York	2026-04			221		245	Target
Induction of labour - York	2026-04			46.1%		40.9%	Baseline
Elective caesarean - York	2026-04			15.3%		17%	Baseline
Emergency caesarean - York	2026-04			25.7%		23%	Baseline
BBA - York	2026-04			4		2	Target
Total number of Stillbirths - York	2026-04			0			No Target
Neonatal Death - York	2026-04			0		0	Target
Number of maternity diverts/unit closures - York	2026-04			4			No Target
Homebirth service suspended - York	2026-04		F	22		3	Target
SCBU at capacity - York	2026-02		P	0		0	Baseline
% of 3rd and 4th degree tears - York	2026-04			0.9%			No Target
L/W Co-ordinator supernumerary % - York	2026-04	H		100%		100%	Target
Breastfeeding Initiation rate - York	2026-04			70.7%		75%	Target

Maternity York
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - York	2026-03			1		0	Target
% of women seen within 15 minutes in triage - York	2026-04			93.1%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - York	2026-04			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - York	2026-04			9			No Target
Number of babies born with an Apgar of 7 at 5 mins - York	2026-04			4			No Target
Number of maternal deaths - York	2026-04			0			No Target
Number of midwifery red flags - York	2026-04			1			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - York	2026-03			1			No Target
Number of planned caesarean sections > 24 hours - York	2026-04			0			No Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

June 2026

Executive Owner: Lydia Larcum

1. Highlights

- Workforce size remained aligned with plan in April at 9,987 whole time equivalents, with sustained reduction in the use of agency workers.
- Recruitment activity continues, including new medical appointments, offers for consultant posts, and a pipeline of health care support workers progressing through pre-employment and training.
- A new wellbeing facility has opened at Scarborough Hospital, strengthening support for colleagues alongside existing provision across the Group.

2. Concerns

- Sickness absence remains above plan, with an annual rate of 5.4% compared to a planned trajectory of 5.2%, and 489 whole time equivalents lost in April alone.
- Ongoing industrial action and the need to maintain safe staffing levels are expected to increase temporary staffing costs, alongside a slight rise in bank rate escalations.
- Workforce supply risks remain in key areas, including 13 unfilled resident doctor posts ahead of August.

3. Future

- Further action is planned to reduce temporary staffing costs, including continued negotiation with agencies, tighter control of escalation processes, and conversion of agency staff to bank or substantive roles.
- Work is underway to support the August doctor changeover, including onboarding of new doctors and exploration of parallel recruitment to fill unallocated posts.
- A programme of organisational development is planned over the summer, including a Group-wide engagement exercise to inform future improvements in accountability, quality, and culture.

Summary MATRIX

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

MATRIX KEY

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

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

Workforce
Scorecard (1)

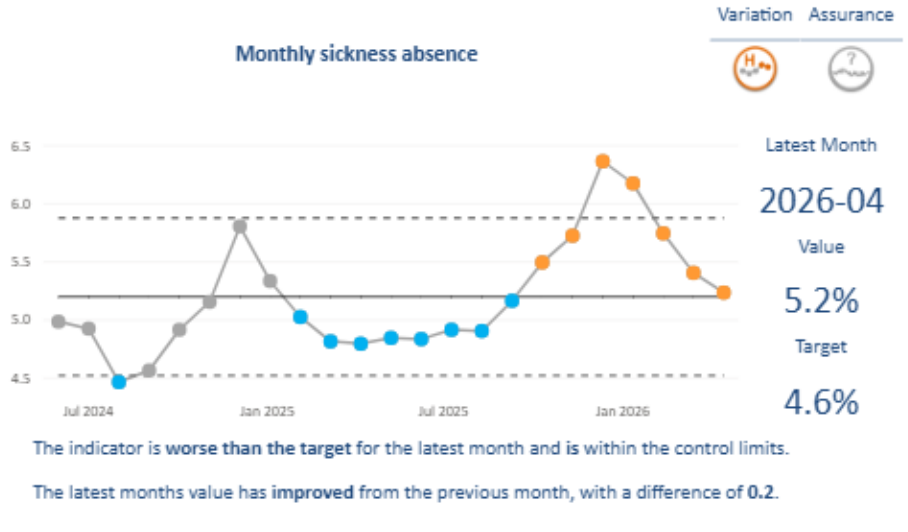
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

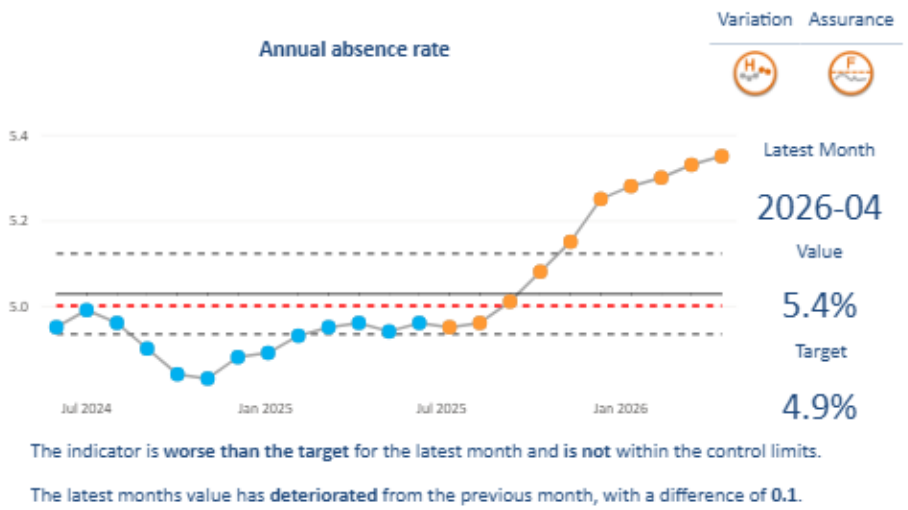
Executive Owner: Lydia Larcum **Operational Lead:** Amy Messenger/Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-04	H	?	5.2%	4.7%	4.6%
Annual absence rate	2026-04	H	F	5.4%		4.9%
Total Agency Whole Time Equivalent Filled	2026-04	L	F	42.2	55	52
Total Bank Whole Time Equivalent Filled	2026-04		?	552.8	542	536
12 month rolling turnover rate Trust (FTE)	2026-05	L	?	7.6%		8.5%
Overall vacancy rate	2026-05		?	8.3%		7.7%
HCSW vacancy rate	2026-05		?	13.1%		8%
Midwifery vacancy rate	2026-05	H	?	6.1%		0%
Medical and dental vacancy rate	2026-05	L	?	3.7%		6%
Registered Nursing vacancy rate	2026-05	L	?	3.6%		5%
AHP vacancy rate	2026-05		?	6.8%		7%

Executive Owner: Lydia Larcum

Operational Lead: Nicola English





Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.9% annual absence rate (March 2027)

Factors impacting performance and actions:

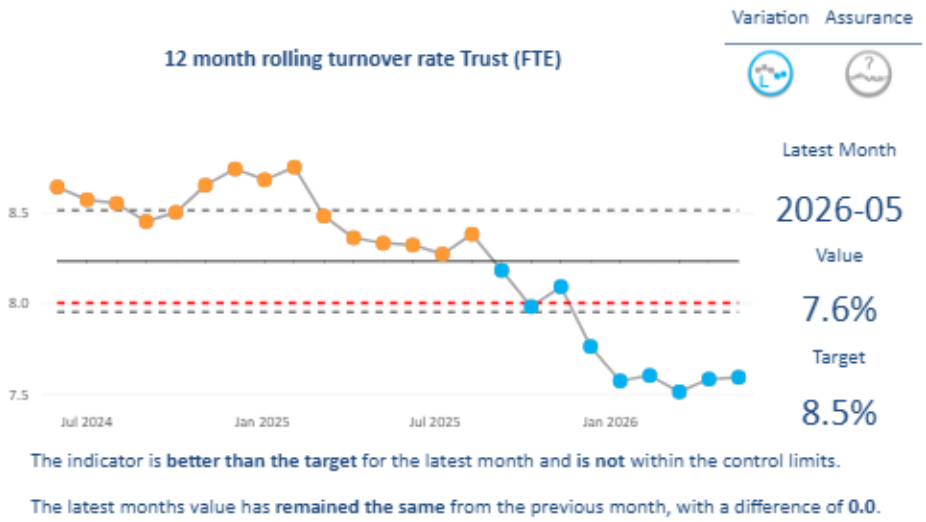
In April, the rate of sickness absence amongst colleagues was 5.2%. This translates into 489 WTE being lost to sickness over the month. The main reasons for sickness were largely unchanged: stress and anxiety accounted for 28% of absences and 14% were attributed to musculoskeletal issues.

The position in April contributed to an annual absence rate of 5.4% across the Group. This is 0.2% higher than the trajectory in the workforce plan. The Group has planned for a 4.9% absence rate in the 12-months up to and including March 2027.

The new wellbeing room at Scarborough Hospital has opened, providing a dedicated, tranquil space for colleagues to reflect and recharge during demanding shifts. Funded with support from York and Scarborough Hospitals Charity, it complements existing facilities at York and Bridlington and forms part of the Group's wider commitment to supporting colleague wellbeing.

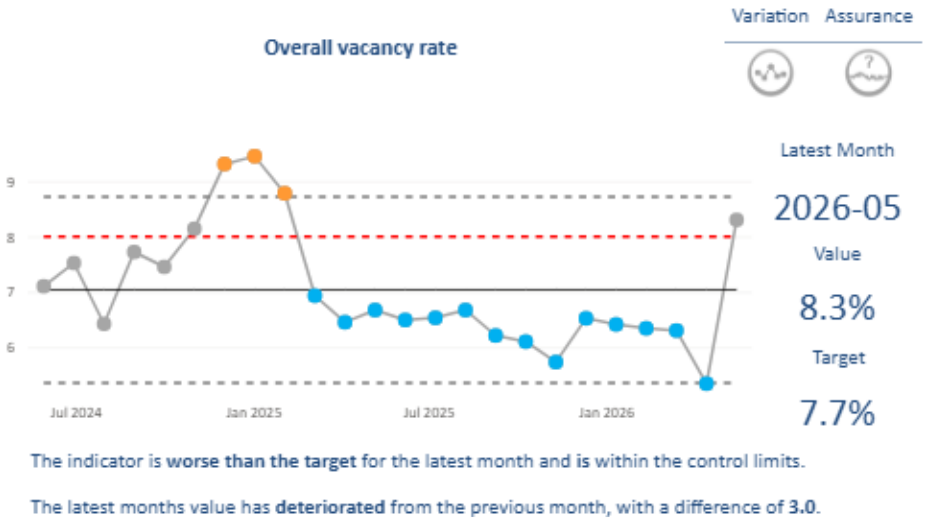
Executive Owner: Lydia Larcum

Operational Lead: Will Thornton



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

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



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

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

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 8.5% Vacancy Rate 7.7%

Factors impacting performance and actions:

In April 2026, the Group's total workforce WTE was 9,987, exactly in alignment with its workforce plan. This breaks down as follows:

Type	Apr-26 WTE plan	Apr-26 WTE actual	WTE Variance with plan	Apr-25 WTE actual for comparison
Substantive	9391	9392	+1	9297
Bank	542	553	+11	542
Agency	55	42	-13	90

The net change in workforce size between March and April was -89 WTE, which fits with a seasonal pattern.

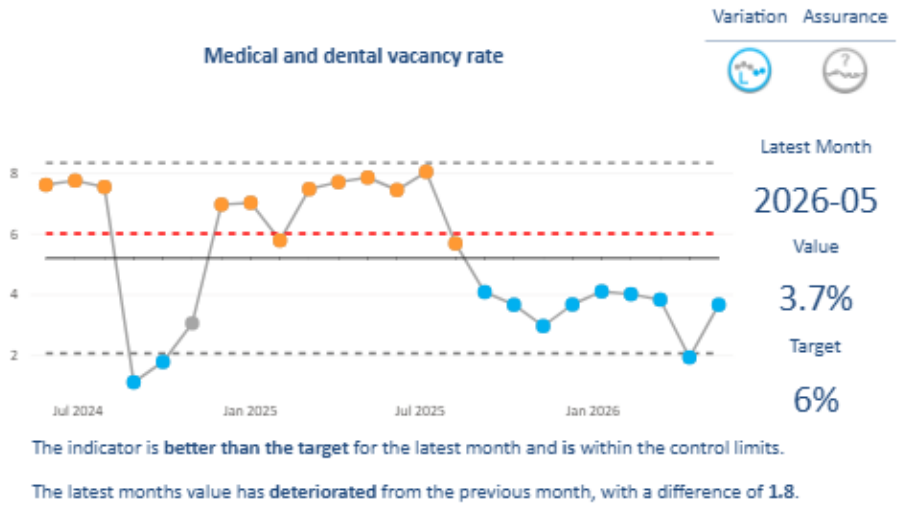
WTE in April was +57 WTE greater than in the same month in 2025, driven by an increase in the number of substantive colleagues.

Although the charted vacancy rate shows movement between March and May 2026, the actual number of substantive colleagues has remained relatively consistent throughout this period (9408 in March, 9391 in April, and 9390 in May). This indicates that the denominator used in the rate (recorded budget) changed between these months.

Executive Owner: Lydia Larcum

Operational Lead: Amy Messenger

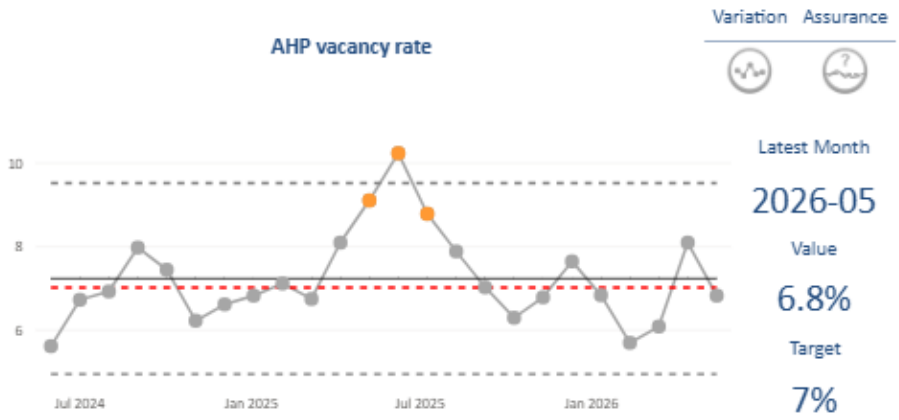
Medical and dental vacancy rate



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

The latest months value has **deteriorated** from the previous month, with a difference of **1.8**.

AHP vacancy rate



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

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

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 7%

Factors impacting performance and actions:

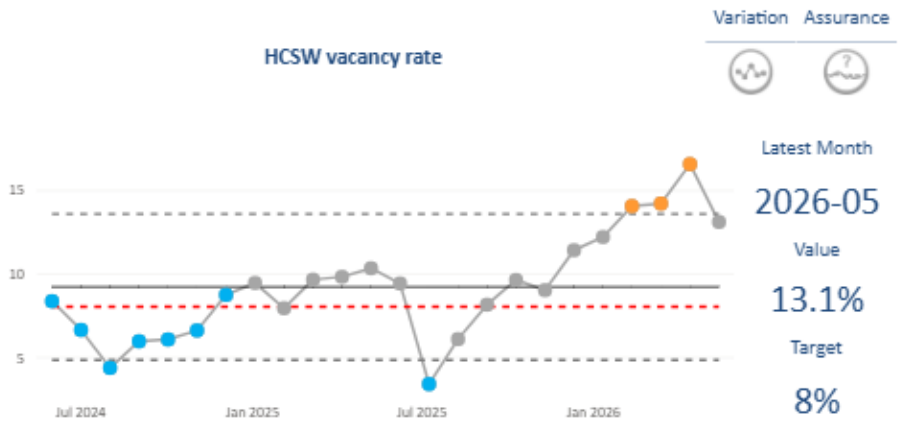
In May, the Trust welcomed nine new medical colleagues, including a permanent Consultant within Surgery. In addition, 14 offers of employment for medical posts were made, including six permanent Consultant posts within Ophthalmology (four posts), Rheumatology and Care of the Elderly.

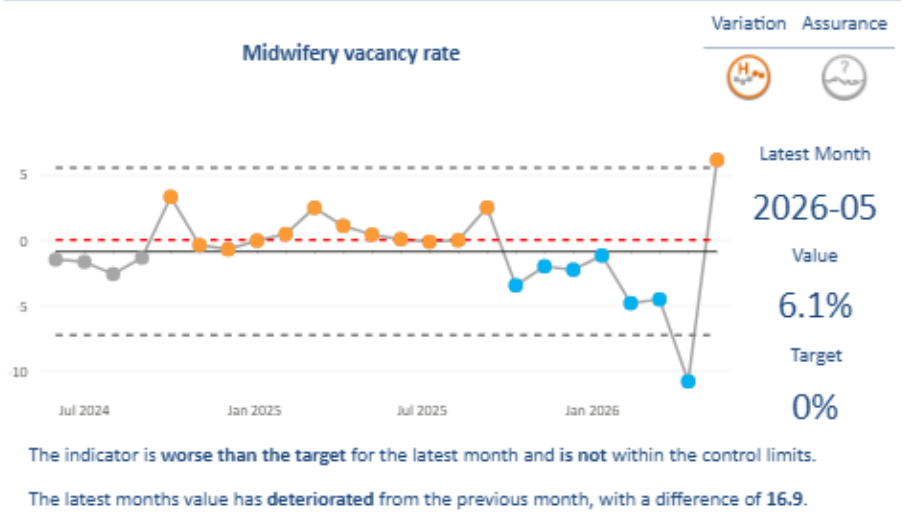
Ahead of changeover in August, the Trust has begun the process of onboarding 216 new resident doctors, including 31 under an honorary contract arrangement. The organisation has been informed of 13 positions which do not currently have a resident doctor allocated for an August start. To address this, the Trust is exploring the possibility of recruiting to non-training roles at equivalent grades - a process known as parallel recruitment.

Executive Owner: Lydia Larcum

Operational Lead: Amy Messenger

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 8%, Midwifery vacancy rate 0%





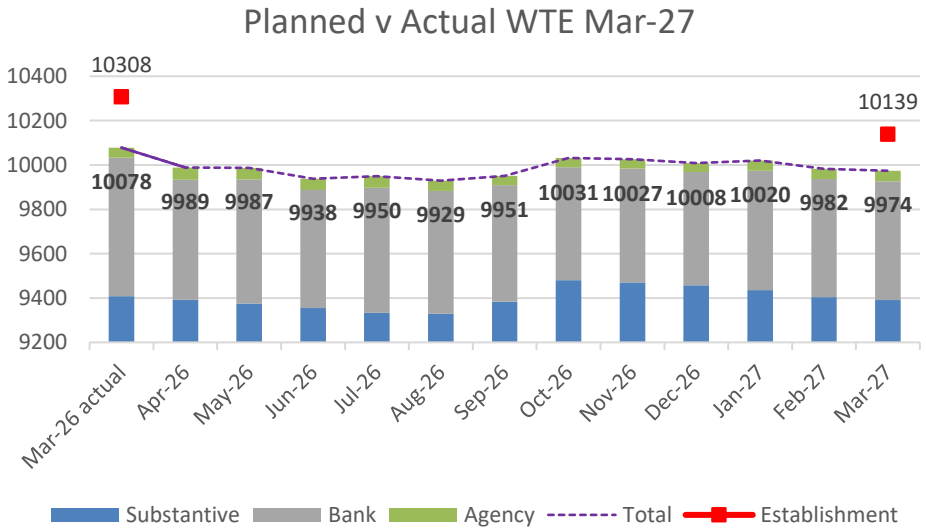
Factors impacting performance and actions:

In May, the Health Care Support Worker establishment in the Trust decreased by 68 WTE, leading to a reduction in the vacancy rate. This reflects adjustments to the roster to provide more long day shifts which creates an efficiency. At the same time, the Midwifery establishment increased by 33 WTE, resulting in a substantial increase in vacancy rate. This is linked to the programme of work to improve the quality and safety of Maternity services, with recruitment planned across 2026 to increase the size of the substantive workforce.

The HCSW recruitment pipeline currently includes 21 WTE undertaking pre-employment checks, and 19 WTE who are booked onto the next Academies in June and July.

The number of Nursing Associates within the Trust increased by 1 to 51 from April to May (this number does not include Nursing Associate Apprentices).

Executive Owner: Lydia Larcum **Operational Lead:** Amy Messenger



The table below shows planned and actual WTE totals for each staff group. These totals include substantive, bank and agency WTE.

Staff Group	Apr-26 WTE plan	Apr-26 WTE actual	Variance
Medical and Dental	1164	1168	+4
Nursing and Midwifery	2720	2702	-18
Support Workers	2779	2777	+2
NHS Infrastructure	1975	2014	+39
Scientific Therapeutic & Technical	1347	1353	+6
Total	**9987**	**9987**	**0**

Factors impacting performance and actions:

Reducing bank and agency spend remains a key focus for the Trust, with the organisation required to reduce agency spend by at least 30% and bank spend by 10% in the current financial year 2026/27. To support this, the Trust has been monitoring the number of rate escalations for medical bank shifts after changes to the rate escalation process were implemented in August 2025. For context, in the final week prior to the change of process, 432 shifts had rates escalated. The number of rate escalations requested in May increased slightly to an average of 50 shifts a week, up from 42 shifts a week on average in April (for weeks outside industrial action). With further resident doctor industrial action planned between 15th and 19th June, the Trust is anticipating an increase in temporary staffing costs in June, to maintain safe staffing levels.

The Trust continues to negotiate with agency providers to reduce rates, recently agreeing a further rate reduction for theatres staff, bringing the hourly rate closer to the NHSE agency price caps. The organisation also continues to convert agency workers on block bookings into bank or substantive positions, with two individuals (a Biomedical Scientist and an Administrator) due to move to bank posts this month.

Administrative bank activity in May increased to 897 shifts worked, compared to the 809 shifts recorded in April. A large factor in the increase was 141 bank shifts undertaken by Floorwalkers, supporting the Nervecentre implementation.

Workforce
Scorecard (2)

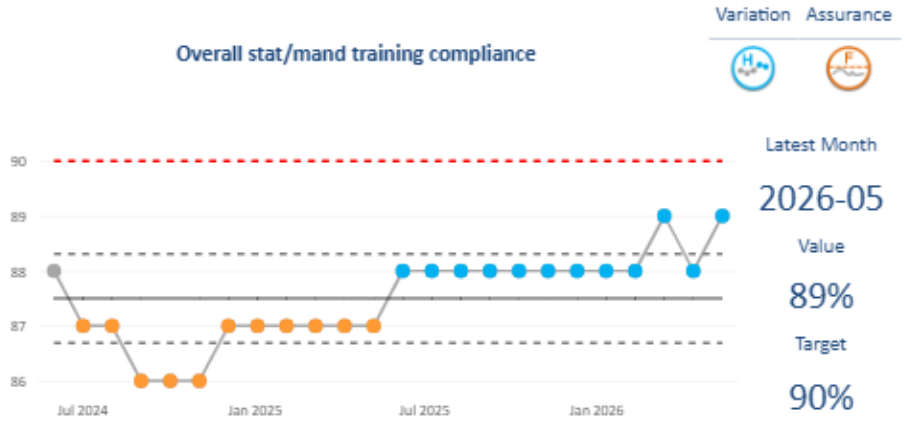
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

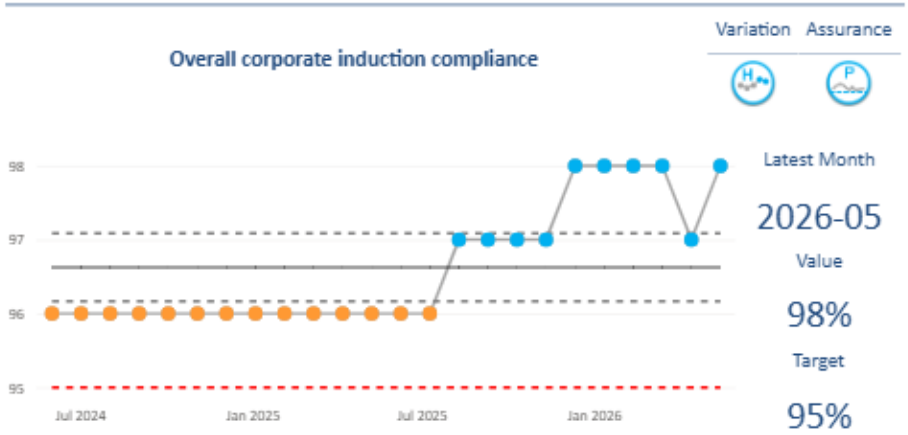
Executive Owner: Lydia Larcum **Operational Lead:** Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2026-05	H	F	89%		90%
Overall corporate induction compliance	2026-05	H	P	98%		95%
A4C staff stat/mand training compliance	2026-05	H	?	90%		90%
A4C staff corporate induction compliance	2026-05	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2026-05	H	F	78%		90%
Medical & dental staff corporate induction compliance	2026-05	H	?	97%		95%
Appraisal Activity	2025-11	H	?	87.2%	81.8%	95%
I would recommend my organisation as a place to work	2026-03			48.7%		50%
If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation	2026-03			46.7%		49%
If I spoke up about something that concerned me I am confident my organisation would address my concern	2026-03			37.3%		40%
I am able to make improvements happen in my area of work	2026-03			51.4%		53%

Executive Owner: Lydia Larcum

Operational Lead: Will Thornton





Rationale: Trained workforce delivering consistently safe care
Target: Mandatory Training 90% and Corporate Induction 95%

Factors impacting performance and actions:

Last year, the Group adopted a new target for statutory and mandatory training compliance. The 90% target strives for a 3% increase in the level of completions compared with our previous aim for 87% compliance. In May, mandatory training compliance returned to 89%.

As part of its review of organisational development, the Group is planning a 'Big Conversation' with colleagues to review its values and behaviour framework. The exercise is planned to take place over the summer, and will provide a foundation for plans to implement an Integrated Accountability Framework and Continuous Quality Improvement Model later in the year.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

June 2026

Executive Owner: James Hawkins

Highlights

EPR implementation:

- Nervecentre went live successfully across York, Scarborough, Bridlington, Selby, Easingwold and Malton, one of the most significant transformations in our Trust's history
- The implementation went very smoothly with no major issues to report. As with all EPR implementations there were minor issues raised and addressed as users became familiar with the new business processes.
- The first Tranche included observations, clinical documentation for inpatients, urgent & emergency care, electronic prescribing & medicine administration, bed management and read-only diagnostic results.
- The Trust and Nervecentre are working through finalised go-live dates on Tranche 2 (indicative August 2026) and Tranche 3 (indicative 2027).

Wider Digital Portfolio delivery continues with key focus on:

- Multi-year programme of paper records scanning and storage consolidation continues, with the initial metrics resulting from Nervecentre EPR encouraging.
- Supporting AI trials in both diagnostics and Ambient Voice Technology in outpatients, alongside widespread trial of Microsoft Copilot across the organisation with focus on efficiency and productivity opportunities.
- Supporting the launch of the new Sexual Health EPR system.

Concerns / Risks

- Ability to manage Y&S Digital business as usual work, whilst delivering the new EPR.
- Data Security and Protection Toolkit 2026 audit being finalised, and will highlight known gaps that will require multi-year investment and remediation.

Executive Owner: James Hawkins

Future / Next Steps

EPR implementation:

- Finalise revised Tranche 2 and 3 timelines with Nervecentre.
- Progress Nervecentre Tranche 2 and Tranche 3 design and implementation.

Wider Digital Portfolio:

- Overall cyber security posture: Finalise Data Security and Protection Toolkit 2026 submission and audit.
- Progress trials of AVT in outpatients.
- Finalise governance model for greater alignment of departmental IT systems with Y&S digital.
- Support rollout of electronic ordering for image diagnostics in primary care.
- Support go-live of Scarborough Community Diagnostics Centre.

Summary MATRIX

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

MATRIX KEY

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

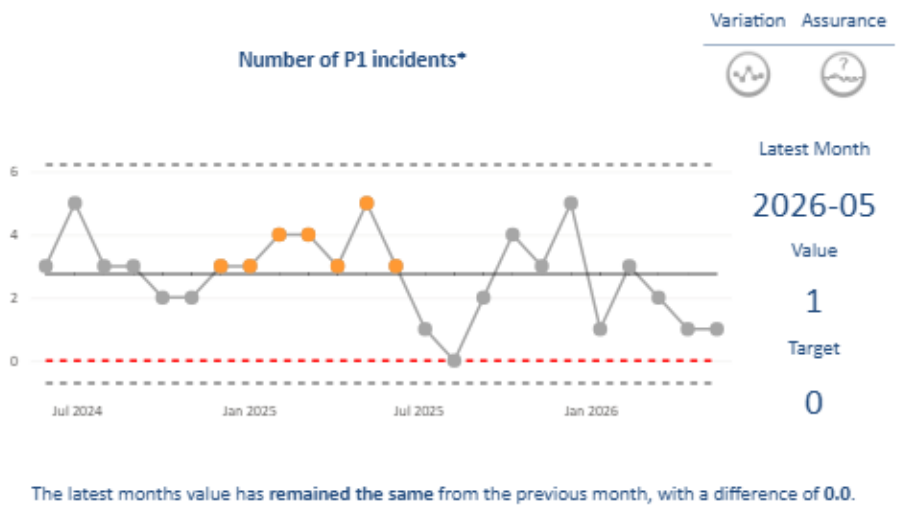
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* Percentage of FOIs and EIRs responded to within 20 working days (monthly)	* Number of P1 incidents*	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests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

Executive Owner: James Hawkins

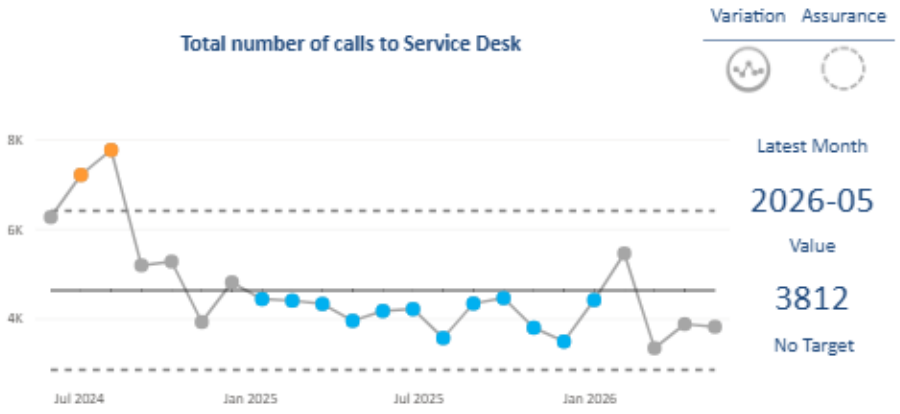
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-05			1		0
Total number of calls to Service Desk	2026-05			3812		
Total number of calls abandoned	2026-05			1105		
Number of information security incidents reported and investigated	2026-05			42		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-05			352		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-05			228		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-05			64%		80%
Number of FOIs and EIRs received (monthly)	2026-05			52		
Number of FOIs and EIRs completed (monthly)	2026-05			59		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-05			98%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



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



The latest months value has **improved** from the previous month, with a difference of **60.0**.

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

Target: 0 P1 Incidents

Factors impacting performance:

1x P1 incident occurred in May.

18/5 Nervecentre was unavailable or gave intermittent “503” errors starting at 0855. Nervcentre investigated and undertook corrective actions to quickly restore services.

Root Cause Analysis identified problems with load on proxy services affecting customers using the cloud hosted Nervecentre, and further changes were made at 1800 to allocate additional resources to avoid a recurrence.

Telephone performance was unchanged, despite the Nervecentre go live. Much of the associated support demand was met via alternate channels:

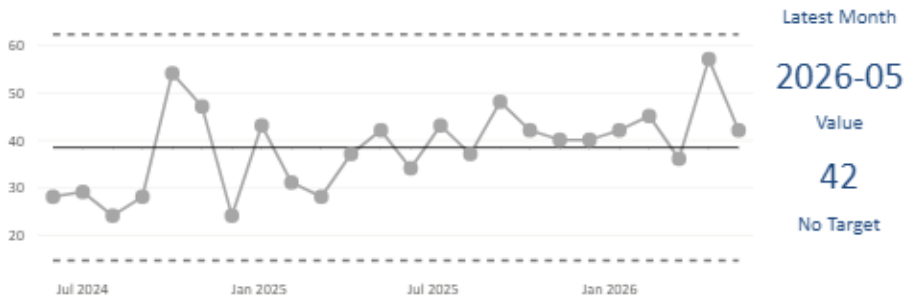
- in person support via Floor Walker and Digital Champions staff
- higher rates of online ticket creation via IT Self Service

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2026-05
Value
42
No Target

The latest months value has **improved** from the previous month, with a difference of **15.0**.

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

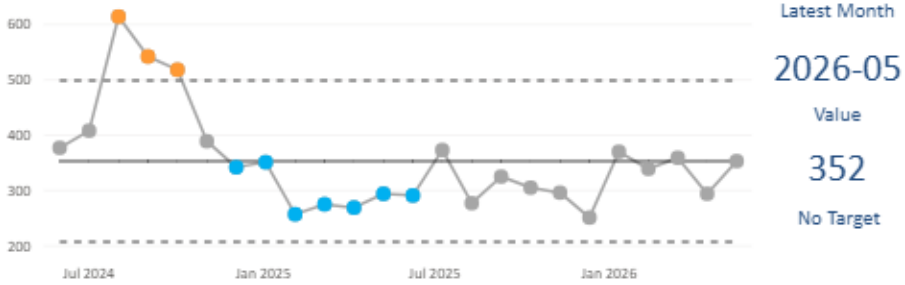
Number of information security incidents reported and investigated

Factors impacting performance:

Information security incidents have decreased in May. The team are seeing a lot of incidents misattributed to data protection which are actually process issues such as inboxes not being managed appropriately. These have been recategorised.
Actions: Trends will be communicated to staff and root cause analysis will be completed on all incident investigations.

Variation Assurance

Number of patient Subject Access Requests (SAR) received (monthly)



Latest Month
2026-05
Value
352
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **59.0**.

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

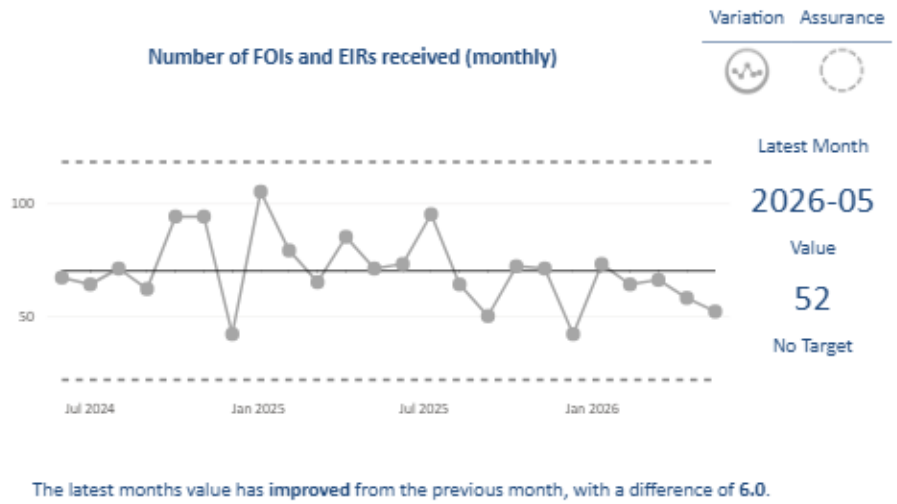
Number of Subject Access Requests (SAR) submitted by patients

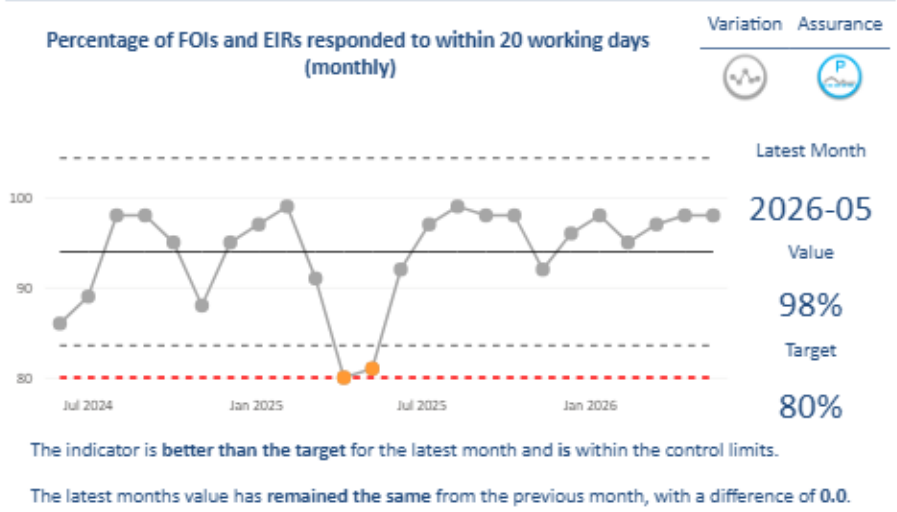
Factors impacting performance:
The reporting for SARs has changed to only include patient access requests. Previous reports have also included police requests, access to health records (deceased patients) and ad hoc external requests which are no longer included in this count.

Volumes received have increased; we are still seeing high volumes with other types of information requests. The Trust is currently experiencing a backlog and response times have been impacted. This is being communicated to requesters.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley





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

Factors impacting performance:.

Number of FOIs Received

The number of FoIs the Trust received has decreased slightly.

Actions: N/A

Percentage of FOIs responded to within 20 working days

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

June 2026

Executive Owner: Andrew Bertram

Highlights

At the end of May 2026, the Trust is reporting an adjusted year to date deficit of **£5.0m**, compared to a planned deficit of **£4.1m**, resulting in an adverse variance of **£1.0m**. The in-month position for May is **£0.6m adverse**. Of note is that April resident doctor strike cover costs of £0.6m were paid in May. While the forecast continues to assume delivery to plan, performance in the first two months indicates that delivery will be increasingly reliant on recovery actions, particularly in relation to productivity and workforce costs. Delivery of the Waste Reduction & Productivity Programme (WRAP) has made a strong start to the year delivering in full-year terms **£20.6m** against a target of **£61.6m** of which **£15.8m is recurrent**. The programme is however behind plan at month 2 with a shortfall of **£2.7m.**

The Group's cash position has deteriorated, with a May closing balance of **£9.0m** against a plan of **£11.7m (£2.7m adverse).** This is attributed to the **£0.9m** income and expenditure shortfall and a **£2.9m** delay in reclaimable VAT, now expected in June. The balance includes **£9m** temporary benefit from year-end capital PDC, which is due to unwind in Q1, leaving the underlying position at break-even. On current trends, the run-rate indicates that external cash support may be required from September if no significant run rate spend reductions are evident or deficit support funding is agreed with NHSE.

The activity-related investment reserve has been adjusted to **£6.0m** following the **£3.0m plan adjustment** and the **£2.7m** WRAP shortfall at Month 2. Approvals to date total **£1.7m**, leaving **£4.3m** available to support further specialty investment where required but subject to savings progressing.

Concerns

The principal risk remains delivery of the WRAP programme. At Month 2, **£6.9m** of year-to-date savings have been delivered against a target of **£9.6m**, leaving a shortfall of **£2.7m**. The shortfall has been managed through deferral of planned investments and the bringing forward of **£2.7m** of income from future months. These actions are non-recurrent and increase the level of delivery required later in the year.

Workforce pressures continue. Agency expenditure is in below plan at **£0.7m year to date** (plan £1.1m), within the **annual limit of £6.3m**. However, bank spend is **£5.8m** year to date against a plan of **£4.4m**, an adverse variance of **£1.4m**. Medical and dental staffing continues to be the primary driver, including **£0.6m** of costs incurred to cover industrial action. As this cost will not be reimbursed, it must be absorbed within the overall Trust position, increasing reliance on sustained vacancy management, rota control and reduction of premium staffing usage.

There is also a need to ensure clarity and alignment in contracting and income reporting following delegated commissioning arrangements. The reported **£5.8m adverse** variance on NHS England income is offset by an **£8.4m favourable** variance on ICB income, reflecting services delegated to ICBs and additional funding linked to the Agenda for Change pay award. While this is expected to be broadly neutral, it is essential that contracting assumptions and reporting lines are fully reconciled to avoid obscuring any underlying over- or under-performance. Early indications show activity running £0.4m ahead of plan. As this is outside the agreed Indicative Activity Plan, the Trust must now engage with commissioners. Continuing to deliver activity above plan without agreement presents a risk that activity may not be fully funded. No income assumption has been made to include this income in the position although if confirmed this could be used to start to offset the investment funding currently covering the WRAP shortfall.

Executive Owner: Andrew Bertram

Future

The Trust's financial plan continues to show a cumulative deficit position through the year, with a planned outturn deficit of £22.6m in March 2027. This plan does not currently meet NHSE requirements and remains subject to further discussion. The Trust is not eligible for additional Deficit Support Funding, which means delivery of the plan must be achieved through in-year control of costs and productivity rather than reliance on external support.

OPERATIONAL FINANCIAL MEDIUM TERM FINANCIAL PLAN - 2026/27 TO 2028/29

	Year 1 2026/27 £'000	Year 2 2027/28 £'000	Year 3 2028/29 £'000
Income	887,777	906,450	925,320
Gross Operating Expenditure	-967,732	-948,217	-950,438
Less: WRAP	61,640	40,122	39,929
OPERATING SURPLUS / (DEFICIT)	**-18,315**	**-1,646**	**14,811**
Finance Costs	-12,677	-13,171	-13,564
SURPLUS / (DEFICIT)	**-30,992**	**-14,817**	**1,247**
Technical Adjustments	8,346	-1,124	-1,079
ADJ FINANCIAL SURPLUS / (DEFICIT)	**-22,646**	**-15,941**	**168**

The most significant factor in determining the year-end position will be delivery of the WRAP programme. Early-year performance shows a clear gap between delivery and plan, which has been managed to date through non-recurrent actions, including deferral of investment. These actions cannot be relied upon for the remainder of the year. The focus now is on converting WRAP plans into delivered, recurrent savings, with clear ownership, realistic phasing and active management of slippage through the Financial Improvement Boards. Where schemes are high risk or not yet fully developed, the expectation is that this is addressed quickly through either recovery plans or replacement schemes.

Workforce costs remain a key pressure and will continue to require close management. While agency spend is currently below plan, bank usage is above plan and medical and dental staffing continues to drive the overall pay position, including the unfunded cost of industrial action. Over the coming months, the priority is to stabilise the workforce run rate by reducing avoidable premium usage, tightening rota management and ensuring that recruitment plans translate into a reduction in temporary staffing costs. Where premium cover is unavoidable in the short term, this needs to be explicitly reflected in forecasts and mitigated elsewhere.

On income and activity, the new variable activity arrangements mean that early identification of material variances to plan is critical. The Trust will continue to monitor activity closely and engage with commissioners where activity moves outside the agreed Indicative Activity Plan. It is particularly important to clearly separate tariff and price changes, delegated commissioning impacts and genuine activity growth, so that any emerging over-trade is understood and managed within system affordability.

Capital delivery is currently behind plan at Month 2, largely due to the phasing of RAAC schemes, with no significant issues identified at this stage. The capital programme remains deliverable within the approved £63.4m plan (net CDEL £58.9m), but continued attention is required to align scheme phasing, revenue impact and cash assumptions as the year progresses.

Overall, the next quarter will be critical. The Board should expect to see clearer evidence of WRAP delivery, firmer control of workforce run rates and reduced reliance on non-recurrent actions. This will determine whether the Trust can remain on track within its wider medium term financial plan that looks to bring the Trust to balance by the end of March 2029.

Executive Owner: Andrew Bertram

Key Financial Risks

Key Risk Area	Board Level Risk Statement	Mitigations
Waste Reduction & Productivity (WRAP)	Risk that the WRAP is not delivered in full and / or schemes are not delivered recurrently	• Weekly/Monthly tracking of WRAP delivery (£ and %) with variance analysis (Slide 15) & weekly progress from scheme leads. • Formal review and accountability meetings through Financial Improvement Boards (FIB) • Rolling review of recurrent vs non-recurrent delivery to ensure sustainability
Workforce sustainability	Risk that pay and temporary staffing costs exceed plan assumptions, impacting delivery of the financial plan	• Monthly monitoring of bank and agency spend against plan and trajectory – Slide 13 • Active vacancy management – internal triple lock process still in place as established by NHSE. • Bank fill rate monitoring to reduce agency reliance • Premium pay controls (agency caps / approval thresholds) with exception reporting
Drugs and devices	Risk that growth in drugs and devices exceeds contract for 'in-tariff' drugs	• Monthly tracking of drugs and devices spend against plan and activity growth • Monitoring of key cost drivers (top spend lines) with targeted mitigation plans • Review of high-cost drugs against contract assumptions (in-tariff vs excluded)
System affordability	Risk that system plans remain unaffordable, increasing delivery expectations at Trust level	• Monthly tracking of delivery against control total and system efficiency requirements • Monitoring of contract performance (over/under-performance vs plan)

Board Assurance Framework

BAF Principal Risk	How this report provides assurance	Outlook
Financial sustainability	Month-end I&E, forecast outturn, key variance analysis and cash position.	Current WRAP delivery and workforce costs indicate a risk to delivering the plan over the next quarter.
Delivery of recovery plans	WRAP delivery, high-risk schemes, slippage and recovery actions	Slippage in high-value schemes is increasing reliance on recovery actions, with a risk to achieving recurrent savings.
External financial compliance	Agency and bank controls, capital and cash management, system reporting	No immediate compliance issues identified; risk remains if spend and system assumptions are not brought back on plan.

Summary Dashboard and Income & Expenditure

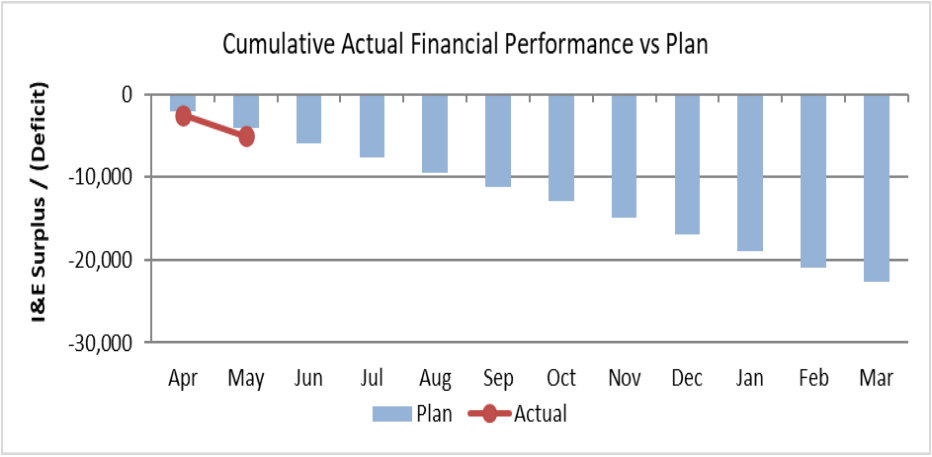
Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

	Plan	In Month Plan	In Month Actual	In Month Variance	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000	£000	£000	£000
Clinical Income	807,568	67,365	69,072	1,707	134,595	137,033	2,439
Other Income	83,395	7,070	8,484	1,414	13,899	15,964	2,065
Total Income	890,963	74,435	77,556	3,120	148,494	152,997	4,503
Pay Expenditure	-626,129	-49,905	-52,073	-2,168	-101,572	-102,557	-985
Drugs	-68,286	-5,688	-6,809	-1,121	-11,396	-13,583	-2,187
Supplies & Services	-99,208	-8,162	-8,537	-375	-16,287	-15,956	331
Other Expenditure	-156,701	-11,975	-11,342	633	-23,400	-23,308	92
Outstanding WRAP	41,048	808	0	-808	2,750	0	-2,750
Total Expenditure	-909,278	-74,923	-78,761	-3,838	-149,905	-155,405	-5,499
Operating Surplus/(Deficit)	-18,315	-488	-1,205	-717	-1,412	-2,408	-996
Other Finance Costs	-12,677	-1,223	-1,029	194	-2,113	-2,025	88
Surplus/(Deficit)	-30,992	-1,711	-2,234	-523	-3,524	-4,433	-908
NHSE Normalisation Adj	8,346	-272	-327	-55	-544	-598	-54
Adjusted Surplus/(Deficit)	-22,646	-1,983	-2,561	-578	-4,068	-5,031	-962

The I&E table confirms an actual adjusted year to date deficit of £5.0m against a planned deficit of £4.1m, leaving the Trust with an adverse variance to plan of £1.0m. The in-month position for May was an adverse variance of £0.6m.

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 May 2026 is an adverse variance to plan of £1.0m

Key Subjective Variances: Trust

Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

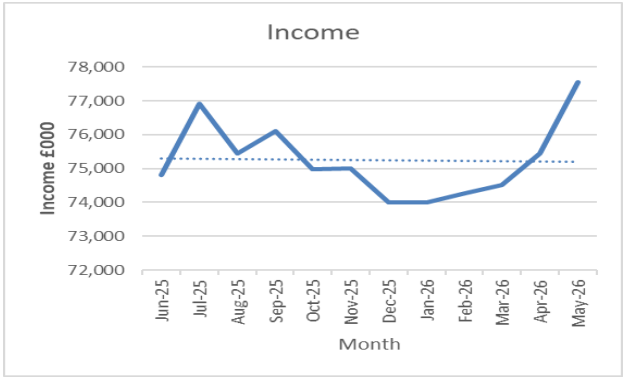
Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	-£5.8m	NHSE under trade linked to services which have been delegated to ICBs to commission. There is a corresponding over trade on the ICB line below.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27.
ICB Income	£8.4m	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	£1.9m	£2.7m income brought forward to compensate shortfall in delivery of WRAP scheme. This approach has been discussed with NHSE.	Shortfall in WRAP delivery needs to be recovered, this may be delivered through delay / avoidance of investments included in plan.
Employee Expenses	-£1.0m	Adverse variance due to costs incurred on medical bank and extra contractual payments covering industrial action in April (£0.6m). In addition, redundancy costs of £0.1m are contributing to the overspend position. The position has also deteriorated from the reported April underspend due to the removal of vacant posts to the WRAP programme.	NHSE have confirmed that there will be no funding to cover the cost of industrial action. This will have to be managed within the overall Trust position. The Trust will continue to apply NHSE best practice controls to manage agency expenditure and continue to recruit to posts being covered through bank, agency and other premium cost measures. Vacancy control measures remain in place.
Drugs and Devices	-£2.2m *Net of income: -£1.1m*	Drugs expenditure is £2.2m above plan. £1.2m relates to activity funded through pass-through arrangements and is reflected within the income position. The remaining variance reflects costs incurred which are not yet fully offset by income recovery, resulting in a net in-year pressure. High-cost devices are £0.2m above plan. These are commissioned on a pass-through basis and full reimbursement is assumed within the income position.	The residual £1.0m pressure largely relates to drugs previously subject to pass-through arrangements where recovery is not yet fully reflected. Work is underway with commissioners to validate activity and confirm income recovery in line with contractual arrangements. This income is not yet secured and not reflected in the position. There remains a risk of partial or delayed recovery.
WRAP	-£2.7m	Year to date savings of £6.9m have been delivered compared to a target of £9.6m. This is a shortfall of £2.7m. In full year terms, £20.6m has been delivered against the target of £61.6m.	Continued focus on delivery of the WRAP overseen through the Finance Improvement Boards. The shortfall has been managed to date through the deferral of planned investments.
Other Non Pay	£0m	Other non-pay expenditure budgets are in balance.	Continue to monitor

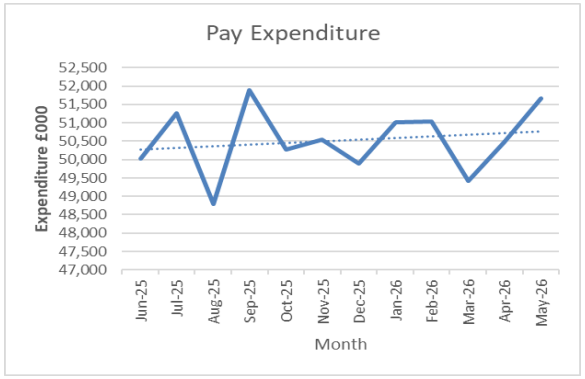
Activity Related Investments	Reserve
Total	**11,797**
£3m plan adjustment	- 3,000
Shortfall of WRAP - M2 YTD	- 2,750
Revised Reserve	**6,047**
Approved to date by specialty:	
Acute Medical Model	433
Audiology	184
Colorectal Surgery	138
ENT	164
Gynaecology	35
Oral Surgery	41
Paediatric SaLT	507
Pain Management	85
Respiratory	46
Urology	39
Total approved as at 31st May 2026	**1,673**
Remaining reserve	**4,374**

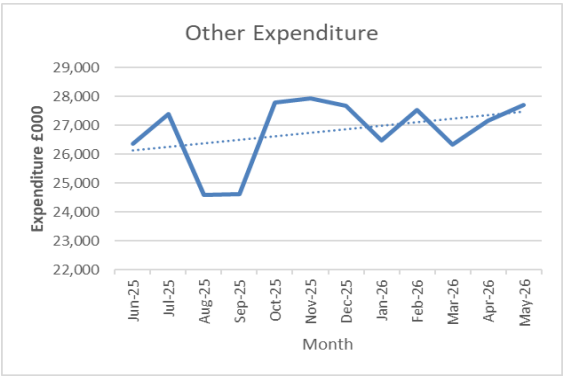
The activity related investment provision in the plan totalled £11.7m, with the reserve adjusted to £6m after the £3m plan adjustment and £2.7m M2 YTD WRAP shortfall. Approvals to date are £1.7m, leaving a remaining reserve of £4.3m to support further specialty investments.

Income and Expenditure Run Rate

Finance







	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD Average	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	74,806	76,912	75,443	76,095	74,981	75,011	73,986	74,000	74,268	74,525	75,442	77,557	75,043	2,514
Pay Expenditure	50,028	51,273	48,784	51,884	50,282	50,548	49,895	51,005	51,041	49,416	50,484	51,676	50,422	1,254
Other Expenditure	26,376	27,404	24,599	24,629	27,807	27,945	27,683	26,486	27,538	26,333	27,156	27,718	26,723	995

The graph and table above show the monthly run rate for income, pay and other expenditure. The figures for 2025/26 have been normalised through the removal of one – off items including increased pension contributions, impairment, ERF overtrade from 2024/25 write off and sparsity funding.

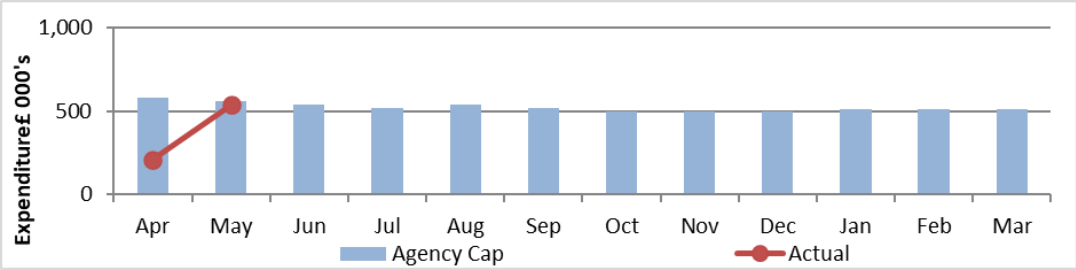
Income in May 2026 was £77.5m, which was £2.5m higher than the average monthly income for June 2025 to April 2026. The income position in May includes £2.7m income brought forward from future months to offset shortfall in delivery of WRAP.

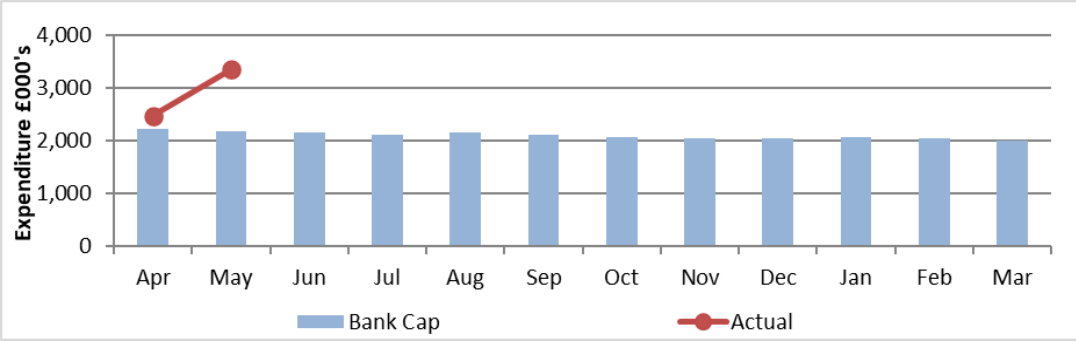
Pay expenditure in May 2026 was £51.6m which was £1.2m higher than the average monthly pay expenditure for June 2025 to April 2026. The increased costs in May are linked to pay awards for agenda for change staff and costs linked to Industrial Action cover paid in May.

Other expenditure was £27.7m in May 2026, which was £1.0m higher than the average monthly expenditure for May 2025 to March 2026. The increase was largely due to increased CNST and depreciation charges which were included in plan. There are also moderate increases in costs linked to utilities and minor works.

Agency, Bank and Workforce

Finance





	Year to Date Expenditure		
	Budget	Actual	Variance
	£000	£000	£000
Registered Nurses	26,389	27,015	-626
Scientific, Therapeutic and Technical	13,386	13,324	62
Support To Clinical Staff	11,890	9,727	2,163
Medical and Dental	27,200	28,810	-1,610
Non-Medical - Non-Clinical	22,121	23,277	-1,156
Reserves	225	0	225
Other	360	404	-43
TOTAL	101,572	102,557	-985

Agency Controls

The Trust has an agency staffing spend limit of £6.3m in 2026/27. This represents a reduction of 4% on the 2025/26 expenditure level. The year-to-date expenditure on agency staff at the end of May 2026 is £0.7m, compared to a plan of £1.1m, representing a favourable variance of £0.4m.

Bank Controls

The Trust has a bank staffing spend limit of £25.2m in 2026/27. This represents a reduction of 45% on the 2025/26 expenditure level. The year-to date expenditure on bank staff at the end of May 2026 is £5.8m, compared to a plan of £4.4m, representing an adverse variance of £1.4m. Note; May includes April resident doctors strike cover costs of £0.6m.

Workforce

This table presents a breakdown, by staff group, of the budget and actual expenditure for the year to date. The table illustrates that the key driver for the operational pay overspend is on Medical and Dental staffing. This includes £0.6m of cost linked to covering Industrial Action.

Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Trust Variable Activity Performance Report vs Commissioner Values in Contract.

		16.47%		
Commissioner	Value VAPR scope Indicative Weighted Values at 26/27 prices	VAPR Month 2 Phase (Av %)	Weighted Activity to Month 2 Actual	Variance - (Clawback Risk) M2
Humber and North Yorks	£178,032,778	£29,316,064	£29,757,842	£441,778
West Yorkshire	£1,579,629	£260,112	£262,972	£2,860
Cumbria and North East	£263,424	£43,377	£42,212	-£1,166
South Yorkshire	£146,877	£24,186	£18,877	-£5,309
				£0
All ICBs	***£180,022,708***	***£29,643,739***	***£30,081,902***	***£438,163***
NHSE Specialist Commissioning	£4,623,000	£761,254	£674,730	-£86,524
Other NHSE	£285,266	£46,974	£48,886	£1,912
All Commissioners Total	**£184,930,974**	**£30,451,967**	**£30,805,518**	**£353,551**

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 2, across all commissioners, the weighted activity position is above the target weighted value by £354k. 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 2 activity is fully coded and costed. As this is provisional data, and discussion needs to take place with the commissioners, income relating to the overtrade has not been assumed in the income position. Note; this analysis of the variable elements of the contract excludes the position with regard to the previously excluded drugs that are now in tariff. If confirmed with commissioners, this would represent a further circa £1m income for consideration in our position. This could be used to offset the investment drawings currently being used to cover the WRAP shortfall, if confirmed with commissioners. These discussions are just commencing as the extent of the position, the detail of the new 2026/27 tariffs and the list of drugs switching from excluded to included in tariff are just being worked through.

Trust Waste Reduction and Productivity Programme

Executive Summary

Programme Summary Position

	Full Year	YTD Position
Target	£ 61,639,999	£ 9,615,844
Delivered	£ 20,592,477	£ 6,865,506
Variance	**-£ 41,047,522**	**-£ 2,750,338**
Addititional Plans to be delivered		
Planned Low Risk	£ 14,758,157	£ 525,135
Planned Medium Risk	£ 18,973,325	£ 448,078
Planned High Risk	£ 4,233,623	£ 16,008
Total Additional Plans	**£ 37,965,106**	**£ 989,221**
(Planning Gap)/Over delivery	**-£ 3,082,416**	**-£ 1,761,117**

WTE Plan	179.06
WTE Delivered	11.69

Scheme Governance

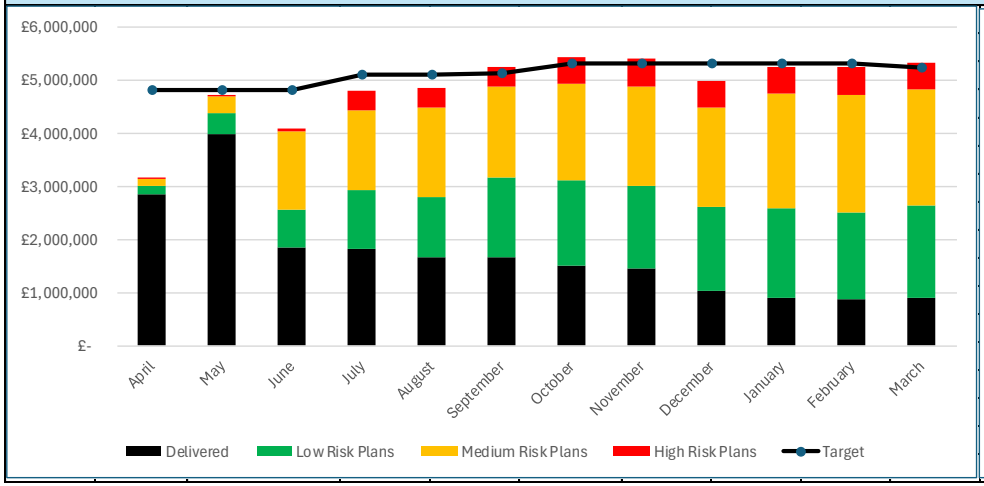
Total Number of Live Schemes	**144**
EQIA Outstanding	48 — 33%
Pre-Pipeline	49 — 34%
Opportunity	5 — 3%
Plan in Progress	13 — 9%
Fully Developed	77 — 53%

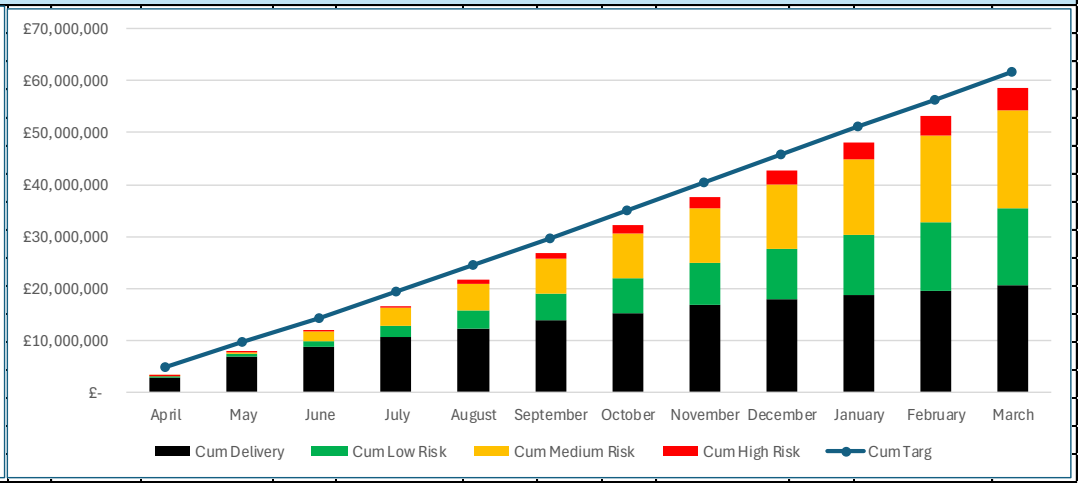
	Plans	%	Delivered	%
Recurrent	£ 39,238,398	64%	£ 15,880,846	26%
Non Recurrent	£ 19,319,185	31%	£ 4,711,631	8%
Total	**£ 58,557,583**	95%	**£ 20,592,477**	33%

	Plans	%	Delivered	%
Pay	£ 26,288,070	43%	£ 6,557,273	11%
Non Pay	£ 31,954,150	52%	£ 13,815,841	22%
Income	£ 315,363	1%	£ 219,363	0%
Total	**£ 58,557,583**		**£ 20,592,477**	

YTD Period Name	May 2026

In Year Plan Profile





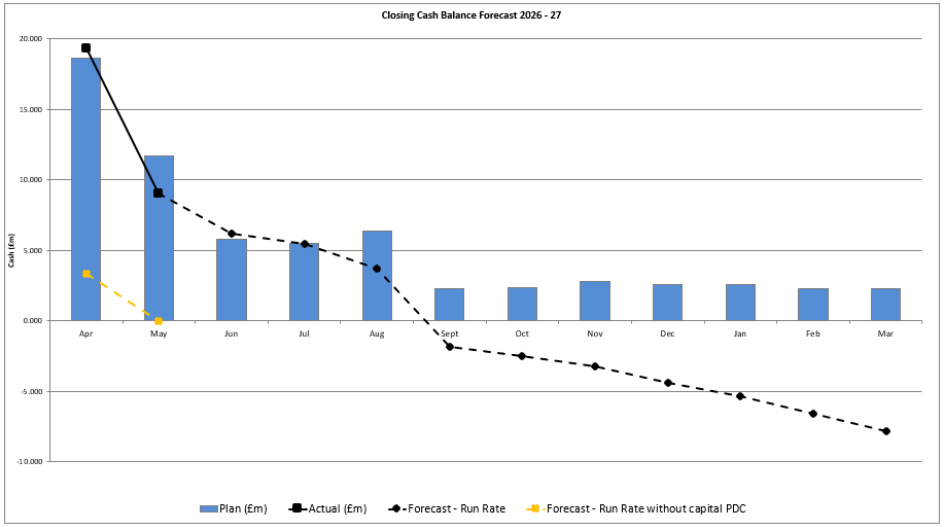
Current Cash Position and Better Payment Practice Code (BPPC)

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Group's cash plan for 2026/27 is for the cash balance to reduce through the year resulting in a closing balance of £2.3m at the end of March 2027. The table below summarises the planned and actual month end cash balances. Note; the plan assumed emergency cash support.

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	9,017										



Closing cash was £9m against a plan of £11.7m, which is £2.7m below plan.

The significant factors creating the variance are:

£0.9m – Adverse variance in I&E position.

£2.9m – Adverse variance due to timing of reclaimable VAT which was planned to be received in May, but receipt now expected in June.

These two variances are offset by timing of other working capital movements.

The closing May balance includes a £9 timing gain from receipt of year end capital PDC to unwind during Q1. This effectively means that the Trust is at zero cash balance excluding PDC. This is £3m lower than the previous months forecast linked to the timing of VAT receipt described above which is reducing overall cash.

The run rate forecast, is based on continuation of cash receipts & payment run rates in line with current levels and any known adjustments. We have seen continued pressure with supplier payments which has been extrapolated in the run rate to give an indication of emerging cash pressures. This forecast indicates cash support would be required in September if the trajectory continues.

<u>Better Payment Practice Code</u>

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

The graph illustrates that in May the Group managed to pay 94% of its suppliers within 30 days, improving on the previous 3 months positions.

Current and Forecast Capital Position

Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Annual Plan £000s	Forecast Outturn £000s	YTD Plan £000s	M2 Actual £000s	YTD Variance £000s
58,892	58,692	3,677	1,488	(2,189)

The M2 position is £2m behind plan.

This is mainly due to the RAAC schemes running behind the planned phasing offset by backlog maintenance and digital schemes running ahead of planned phasing but within the agreed scheme allocations.

2025/26 Capital Position	Annual Plan £000s	Forecast Outturn £000s	YTD Plan £000s	M2 Actual £000s	Variance to YTD Plan £000s
PDC Funded Schemes	37,100	37,100	3,129	33	(3,096)
IFRS 16 Lease Funded Schemes	5,600	5,600	-	-	-
Depreciation Funded Schemes	16,517	16,517	548	1,455	907
Charitable & Grant Funded Schemes	4,160	4,360	373	500	127
Total Capital	**63,377**	**63,577**	**4,050**	**1,988**	**(2,062)**
Less Charitable & Grant Funded Schemes	(4,160)	(4,360)	(373)	(500)	(127)
Less Sale of Clarence Street	(325)	(325)	-	-	-
Less PPE / Lease Disposals	-	-	-	-	-
Total Capital (Net CDEL)	**58,892**	**58,892**	**3,677**	**1,488**	**(2,189)**

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.

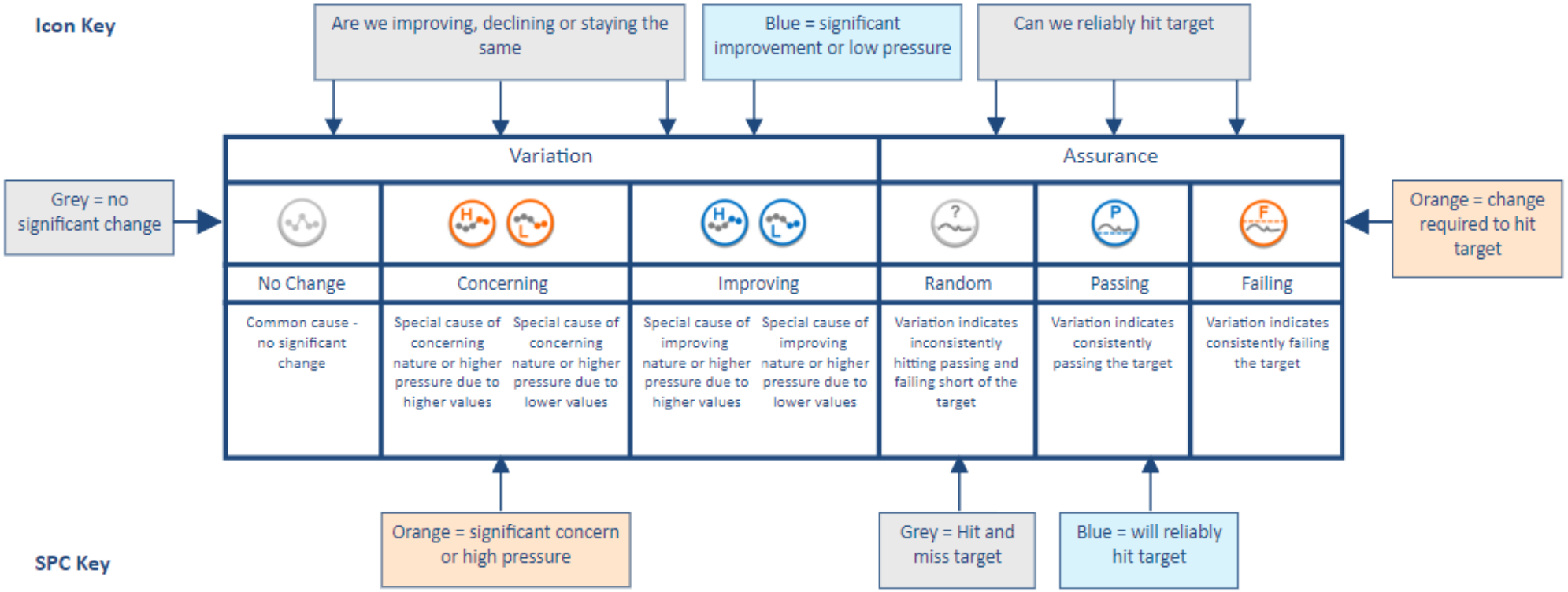
The main schemes within the plan are:

- £25m – Scarborough RAAC (Theatres & Pathology)
- £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

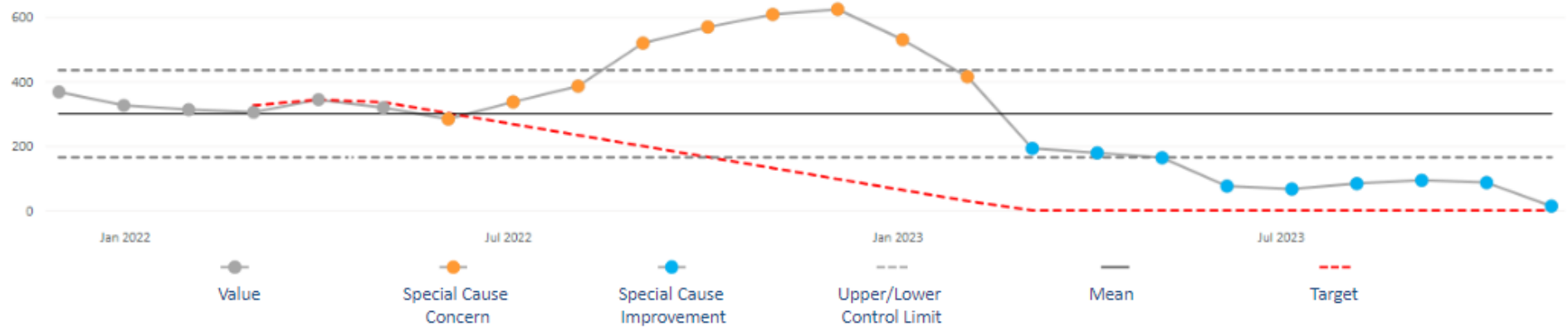
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



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

Icon Descriptions

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Report to:	Board of Directors
Date of Meeting:	24 June 2026
Subject:	Strategic Scorecard Report 2025-2026
Director Sponsor:	Claire Hansen, Chief Operating Officer
Author:	Tilly Poole, Head of Strategy and Planning

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☐ Not Applicable

Executive Summary:

The 2025/26 Strategic Scorecard provides a clear and balanced assessment of progress against the Trust's strategic objectives. While most metrics improved compared with 2024/25, the Trust did not meet the majority of the Board-approved trajectories set in February 2025. This reflects the significant operational, workforce, diagnostic and financial pressures described in the Trust Strategy, and the wider system context in which services have been delivered.

There were some areas of stronger performance, including patient safety incidents, research recruitment and sustainability, where trajectories were exceeded. However,

urgent and emergency care, cancer pathways, RTT, diagnostics and staff experience, despite showing improvement, all remained below the level of ambition set for the year.

A small number of metrics remain under development or pending full-year data, including FFT, equity of access and carbon footprint.

The financial position represents the most material deviation from plan and remains the key strategic risk entering 2026/27.

Overall, the scorecard demonstrates that the Trust is moving in the right direction across the majority of metrics, but not yet at the pace required to achieve the level of ambition set for 2025/26. This paper therefore provides not only a year-end assessment of performance, but also an articulation of where risks are considered controlled, where improvement has been insufficient and requires a strengthened response, and where material residual risk remains. These conclusions directly inform the refocusing of organisational priorities, executive accountability and governance arrangements being taken forward through the 2026/27 Annual Operating Plan.

Recommendation:

The Board is asked to:

- Note the year-end performance against the Strategic Scorecard for 2025/26;
- Take assurance where progress has been delivered and risks are considered controlled, supported by strengthened executive oversight, Care Group recovery plans and Board Committee assurance routes;
- Acknowledge the most material strategic risks entering 2026/27, particularly financial balance and those operational metrics that remain below trajectory; and
- Support the refocusing of trajectories, recovery actions and improvement priorities through the 2026/27 Annual Operating Plan and associated governance framework.

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

No ☒ Yes ☐

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

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation
Corporate Directors	18 May 2026	

1. Introduction and Background

In February 2025, the Trust Board approved the Strategic Scorecard (appendix one) as the primary mechanism for monitoring delivery of the Towards Excellence: Trust Strategy 2025–2030.

The scorecard provides a balanced view of progress across the six strategic objectives: Quality of Care, Our People, Partnerships, Research & Innovation, Sustainability, and Governance & Finance.

It forms the core of the Trust's annual assessment of progress against its ambition "to provide an excellent patient experience every time."

The Strategic Scorecard is explicitly aligned to the commitments set out in the Trust Strategy, which emphasises:

- Delivering timely, responsive, safe, accessible and effective services
- Creating a great place for our people to work, learn and thrive
- Working with partners to improve the health and wellbeing of our communities
- Challenging the ways of today through research, innovation and transformation
- Using resources sustainably to protect future generations
- Ensuring the Trust is well-led with effective governance and sound finance

The strategy highlights the challenges facing the organisation, including rising demand, workforce pressures, ageing estate, financial constraints, and persistent inequalities across the geography we serve. It also recognises the opportunities created by our integrated acute and community footprint, our role within the Humber and North Yorkshire ICS, and our growing research capability.

This context is essential when interpreting performance against the 25/26 trajectories. This paper provides the Board with:

- A narrative assessment of performance against each metric
- The March 2025 baseline, 25/26 trajectory, and March 2026 outturn position
- SRO commentary and response to performance against trajectory during 2025-2026 and key areas for improvement during 2026-2027.

It is intended to support Board oversight of strategic delivery and inform the Annual Plan refresh for 26/27.

The year-end Strategic Scorecard has been used to inform the development of the 2026/27 Annual Operating Plan. In particular, areas where improvement has been insufficient against trajectory have shaped the proposed organisational priorities, the clarification of success measures, and the strengthening of executive accountability and Board Committee assurance routes. This ensures a clear line of sight between retrospective performance assessment and forward delivery planning.

2. Overall Position

Across 25/26, the Trust delivered broad improvement compared with 24/25, with 17 of 22 metrics showing positive movement from March 2025 position. This reflects sustained operational focus and targeted improvement actions across several domains.

Performance against the Board-approved trajectories (set in Feb 2025) shows a more mixed picture, with some areas exceeding expectations, others improving but not reaching the planned level of ambition, and a small number remaining significantly challenged.

Taken together, the year-end position presents a mixed assurance profile entering 2026/27. Some metrics provide evidence of strengthened delivery and offer a degree of assurance to the Board; several domains have improved but remain below trajectory and require continued recovery focus; and a small number of areas, most notably financial balance, represent sustained strategic risk. These conclusions underpin the prioritisation and governance arrangements proposed through the 2026/27 Annual Operating Plan.

2.1 Metrics that improved compared with 24/25

The majority of indicators demonstrated year-on-year progress, including:

- Emergency Care Standard: 4-hour performance
- Emergency Department 12-hour waits
- Cancer 62-day treatment and Faster Diagnosis Standard (FDS)
- Referral to Treatment (RTT) and diagnostics
- Staff survey domains
- Complaints reduction
- Patient safety incidents
- Research recruitment
- Sustainability (Green Plan Support Tool (GPST) score)

These improvements reflect the Trust's continued efforts to strengthen safety, flow, research activity, and staff experience.

2.1 Metrics that exceeded their 25/26 trajectory

A smaller number of metrics outperformed the planned trajectory, representing areas of strongest delivery:

- Patient safety incidents (moderate/severe harm) – exceeded trajectory

Patient safety incidents (moderate/severe harm) improved beyond the planned trajectory, supported by the Trust's continued emphasis on safety culture, learning and quality improvement. The True North and Quality sections of the Trust Priorities Report highlight strengthened clinical governance, thematic reviews, improved incident oversight, and the embedding of quality improvement methodologies. These actions have contributed to safer care and reduced harm, despite operational pressures. This performance provides assurance that the Trust's strengthened focus on safety culture, incident oversight and quality improvement is translating into improved outcomes. Ongoing assurance will be maintained through established Quality Committee oversight and continued reporting within the Strategic Scorecard and Annual Operating Plan framework.

- Research recruitment & externally won income for research - significantly exceeded trajectory

The Research and Innovation (R&I) team has delivered another strong year, exceeding the trajectories within the Strategic Scorecard. Research recruitment (accrual) has been

particularly positive; however, it should be noted that overall accrual has been significantly supported by two large regional studies in maternity and gastroenterology, which account for the majority of recruitment. The Trust has also maintained a strong pipeline of research and innovation grant submissions and continues to pursue the next major funding opportunity.

During the year, the Trust secured £600k of capital funding to strengthen research infrastructure, with investment targeted particularly within Pharmacy to support future study delivery. Innovation activity has also grown, despite 25/26 being the first year of formal innovation support within the team; work to date includes support to a range of locally generated ideas, delivery of the Trust's innovation competition, and development of a Trust-wide Ideas Hub. The commercial research portfolio has continued to expand, doubling year on year and achieving the target referenced in national ambitions for commercial clinical research growth.

This represents a relative area of strength for the organisation and provides assurance that research and innovation capability continues to progress positively. Continued oversight will be required to ensure sustainability of performance, particularly in relation to reliance on a small number of large studies.

- GPST sustainability score – exceeded trajectory

The GPST sustainability score also exceeded trajectory, demonstrating strong progress in delivering the Trust's Green Plan commitments. Ongoing estates modernisation, decarbonisation initiatives, and investment in greener technologies has supported the improvement in the Green Plan Support Tool.

This performance provides assurance that delivery of the Trust's Green Plan is on track. Progress will continue to be monitored through existing sustainability governance arrangements.

2.2 Metrics that improved but did not meet trajectory

Across these domains, the Trust delivered clear improvement compared with 24/25, but performance did not reach the level anticipated in the Board-approved 25/26 trajectories. This pattern reflects the operational pressures detailed monthly in the Trust Priorities Report and True North Report:

- Urgent and Emergency Care / Flow metrics

Urgent and Emergency Care performance strengthened following the introduction of new models of care (EEMAC and EAU), with improvements in 4-hour performance, ambulance handover times and a marked reduction in 12-hour waits. However, sustained high demand, rising ambulance conveyances, workforce fragility and limited community discharge capacity meant the Trust did not achieve the planned trajectory.

Performance improved during 2025/26 but remained below the Board-approved trajectory, indicating that pressures relating to demand, flow, workforce and discharge capacity continue to constrain delivery. In response, these issues are being taken forward as a core organisational priority for 2026/27 through the focus on **Care without Corridors**, supported by clearer flow metrics, Care Group recovery plans and strengthened executive and committee oversight.

- Cancer Faster Diagnosis Standard and 62-day treatment standard

Cancer pathways showed the strongest improvement seen in recent years, with Faster Diagnosis Standard performance reaching its highest level since the standard was introduced. Despite this, the Trust remained below trajectory due to persistent diagnostic delays, high dermatology referral volumes, incomplete image-supported referrals, and bottlenecks in urology, gynaecology and colorectal pathways.

While cancer pathways delivered the strongest improvement seen in recent years, sustained diagnostic and pathway constraints meant trajectories were not met. Cancer recovery therefore remains a central element of the **Timely Care** priority for 2026/27, with clarified success measures, continued system engagement and clearer governance routes through the Annual Operating Plan framework.

- RTT 18-week standard

RTT performance improved, with zero 65-week waits maintained and strong outpatient productivity. However, the Trust did not meet its trajectory for 18-week performance, total waiting list size or 52-week waits. The main drivers were 5% growth in GP referrals, national CPD logic changes increasing RTT clock starts, diagnostic delays, and workforce and estate constraints affecting elective capacity.

The year-end position reinforces the need to move beyond incremental improvement and towards a more focused outpatient and diagnostic recovery approach. These issues have directly informed the inclusion of outpatient transformation and diagnostics within the **Timely Care** priority for 2026/27, supported by clearer performance metrics, agreed trajectories and strengthened assurance through Board Committees.

- 6-week diagnostics

Diagnostics (DM01) improved compared with 24/25, supported by insourcing, backlog-focused clinics and additional MRI/echo capacity. However, the Trust remained below trajectory due to workforce shortages, equipment failures, and the need to prioritise cancer fast-track patients.

- Staff survey domains (recommend as place to work; ability to make improvements; confidence concerns would be addressed and Staff recommend as place to receive care).

Staff survey domains all improved compared with the previous year, reflecting progress in leadership development, engagement, and culture programmes. Nonetheless, none reached their trajectories, with sickness, vacancies, morale pressures and inconsistent empowerment continuing to affect staff experience.

Although staff survey domains showed year-on-year improvement, performance remains below the level of ambition set by the Trust. This has informed the decision to carry forward **Leadership, Values and Behaviours** as a defined organisational priority for 2026/27, strengthening the link between staff experience metrics, leadership interventions and Board-level assurance.

2.3 Metrics significantly off-track

The most material deviation from trajectory relates to the financial position, with the Trust ending the year with a £28.1m deficit against a planned balanced position. This reflects financial pressures, including inflationary impacts, high agency spend, operational pressures, and the cost of maintaining ageing estate and equipment. The deficit also aligns with the national oversight framework findings, where the Trust's finance and productivity domain score remains challenged. This metric represents the most significant strategic risk and will require strengthened financial governance, cost control and system-wide collaboration in 26/27.

Financial balance remains the most material deviation from trajectory and represents the area of greatest residual risk entering 2026/27. This will continue to be treated as a principal Board risk, with sustainable finance retained as a core planning metric within the 2026/27 Annual Operating Plan and subject to strengthened governance, cost control measures and system-level engagement.

2.4 Metrics with data pending or under development

A small number of metrics remain incomplete for year-end assessment.

During 25/26, the Trust transitioned to a new FFT provider, with implementation phased across specialties. Early data from January to March 2026 shows an average 92% of patients recommending the service, broadly consistent with the Trust's 24/25 performance. As rollout continues, the new system is expected to provide richer, more granular patient experience data than previously possible, supporting improved insight at specialty and service level. Progress and thematic findings are being monitored through the Patient Experience Sub-Committee, ensuring oversight as the system embeds. Board assurance remains limited while implementation of the new FFT system continues; however, oversight is in place through the Patient Experience Sub-Committee as the system embeds and data maturity improves.

Constructing a robust indicator for equity of care continues to be challenging, reflecting the complexity of meaningfully measuring access across a geographically large, diverse population with significant variation in deprivation, rurality, and service configuration.

Rather than adopting a simplistic proxy, the Trust is progressing this work as part of the wider Clinical Strategy implementation, ensuring that any future metric aligns with our ambitions to tackle health inequalities and provide care closer to people's homes.

The development of the equity metric will therefore be integrated with pathway redesign work, neighbourhood-level models of care and programmes to reduce inequalities. This ensures that the final measure is not only technically sound but also strategically meaningful, reflecting the Trust's commitment to improving outcomes for the communities we serve.

The carbon footprint metric is not yet available for year-end reporting, with validated data expected in Quarter two enabling a view of progress against our Net Zero commitment, therefore full assurance cannot yet be provided pending validated year-end data, which is expected in Quarter 2 of 2026/27.

3. Board Assurance Implications

The year-end Strategic Scorecard highlights differing levels of assurance across the Trust's principal risks. While improvement is evident across many domains, mitigation of strategic risks remains variable and, in some cases, incomplete.

BAF Principal Risk	Relevant Scorecard Findings	Assurance / Gap
Effective Clinical Pathways	UEC, cancer, RTT and diagnostics improved but remained below trajectory	Partial assurance; direction of travel positive but operational and capacity constraints persist
Trust Culture	Staff survey domains improved but remained below ambition	Partial assurance; interventions in place but impact not yet sufficient
Financial Balance	£28.1m deficit against plan	Limited assurance; high residual risk entering 2026/27
Sustainability / Green Plan	GPST exceeded trajectory	Strong assurance
Effective Governance	Clear articulation of performance and forward response; strengthened AOP governance proposed	Governance strengthening in progress; delivery risk remains in challenged areas

4. Summary

Overall, the 2025/26 Strategic Scorecard shows that while the Trust made improvement across most metrics, the organisation did not meet the majority of its Board-approved trajectories. This reflects the significant operational, workforce and system pressures described in the Trust Strategy, including sustained demand, diagnostic constraints, flow challenges and financial pressures.

There were pockets of stronger performance, notably in patient safety, research recruitment and sustainability, where trajectories were exceeded. However, urgent and emergency care, cancer pathways, RTT, diagnostics and staff experience all improved but remained below the level of ambition set for the year. A small number of metrics remain under development or pending full-year data.

The financial position represents the most material deviation from plan and remains the key strategic risk entering 2026/27.

The 2025/26 Strategic Scorecard provides a clear and honest assessment of performance: the Trust has delivered improvement in many areas, but not to the pace required to achieve the agreed trajectories. Looking forward, the key issue for the Board is therefore the extent to which credible recovery priorities, strengthened executive accountability and clearer assurance routes are now in place. On this basis, the Board can take assurance where delivery has strengthened, recognise where recovery actions are underway but not yet proven, and maintain close oversight of those risks that remain most material entering 2026/27, particularly financial balance.

Appendix One – Strategic Scorecard
Green – Trajectory met or exceeded
Amber – Improved year-on-year but below trajectory
Red – Material deviation from trajectory / high residual risk
Grey – Data pending or metric under development

Strategic Scorecard Metrics - Draft trajectories				
Number	**Metric**	**Mar-25**	**Target 25/26**	**March 2026 Actual**
Quality of Care				
1	Reduction in complaints and complex complaints	1210		1068
2	Improvement in FFT score	93% 24/25 average		92% (data incomplete for 25/26)
3	Reduction in no criteria to reside bed occupancy	4.2	3.9	4.5
4	Staff Survey: Recommend as place to receive care	44.0%	49.0%	46.74%
5	95% of patients attending A&E should be admitted, transferred, or discharged within 4 hours of arrival.	65%	78%	71%
6	ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	16%	9%	9.30%

7	62 Day Standard for Cancer Treatment: 85% Patients should start their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.	68%	75%	71.1%
8	FDS 80% of patients getting a cancer diagnosis, or having cancer ruled out within 28 days of being referred by GP for suspected cancer, being referred because of breast symptoms or having been picked up through cancer screening	71%	80%	77.2%
9	18 Weeks Referral to Treatment (RTT) Standard: 92% Patients have the right to start consultant led treatment within 18 weeks of being referred by a GP, unless they choose to wait longer or it is clinically appropriate to delay.	55%	61%	56.6%
10	6 Week Wait for Diagnostics: 95% Patients should have access to diagnostic tests (like scans or endoscopies) within 6 weeks of being referred.	67%	89%	77%
11	Reduce % of patient safety incidents with moderate or severe harm	6%	5.5%	4.90%
12	Achieve good rating in CQC inspection for Maternity		No target for 25/26	No target for 25/26
People				
Number	**Metric**	**Mar-25**	**Target 25/26**	**March 2026 Actual**
13	Staff Survey: Staff recommend Trust as a place to work	45%	50%	48.72%
14	Staff Survey: I am able to make improvements happen in my area of work	48%	53%	51.35%
Partnerships				

15	Equity of Access metric – IMD / TBC			
Research & Innovation				
16	Increase number of patients enrolled onto trials		3,500	5,385
17	Increase research externally won income into the trust	£1,908,802	£1,462,272	£ 3,690,756
Sustainability				
18	Green Plan Support Tool (GPST) Self-Assessment score)	45%	60%	66%
19	NHS Carbon Footprint (tCO2e)	20,800	19,600	Not available until Q2
Governance and Finance				
Number	**Metric**	**Mar-25**	**Target 25/26**	
20	Live within our financial means		Balanced position	£28.1m deficit
21	CQC rating of outstanding by March 2030, and good by 2028.			No target for 25/26
22	Staff Survey: I am confident that my organisation would address my concern. (q25f)	35%	40%	37.25%

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 June 2026
Subject:	Care Quality Commission (CQC) Update
Director Sponsor:	Joseph Hague, Chief Nurse Adele Coulthard, Director of Quality, Improvement and Patient Safety
Author:	Emma Shippey, Head of Compliance and Assurance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The Trust has undergone significant CQC activity across multiple services since October 2025. This includes the recent unannounced inspection at the Easingwold Renal Unit in May 2026.

Recommendation:

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

CQC Update

1. CQC Activity

1.1 York and Scarborough Hospital Inspection of Easingwold Renal Unit (May 2026)

A Care Quality Commission (CQC) inspection team attended the Easingwold Renal Unit on Tuesday 19 May 2026 for a one day inspection visit. This inspection was part of the CQC's routine inspection programme and was not undertaken in response to specific concerns.

As this was the first inspection of the unit, there is currently no existing CQC rating. Following the visit, an evidence request was issued by the CQC, with all supporting information required to be submitted by 8 June 2026.

The feedback received following the visit can be seen in Appendix A.

1.2 York and Scarborough Hospital Inspection of Maternity Services (April 2026)

The CQC inspection team attended York Hospital on 14 and 15 April, and Scarborough Hospital on 16 and 17 April. The inspection formed part of a planned re-assessment following the 2023 inspection, during which services were rated as inadequate.

Following the inspection, the CQC requested additional evidence which was all submitted by the deadline of 6 May 2026.

As part of the inspection, the Director of Midwifery (Sascha Wells-Munro), Clinical Director (Jo Mannion) and Associate Chief Operating Officer (Gemma Ellison) met with the CQC lead inspectors on 26 May 2026.

1.3 York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER) Inspection : Nuclear Medicine (January 2026)

The CQC conducted an onsite inspection of Nuclear Medicine at York Hospital on 28 January 2026 as part of its proactive Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) programme.

No breaches of IR(ME)R 2017 were identified that met the threshold for regulatory action; however, two recommendations were made. IRMER reports are not published on the CQC website.

An action plan to address these recommendations was submitted to and approved by the IR(ME)R inspection team by the deadline of 7 April 2026. Progress against these actions will be monitored and reported through the Trust Regulations and Accreditations Group.

1.4 Scarborough Hospital Inspection of Urgent and Emergency Care and Medical Care (October 2025)

There was an unannounced CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital between 7 and 9 October 2025.

The final report was published on 20 March 2026 click here to view.

Six legal breaches in regulation were identified. A response to these breaches was submitted to the CQC by the deadline of 10 April 2026. The CQC approved the Trust response on 12 May 2026.

1.5 York Inspection of Urgent and Emergency Care and Medical Care (January 2025)

In response to the CQC inspection report published on 2 July 2025 (click here to view), the CQC have asked for quarterly updates on progress with actions to be provided, the first of which was sent in November 2025.

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

1.6 Section 31: Care and Assessment of Patients with Mental Health Needs in the Emergency Department

An application to remove the conditions is being drafted with approval through the Executive Committee initially planned for February 2026. This has been delayed with recent inspection activity but aim to complete in June 2026.

1.7 Ongoing CQC Engagement

Quarterly engagement meetings are scheduled with our CQC colleagues and a workplan for 2026 has been developed. The onsite visit for Surgery has been rearranged for October 2026.

2. CQC Cases / Enquiries

The CQC receive information from a variety of sources in relation to the quality of care provided at the Trust. This information can be related to known events, for example patient safety incidents (PSI's), formal complaints and Datix incidents, or unknown events, such as concerns submitted directly to the CQC from either patients, staff, members of the public, or other organisations. Following receipt of such information, the CQC share the concerns with the Trust for review, investigation, and response. The CQC monitor themes and trends of enquiries received, and these can inform inspection and other regulatory activity.

As of 2 June 2026, there are 24 open CQC cases. Nine cases have had responses submitted, and we are awaiting feedback from the CQC. The capacity to respond to CQC cases has been impacted by team absence and recent inspection activity. Responses to CQC cases will continue be prioritised over the next month.

Date: 2 June 2026

Appendix A – Easingwold Renal Unit Feedback

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Telephone: 03000 616161
Email: enquiries@cqc.org.uk
www.cqc.org.uk

By email
clare-louise.smith@nhs.net
emma.shippey@nhs.net
england.cqcreportsney@nhs.net

Our reference: AP24275

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

21/05/2026

CQC Reference Number: AP24275
Provider account Number: RCB23

Dear Ms Smith

Re: CQC inspection of Easingwold Satellite Renal Unit

I am writing to provide written confirmation of the verbal feedback of the preliminary findings as highlighted during our inspection and explained to your colleague Sr Sonia Crawford at the feedback meeting.

Name of provider:
York and Scarborough Teaching Hospitals NHS Foundation Trust

Location(s) inspected:
Easingwold Satellite Renal Unit

ASG/s inspected (if applicable) and date(s) of inspection:
Dialysis services

CQC inspection lead:
Suzanne McLeod

Representatives of provider attending feedback meeting:
Sr Sonia Crawford

Initial feedback:

Although the fabric of the building was old and tired it was clean.
There were areas of the unit which were missing functioning locks such as the water plant room, storage rooms where fluids and medicines were held and access into the derelict part of the building.

Some information about patients was not stored securely.

The individual dialysis room was small which could be problematic should the person become unwell and require resuscitation.

The resuscitation trolley was non standard and medicine such as adrenaline was not stored securely on the trolley because there was no place for this to happen.

Patients we spoke with during our inspection told us they were happy with the care and treatment they received as well as how well staff took care of them. None expressed any concerns or complaints about their experiences.

Positive findings:
Dedicated team of staff.
Very happy patients.
Knowledgeable team of staff

Areas for improvement:
Security of restricted areas and stock storage areas including for medicines which were missing functioning locks.
Storage of patient information such as that contained personal details.

This letter does not replace the draft report that we will send to you but simply confirms our verbal feedback. It will also enable you to start to consider any action you may need to take, rather than waiting for the draft inspection report.

We will send you a draft inspection report to check its factual accuracy once we have completed our due processes.

For their information, I am also sending a copy of this letter to David Purdue at NHS England.

Could I take this opportunity to thank you once again for facilitating the inspection, and for the co-operation of you and your staff.

If you have any questions, please contact me through our National Customer Service Centre by telephone on 03000 616161, or you can write to the CQC address at the top of this letter.

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

Yours sincerely

Pp Suzanne McLeod

Chris Storton

Deputy Director

Copy to:

Governance Lead Emma Shipey emma.shippey@nhs.net

David Purdue **england.cqcreportsney@nhs.net**

Report to:	Trust Board of Directors
Date of Meeting:	24th June 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Joseph Hague Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

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☐ Financial Balance
☐ Effective Governance

Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team. The data shared is for the month of April 2026 for performance metrics and May 2026 for workforce, unit diverts and homebirth service provision.

Key Assurance

- The Postpartum haemorrhage rate for the service has improved to 3% (10 cases) in the month of April which is an improvement from 5.1% in March. This is now element 5 of the Maternal care Bundle and is already partially implemented in the service. Further actions will be required to meet full compliance and will be reported quarterly to Trust board in line with national requirements
- The Postpartum risk assessment at 36 weeks has improved compliance of completion from 52.5% to 73.6%in the York and Selby team and 68.8% to 77.7% in Scarborough and the East coast teams. This is a targeted improvement and continues to be monitored on a weekly basis by the Community matron and team leaders.
- Recruitment to current vacancies continue with many applicants. Forty candidates have been shortlisted for interview, six of which are experienced Band 6 midwives. Interview will occur on the 16th and 17th June. Additional funding will be available to support graduate midwives in the coming months form NHS England.
- The process to recruit to the key additional posts critical to high quality safe care following the additional investment will be out to advert by the end of June and interviews planned for the 3rd week in July. A huge amount of interest has been received since the communication of the investment and the posts being advertised.

Key Risks

- There has been a decrease in the compliance of completion of the intrapartum admission risk assessment for PHH over the last two months. In March 67% and down to 47% in April. Targeted work and actions are being undertaken by the Intrapartum Matrons and ward leaders and will report weekly on compliance through the senior midwifery leadership team meetings to ensure professional accountability and standards are improved. This will also form part of the national Maternal Care Bundle requirements.

Key Concerns

- The Local Maternity and Neonatal System (LMNS) will become disestablished on the 31st July. The Integrated Care Board (ICB) will then be the Commissioner of maternity services with oversight and assurance from the Regional team. In addition, there remains no solution to the continued provision of the maternity and neonatal Voice partnership for York and Scarborough hospitals, as well as our other maternity colleagues within the ICB. A solution is being sought with the ICB and region. This is a significant concern recognising the focus of service user input in Maternity incentive scheme year 8 and also with the pending publications of the Nottingham maternity review on the 24th of June and The Amos independent review on the 30th June and the importance of service user input to respond to any recommendations made by both reports. It should be acknowledged the improvements that have occurred in maternity and Neonatal services at York and Scarborough Hospitals has always been underpinned by service user feedback and input through collaboration and co-design.

Recommendation:
The Board is asked to receive the updates from the Maternity and Neonatal Service.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting) No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

Introduction

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, to inform the Trust Board of key areas of improvement to enhance safe maternity care and identify any present or emerging safety concerns and actions required or taken to address them.

The Maternity and Neonatal Services continue to review and monitor improvements in key quality and safety metrics, and this paper provides the Trust Board with the performance metrics for the month of April 2026, and data for May 2026 for workforce, unit diverts and homebirth service provision.

Annex 1 provides the current delivery position for the service against the core national safety metrics.

Perinatal Quality Surveillance Model

In line with the perinatal quality surveillance model (PQSM), the Service is required to report the information outlined in the data measures monthly to the Trust Board. The PQSM data for April 2026 is provided in a separate paper.

Perinatal Deaths

There were no Stillbirths or Neonatal deaths at York and Scarborough in April 2026.

Maternity and Newborn Safety Investigations (MNSI)

No cases met the criteria for reporting to the Maternity and Newborn Safety Investigation (MNSI) programme during April 2026. No new draft or final reports were received into the service. There is currently two cases being investigated by the team

Moderate Harm Incidents and above

There were 26 incidents graded moderate or above in April 2026 along with 6 red flags as per NICE guidance reported. Two were delays to planned Caesarean birth due to capacity and acuity in the service. The women and their family's experienced no physical harm as a result of the delay. There was one delayed category two caesarean section, one delay to receiving an epidural within 30 minutes. Two women experienced a delay of over an hour to receive post-delivery suturing due to acuity and availability of a clinician to undertake the clinical care. Neither woman experienced physical harm because of the delay. All red flag incidents are reviewed to identify any immediate learning and improvement.

Maternity Unit diverts/ closures and suspension of services

In May there was three diverts from Scarborough and two from York. No women were affected in the period of divert on any occasion.

Provision of the homebirth service is shown in the table below

Home Birth Service Provision Overview: May 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

May 2026	East Coast	York and Selby
24hours Homebirth Service Provision Partial night cover either Team A or Team B Day service only	0 4 21 (at lease 3 PNV working)	6 2 23 (at least 3 Earlies)
Number Homebirth completed by Community midwives	1	3
Number of attendances at home with transfer in (with reason)	1 Neonatal resus due to Shoulder Dystocia	0
Number of homebirths not supported due to staffing	1	2
Number of Homebirths where independent midwives have been engaged to provide service	2	1
BBA	0	0
Free Labour/Birth due to Homebirth services not available	1 laboured independently, aimed to free birth but transferred in due maternal concerns.	0

Midwifery Workforce

The midwifery and maternity support worker workforce continue to grow with active recruitment underway to fill the roles vacant following the investment on the 1st April. The table below shows the budgeted establishment, staff in post but shows the over roster vacancy due to sickness, maternity leave and supernumerary hours, this is covered using bank shifts first and then if unable to meet safe staffing levels midwives from an agency provide cover.

Midwifery vacancy and recruitment – current position May 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

	Band 5/6	Band 3/4
Establishment budget	174.61 WTE	42.96 WTE
Staff in post	165.36 WTE (of which 30.09 WTE are band 5)	43.27 WTE
Substantive Vacancy	9.25 WTE	-0.31 WTE
Maternity Leave	8.80 WTE (5.67 WTE York & 3.13 WTE Scarborough)	2.00 WTE (1.00 WTE York & 1.00 WTE Scarborough)
Supernumerary	7.71 WTE	0.62 WTE
Sickness	12.87 WTE	5.34 WTE
Roster vacancy	38.63 WTE	7.65 WTE

The above figures include the phase 1 investment for FY2627

Improvement and Transformation in May 2026

- A review of the midwifery bereavement team capacity has been completed
- An action plan outlining requirements to meet national bereavement care compliance has been collated into short-, medium- and long-term actions
- A review of the current birth reflections service and national guidance has been completed.
- A detailed review of the AMOS interim report has been undertaken to inform the development of our multiyear equity, discrimination, accessibility action plan
- A proposal of videos for service user s that are required on the new website has commenced
- Refreshed maternity website layout and content proposal discussed with corporate communications team and proforma developed to support ensuring content and information is updated in a consistent and efficient way
- Monitoring process for the refreshed escalation policy has commenced. A 12-month post implementation review has been scheduled for April 2027 and findings will be presented at the maternity directorate meeting.
- Communications and engagement materials have been drafted for the roll out of the maternity and neonatal Behavioural charter
- 2026/27 midwifery workforce investment agreed through Care Group Board. Communications agreed shared across the service. (June 2026)
- Non-recurrent MIS funding received, and allocation of funding agreed to meet the requirements of Transitional Care, Smoking and Pre-Existing Diabetes.
- Additional funding for midwifery staffing now within budgets and template change request forms sent to Health Roster for updating.
- MEWs guideline approved at the maternity guideline and audit committee on 21st May 2026
- The NEWT2 tool after implementation review has commenced and continues to be monitored
- Itinerary for "Badger Bites" training sessions on specific topics for all staff to attend including students has been developed
- A review of all IT equipment to ensure teams have the correct number of computers and IPads in each clinical area has been completed

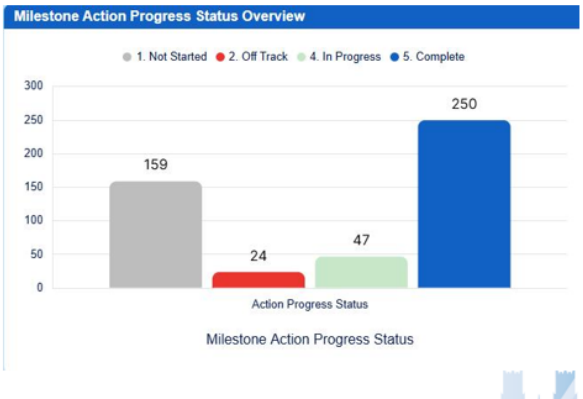
- A full review of current meeting structures, membership, TOR and reporting mechanisms aligned with the quality and patient safety framework has been completed and signed off by the SLT. This is now part of the annual work planner.
- Dihydrocodeine has been implemented with a Patient group Directive in place for midwives across both sites, offering more pain relief options in line with service user feedback from the CQC Maternity Survey
- Postnatal medicine guidance has been updated to reflect proposed medication change
- Postnatal drug rounds have been reintroduced and monitored through matron report at maternity directorate meeting
- A capacity and demand review of pre-existing diabetes specialist service has been completed
- The process for measuring Hb1A1C at the start of the 3rd trimester and pathway of care for those above 48mmol/mmol in line with saving babies lives guidance has been agreed and implemented
- A review of the maternity asset and lease register has commence

The Maternity and Neonatal Single Improvement Plan (MNSIP)

May 2026 Position

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

- 250 out of 480 milestone actions have been completed to date (22 completed in May 2026)
- 47 milestone actions are in progress
- 24 milestone actions are off-track as the delivery date has passed, and the action has not been completed
  - 16 off-track actions have plans in place to deliver these in June 2026.
  - 2 off-track actions have plans in place to deliver these in July 2026.
  - 6 off track actions require further review to assess timelines for completion
- 159 milestone actions are not scheduled to start yet



Key Risks to Delivery of the Single Improvement Plan

The risks to delivery of the MNSIP have been reviewed and scores updated

Risk title	Risk Description	Risk score
Risk of timeline delays impacting overall programme dlivery	There is a risk that key programme actions may not be completed within planned timelines due to factors such as interdependencies with other services, delayed decision making, delayed governance processes,	12 *Impact: High* *Likelihood: Medium*

	resource constraints, extended stakeholder reviews, or unforeseen operational pressures. These delays can cause slippage across key milestones, affecting the ability to meet overall delivery timelines.	
Insufficient investment to support programme and project delivery	There is a risk that the Maternity & Neonatal Service will not receive the required financial investment, resource uplift, or capital funding needed to progress key improvement plan actions	16 *Impact: High* *Likelihood: High*
Expansion of programme scope	There is a risk that the programme's scope expands beyond what was originally agreed, due to informal requests, evolving expectations, national context or pressure from stakeholders to include additional work.	16 *Impact: High* *Likelihood: High*
Loss of key staff impacting programme delivery	There is a risk that key members of the programme leadership team (SRO's, Workstream leads, subject matter experts, programme team, MNVP etc.) may: leave the organisation, move roles, be reallocated to support alternative programmes of work or may not have an identified recurrent funding source. Loss of key staff may lead to gaps in expertise, reduced institutional knowledge, delays in decision making and reduced programme level strategic oversight which will decreased programme momentum..	16 *Impact: High* *Likelihood: High*
Insufficient resources, skills, tools and over-reliance on third parties	There is a risk that the programme will be unable to deliver key actions due to limited internal capacity, shortages of specialist skills, lack of access to required tools or systems, and a dependency on third parties (e.g. contractors, suppliers, business intelligence and partner organisations)	16 *Impact: High* *Likelihood: High*

Recommendations to Trust Board

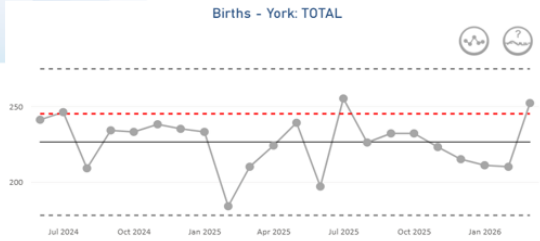
To note the contents of this report

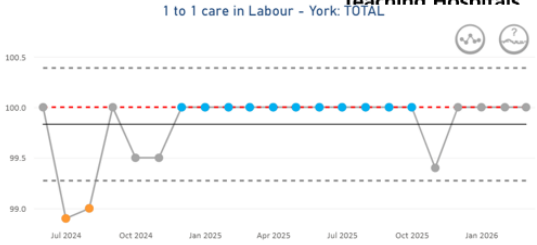
Date: June 2026

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery March 2026

Dashboard Summary – York

NHS
York and Scarborough Teaching Hospitals

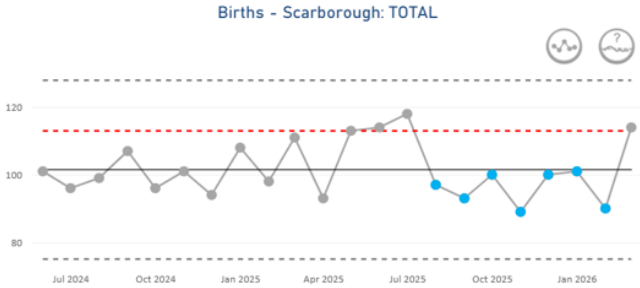


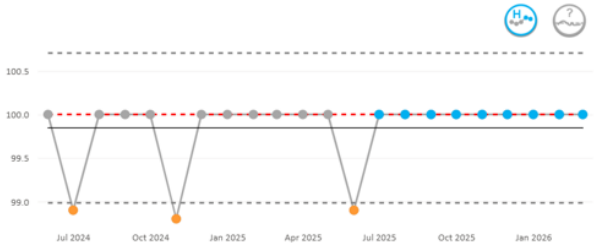


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for births and a special cause for improvement for 1:1 care in labour. The data is extracted from Signal	There is a review of the Maternity Escalation Policy and acuity tools in place. Specialist Midwives, Managers and Matrons are deployed to work clinically when 1:1 care cannot be provided.	In the event 1:1 care cannot be maintained an incident is completed and review of the staffing and acuity is undertaken.

Dashboard Summary – Scarborough

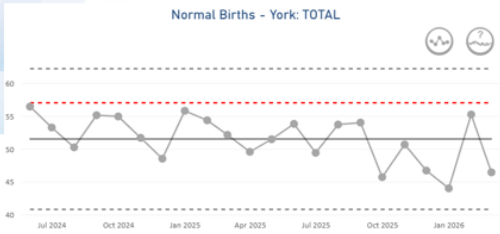
NHS
York and Scarborough Teaching Hospitals

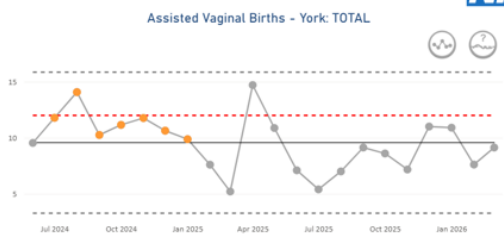


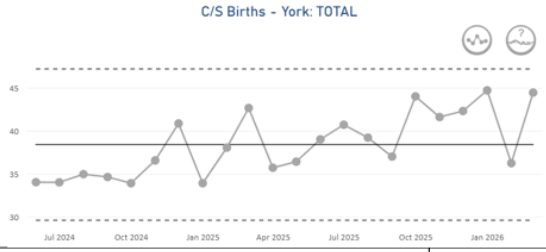


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for births and 1:1 care in labour The data is extracted from Signal	There is a review of the Maternity Escalation Policy and acuity tools in place. Specialist Midwives, Managers and Matrons are deployed to work clinically when 1:1 care cannot be provided.	The data demonstrates 1:1 care has been maintained at the Scarborough site since June 2025. In the event 1:1 care cannot be maintained an incident is completed and review of the staffing and acuity is undertaken.

Dashboard Summary – York

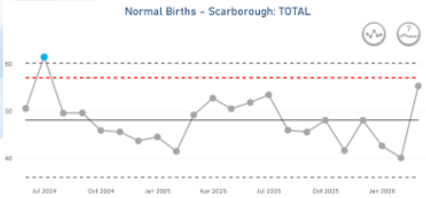


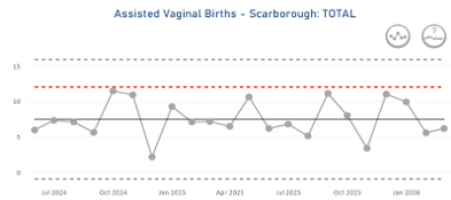


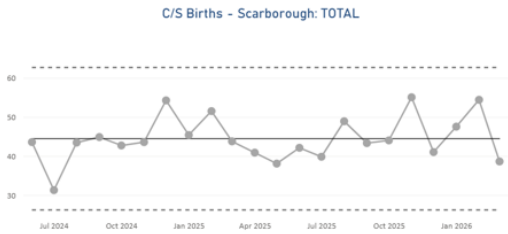


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for vaginal births, assisted births and caesarean births.	No actions required	The national maternity digital dashboard highlights for quality metrics Robson Group 1, and 3 the Trust is below the national.

Dashboard Summary – Scarborough



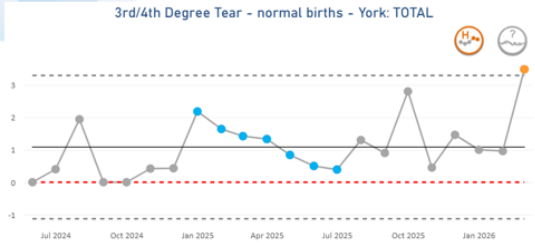


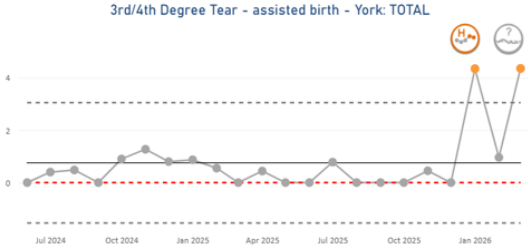


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for vaginal births, assisted births and caesarean births. The data is extracted from Signal.	No action required	The national maternity digital dashboard highlights for quality metrics Robson Group 1, and 3 the Trust is below the national.

Dashboard Summary – York

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

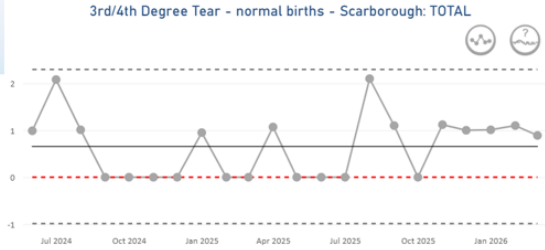


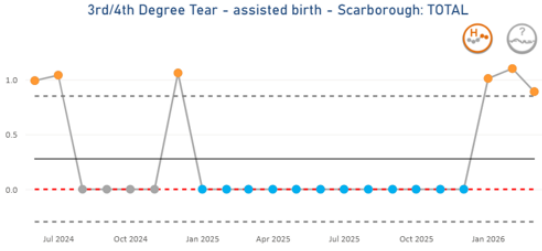


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for third- and fourth-degree tears from assisted and un-assisted births The data is extracted from Signal	There are no new actions	The data from the national digital dashboard for all 3rd/4th degree tear rates demonstrates the Trusts 12 month rolling average is below the national

Dashboard Summary – Scarborough

NHS
York and Scarborough



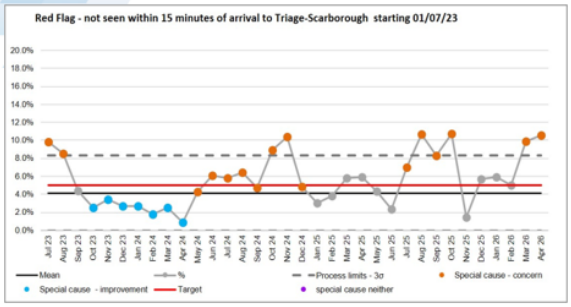


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for third- and fourth-degree tears from assisted and un-assisted births The data is extracted from Signal	The are no new actions	The data from the national digital dashboard for all 3rd/4th degree tear rates demonstrates the Trusts 12 monthly rolling average is below the national

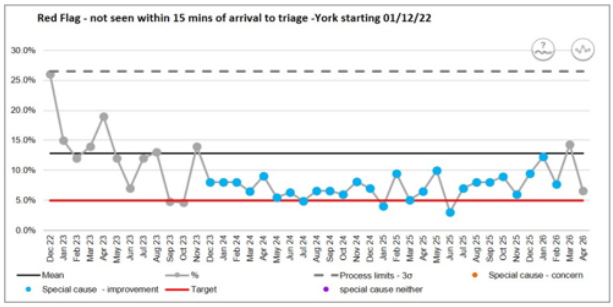
Maternity Triage – April 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust

Scarborough



York



Summary:	Actions:	Assurance:
• Increase in attendances noted on both sites • York – increase in compliance of 15 mins rapid assessment • SGH – decrease in compliance with 15 mins rapid assessment	• Continuing to work on ensuring Triage is open in dedicated area at SGH • Heat Map used from BI to understand peak times • Staffing being increased with the additional funding – template requests now set to HealthRoster for updating • Considering the Introduction of a Triage specific OPEL score to allow timely and appropriate escalation.	• **Compliance continues to be monitored on a weekly basis** • **Staffing increase will reduce relocation to Labour ward in Scarborough and improve compliance at peak times in York**

Report to:	Board of Directors
Date of Meeting:	24th June 2026
Subject:	Saving Babies' Lives Care Bundle
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health
Author:	Lucy Flatley, Transformation Lead Midwife

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

☒ To provide timely, responsive, safe, accessible effective care at all times.
☐ To create a great place to work, learn and thrive.
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☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☐ To use resources to deliver healthcare today without compromising the health of future generations.
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Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This report provides an update on implementation of the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2) across the Trust as of May 2026. A comprehensive self-assessment using the NHS England implementation tool demonstrates that 78% of interventions are fully implemented, with overall delivery assessed as partially compliant.

Strong performance is evident in fetal growth restriction (95%) and reduced fetal movement (100%), supported by established governance and quarterly oversight processes.

However, variation remains in delivery, with key areas for improvement including:

- Smoking in pregnancy (50%) – workforce training, opt-out referrals, and data capture
- Preterm birth (77%) – pathway reliability, optimisation bundle delivery, and higher preterm rates at Scarborough
- Diabetes in pregnancy (67%) – service capacity and clinic model

Across element challenges include training compliance below the ≥90% requirement (reducing smoking in pregnancy and fetal monitoring), inconsistencies in data quality, and service configuration across sites. Inequalities in outcomes are also evident, particularly higher preterm birth rates in more deprived populations.

Targeted improvement actions are in place, including implementation of a maternity tobacco dependency service, optimisation of preterm pathways, and development of the pre-existing diabetes in pregnancy service provision. Progress is monitored through the Single Improvement Plan, with quarterly reporting aligned to MIS Year 8 requirements.

Recommendation:

The Maternity Directorate / Maternity Assurance Group is asked to:

- Note the current level of compliance and variation across SBLCBv3.2 elements
- Receive assurance that governance, monitoring and improvement plans are in place and aligned to national requirements
- Endorse the prioritisation of key improvement areas, specifically:
    - Smoking cessation pathways and tobacco dependency service implementation
    - Preterm birth pathway optimisation and reduction of unwarranted variation
    - Development of the diabetes in pregnancy service model
- Support a continued focus on equity, addressing identified inequalities in outcomes
- Agree ongoing quarterly oversight and reporting to ensure delivery of full compliance

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

No ☒ Yes ☐

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

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Maternity Assurance Group	**8th June 2026**	**Approved**
Quality Committee	**16th June 2026**	**For Information**

Saving Babies' Lives Care Bundle

1. Introduction and Background

This report provides an overview of progress at York and Scarborough Teaching Hospitals NHS Foundation Trust in implementing the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2). It summarises current levels of compliance across all six elements of the care bundle, highlights key areas of achievement and improvement, and outlines the actions required to achieve full implementation.

The Trust has undertaken a comprehensive self-assessment against SBLCBv3.2 using the NHS England implementation tool, supported by local audit data, guideline review, and quality improvement activity. This report reflects the position as of May 2026 and will inform ongoing quality improvement.

The Saving Babies' Lives Care Bundle is a national programme developed by NHS England to reduce perinatal mortality and improve outcomes for babies and families. It sets out a series of evidence-based interventions and best practice standards across the maternity pathway.

Version 3.2, published in April 2025, builds on previous iterations by incorporating:

- Updated implementation guidance to reflect MIS requirements
- Updated NICE and RCOG guidance where available
- A stronger focus on reducing unwarranted variation and improving equity of outcomes

The six elements of SBLCBv3.2 are:

1. Reducing smoking in pregnancy
2. Risk assessment and management of fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring in labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

These elements collectively address key contributors to avoidable perinatal mortality.

2. Approach and methodology

The Trust has completed a self-assessment across all six elements, supported by evidence including:

- Clinical audits
- Guidelines and policies
- Training compliance data
- Quality improvement programmes
- MSDS and NNAP data

The overall position indicates:

- 78% of interventions fully implemented (self-assessed)
- Overall status: Partially implemented across the care bundle

There remain areas requiring focused improvement, particularly:

- Smoking cessation pathways and workforce training (Element 1)

- Preterm optimisation reliability (Element 5)
- Pre-exisiting diabetes pathway development and clinic model (Element 6)

3. Governance

Since the launch of SBLV3 the national implementation tool has been completed on a quarterly basis, reviewed by the LMNS and we have had a quarterly assurance meeting to discuss progress with implementation.

The Humber and North Yorkshire LMNS are no longer operational and as per MIS year 8 requirements we will provide quarterly updates on implementation progress to the trust board.

We will continue to complete the national implementation tool and map identified improvement work into the single improvement plan to ensure progress with identified improvements.

4. Current position for each element

Element 1:

50% compliant. There are 10 interventions to reduce smoking in pregnancy. 5 interventions have been fully implemented, and 5 interventions have been partially implemented.

Two of the partially implemented interventions are on training compliance, this is expected to be met by August 2026.

Two of the partially implemented interventions are around quit data. These are not currently accurate audits in BadgerNet as we refer the women who are pregnant to the local authorities at present. Plans are in progress to implement a maternity specific in-house tobacco dependency service by December 2026 and from this point all quit data will be inputted onto BadgerNet which will support oversight and compliance with these interventions.

One of the partially implemented interventions is the requirement for 90% of women to receive an opt out referral to stop smoking services. For Q4 25/26 this was 85% on the Scarborough site and 76% on the York site. This data is improving and is monitored each month by the team leaders. As part of the implementation of the in-house maternity tobacco dependency service, additional training will be provided to midwives which will support this element.

Element 2:

95% compliant. There are 20 interventions. 19 interventions are fully implemented, and 1 intervention is partially implemented.

For the element which is partially implemented, during Q4 25/26 data for fetal growth restricted babies (<3rd centile) born after 38+6 weeks gestation was above the national GAP average. There is a meeting to review these cases to identify if there were any issues with detection and management of growth restriction. Such cases can occur and be in acceptable discordance. There is also a process in place to exception report these cases and the outcomes of the review will be captured on datix.

Element 3:

100% compliant. Compliance remains maintained with all 3 interventions in this element. The RCOG have published a new reduced fetal movement guideline. Following a rapid review of this against the trust guideline, minor amendments may be needed which is being led by the fetal monitoring lead midwives.

Element 4:

80% compliance. There are 5 interventions in this element. 4 are fully implemented and 1 is partially implemented. The partially implemented element is for training compliance across the MDT which is just below the 90% requirements across staff groups.

A trajectory has been completed, and the trust is expected to meet the requirements in August. Obstetric compliance will be met before then and midwifery compliance in Scarborough however midwifery compliance will remain below 90% over the next few months due to a number of new starters who are to complete the training.

Element 5:

77% compliant. There are 26 interventions for this element. 20 interventions are fully implemented and 6 are partially implemented.

The partially implemented elements currently have oversight; improvement work and monitoring are in progress.

A preterm birth leadership team is in place and preterm clinics exist on both sites however will be reviewed to ensure equitable provision across both sites which meets national best practice standards and service user needs.

The preterm birth rate at the Scarborough site is above the national average of <6%. For Q4 25/26 this was 7.2%. From the initial review of the NHS England equalities dashboard, there is a higher number of women living in deprived areas having preterm births compared to those who live in less deprived areas. This data will be reviewed when considering the locations of our preterm birth clinics which is part of preterm birth prevention.

In Q4 25/26 there were 3 babies born at Scarborough site and 3 babies' born at the York site that were 'off pathway' meaning they did not give birth on the appropriate neonatal unit for their gestation. We review each case as an MDT to look at the entire pregnancy pathway up to birth to identify if there are any learning opportunities and if the 'off pathway' birth was avoidable or unavoidable. These reviews are sent to the regional team for oversight. In June we are meeting as an MDT to complete a sprint review of the cases and complete a thematic review of cases from the last 18 months.

The three other interventions which are partially implemented are around compliance with the optimisation indicators. Which includes antenatal steroids, normothermia and delayed cord clamping. Compliance with these metrics is reviewed monthly and any themes are fed back to the clinical teams. It is not always possible to administer a full course of steroids (two doses) ahead of delivery of the baby however in all cases the first dose was given. In relation to delayed cord clamping, this practice is well embedded however for

some preterm infants who require timely resuscitation this is not always clinically appropriate. Normothermia requirements were met on the York site but not on the Scarborough site, this is 3 cases two babies too cold and 1 baby too hot for quarter 4. This will continue to be monitored, and any learning fed back to the teams.

Element 6:

67% compliant. There are 6 interventions for this element. 4 are fully implemented and 2 are partially implemented.

Compliance has dropped for with the HbA1c blood test (which measures blood sugar levels over the last few months and helps with the management of diabetes) being offered between 24-30 weeks gestation for pregnant women with pre-existing diabetes as per the guidance at the Scarborough site. This was 3 cases which have been reviewed by the diabetes lead midwife, communications have happened with the clinical teams, and this will now be monitored monthly until compliance is sustained.

There is ongoing improvement work to review the diabetes team capacity and the clinics across sites to support the delivery of a pre-existing diabetes clinic as per the care bundle recommendations.

The pre-existing diabetes in pregnancy guideline has now been launched which provides information on maternal medicine referrals for complex diabetes and the HCL requirements as per Version 3.2.

5. Summary

This report provides an update on implementation of the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2) across the Trust as of May 2026. Overall compliance is 78%, with delivery assessed as partially compliant.

High levels of compliance are demonstrated in fetal growth restriction (95%) and reduced fetal movement (100%), reflecting strong governance, established pathways, and effective oversight arrangements.

However, variation persists across several elements, most notably smoking in pregnancy (50%), preterm birth (77%), and diabetes in pregnancy (67%). Key challenges include workforce training compliance below national targets, pathway reliability, data quality, and service configuration across sites. Outcome inequalities are evident, particularly higher preterm birth rates among more deprived populations and at the Scarborough site.

Targeted improvement actions are underway, including implementation of a maternity tobacco dependency service, optimisation of preterm birth pathways and clinic provision, and development of the diabetes in pregnancy service model. These actions are aligned to the Single Improvement Plan and monitored through established governance structures, with quarterly reporting in line with MIS Year 8 requirements.

Continued focus is required to reduce unwarranted variation, strengthen equity of outcomes, and deliver full compliance across all elements of the care bundle.

Date: 2/6/26

Appendix 1: National Implementation Tool (completed in May 2026)

Report to:	Board of Directors
Date of Meeting:	24 June 2026
Subject:	Maternal Care Bundle Interim Review
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical lead for Family Health
Author:	Lucy Flatley, Transformation Lead Midwife

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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☐ Transformative Services
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☐ Effective Governance

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This interim review demonstrates strong organisational engagement with the Maternal Care Bundle and a clear understanding of the gaps that must be addressed to meet national expectations. While full compliance has not yet been achieved, the maternity service has:

- Completed structured benchmarking against all elements
- Identified priority risks, dependencies and system enablers
- Established a clear plan to progress implementation once national tools are released

Recommendation:

Completion of the national implementation tool will be essential to finalise priorities, timelines and develop an implementation plan to be agreed with the trust board and monitored quarterly as outlined in the Maternity Incentive Scheme Year 8 requirements.

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

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity Assurance Group	8th June 2026	Approved
Quality Committee	16th June	For Information and Assurance

Maternal Care Bundle Interim Review

1. Introduction and Background

The NHS England Maternal Care Bundle (MCB) was published in January 2026 and establishes a national baseline of best practice across five clinical areas consistently associated with higher rates of maternal mortality and severe maternal morbidity. The care bundle has been developed in response to repeated findings from MBRRACE-UK that a significant proportion of maternal deaths involve missed opportunities for earlier identification, escalation, senior input, and coordinated multidisciplinary care.

The overarching aims of the Maternal Care Bundle are to:

- Reduce preventable maternal deaths and severe morbidity
- Improve early recognition and response to clinical deterioration
- Reduce unwarranted variation in care across services and settings
- Address persistent inequalities in maternal outcomes related to ethnicity, deprivation and access to care
- Support consistent, system-wide approaches to safety across maternity, emergency, primary and specialist services

The five elements of the Maternal Care Bundle are:

1. Venous thromboembolism (VTE)
2. Pre-hospital and acute care
3. Epilepsy in pregnancy
4. Maternal mental health
5. Obstetric haemorrhage

The care bundle is intended to be implemented by all NHS maternity providers in England by March 2027. This will be achieved by working in partnership with wider Trust services (including emergency care, ambulance services, neurology, maternal medicine, mental health and primary care). While the Maternal Care Bundle establishes minimum standards, it is expected these interventions will be embedded into routine practice, supported by governance, audit and continuous improvement.

This interim review provides an early assessment of local readiness, identifies priority gaps, and supports preparatory work ahead access to the national implementation tool.

2. Approach and methodology

Benchmarking meetings were held with key clinical, operational and digital stakeholders during April and May.

For each element, meetings:

- Reviewed the element description, interventions and supporting guidance
- Benchmarked current practice using a RAG-rated self-assessment
- Identified existing evidence and areas of partial or non-compliance

At the time of this review, the national MCB implementation tool is not yet available, therefore:

- National process, outcome indicators and audit requirements are not yet defined
- This review should be considered interim and formative, rather than a formal compliance assessment

Benchmarking focused on identifying readiness, gaps and system dependencies, recognising that full compliance will require phased implementation once national metrics and audit requirements are confirmed.

3. Governance

The Maternal Care Bundle is recognised within MIS Year 8 as a national maternity safety priority, reflecting the early phase of national rollout following publication in January 2026.

MIS Year 8 does not require maternity services to demonstrate full implementation or compliance at this stage, given that the national implementation tool, metrics and audit framework are not yet available.

Services are expected to evidence active engagement, readiness assessment, clear governance arrangements and a credible plan for phased implementation once national requirements are confirmed.

Audit requirements and plans will be agreed with the maternity audit and guideline group, and associated guidelines have already been identified to be updated via the maternity governance processes.

The implementation plan and progress with the implementation of the care bundle will be discussed at the maternity directorate meetings, the maternity assurance group and reported to trust board on a quarterly basis.

4. Summary of Interim Benchmarking Findings (Current position)

Interim benchmarking against the five elements of the Maternal Care Bundle demonstrates strong engagement across services but also confirms that full national implementation has not yet been achieved. This is expected given the early stage of national rollout and the absence of the national implementation tool, metrics and audit framework at the time of review.

Across all elements, the tables show that:

- No element is currently fully implemented
- All elements have identifiable areas of partial implementation or existing good practice
- Significant system dependencies exist, particularly relating to digital capability many interventions rely on digital functionality which is not yet available in BadgerNet, Trust-wide pathways and cross-organisational working (e.g. Yorkshire Ambulance Service)
- Equity considerations are recognised but not yet systematically embedded. The review demonstrated increasing awareness of equity considerations, including, Translation and accessibility needs, Demographic mapping of referrals and Risks linked to urgent and emergency access routes. However, formal mechanisms to

routinely assess and mitigate inequities are not yet fully embedded across all elements.

Element High Level Overview:

- **Element 1 (VTE):** Currently not implemented; requires new early pregnancy pathways, prescribing arrangements and guideline updates.
- **Element 2 (Pre-hospital and acute care):** Partially implemented; maternal medicine referral pathways are established, but MEWS, ambulance pre-alert and signage require significant development.
- **Element 3 (Epilepsy in pregnancy):** Partially implemented: maternal medicine referral pathways are established, women have access to a local epilepsy in pregnancy team, but this is inconsistent across site and a process for referral from first NHS contact needs to be established.
- **Element 4 (Maternal mental health):** Partially implemented; strong referral and support pathways exist, but national screening tools and time-point coverage are not yet in place.
- **Element 5 (Obstetric haemorrhage):** Partially implemented; strong secondary-care practice and governance, with gaps in community provision, escalation consistency and formalised quality improvement leadership.

Overall Interim Assessment:

The benchmarking tables in Appendix 1 provide detail on each element and the required interventions. This interim assessment demonstrates that the maternity service has a clear understanding of current gaps and system dependencies. Progressing from this interim position to full implementation will require:

- Coordinated Trust-wide leadership
- Digital system development
- Updated guidelines and standard operating procedures
- Structured audit, learning and quality improvement processes
- Continued focus on equity and accessibility

Benchmarking will be refreshed once national implementation requirements are confirmed.

5. Summary

Once the national implementation tool is published (anticipated to be May 2026) next steps include:

- Repeat benchmarking using national indicators
- Agree named action owners with services
- Develop a phased implementation plan aligned to MIS Year 8 requirements
- Integrate required audits and evidence into the maternity audit and guideline programme
- Establish regular Board-level reporting, with quarterly implementation updates

Timelines will be finalised once national requirements are confirmed.

Date: 11 May 2026

Appendix 1: Maternal Care Bundle – Interim Benchmarking Tables

Element 1: VTE

Intervention	RAG	Comments / Actions	Actions
1.1 Women should be offered the national self-assessment questionnaire on VTE risk at first NHS care contact with a positive pregnancy test. Those identified as being at high risk of VTE should be offered low molecular weight heparin (LMWH) and receive it within 72 hours*. The risk factors are: • previous confirmed diagnosis of VTE • hyperemesis gravidarum causing dehydration or immobility (that is, a woman cannot drink without vomiting or struggles to stand up and walk due to symptoms) • body mass index (BMI) greater than 50	Not implemented	Discussed adding link to trust website next to the SPA information To link in with VTE guideline lead. Need to consider role of midwife prescriber.	Implementation plan needs to be agreed in maternity and also info shared with EPAU, GPs, BPAS, ED and to include an inbox to monitor / triage referrals and timely prescribing. SOP / guideline will be needed. VTE guideline to be updated.
1.2 The ICB has arrangements in place for LMWH to be prescribed in early pregnancy (that is, before antenatal booking) within 72 hours, and for a follow-up consultation to take place within 4 weeks in secondary care*.	Not implemented		Follow up process to be agreed and included in VTE guideline.
1.3 Women identified as being at high risk of VTE and not already taking clot preventing medication should be offered a standardised dose of LMWH:	Not implemented		Standardised dosing of current guideline V MCB dosage to be reviewed and agreed.

Element 2: Pre-hospital and acute care

Intervention	RAG	Comments	Actions

2.1 Implement the national maternity early warning score (MEWS) tool across all settings for women who are or have been pregnant in the past 4 weeks. This means ensuring timely obstetric team and/or obstetric physician review in line with the MEWS escalation timeframes, according to the total score identified and relevant additional concerns.	Not implemented	Guideline for discussion at maternity guideline group in June Implementation plan for maternity including mandatory training Capability exists within BadgerNet /NerveCentre	Leads and implementation plan required for the wider trust
2.2 Implement a standardised pre-alert communication system between the ambulance service and labour ward and ensure adequate signage for all labour wards so that ambulance services can convey women with an obstetric emergency or red flags promptly and appropriately.	Not implemented	Telephone triage is the single line and if this isn't answered it diverts to labour ward. Signage does not meet requirements	To implement red phones on labour ward. Plan to engage with YAS and LW teams to discuss implementation and develop a SOP Plan to complete walk around with MNVP / YAS / Maternity and agree required signage on both sites
2.3 Establish acute referral pathways from local services to the maternal medicine centre (MMC) for acutely unwell pregnant or recently pregnant women presenting with symptoms or diagnostic uncertainty necessitating maternal medicine expertise. Maternity services and the maternity medicine network (MMN) should review these pathways annually.	Partially implemented	Clear process and referral pathways are in place. Clarification on acute referrals would be helpful – DS will liaise with the network Demographic data has been mapped against MSDS date and can be used as evidence that maternal medicine referrals are in line with population demographic.	Process for acute referrals to be consistent Review all referrals to assess if translation needs are met.

		Regular MDTs take place with maternal medicine network and the trust.	

Element 3: Epilepsy in Pregnancy

Intervention	RAG	Comments	Actions
3.1 Every pregnant woman with epilepsy has access to a local epilepsy in pregnancy team who will ordinarily lead the early pregnancy, intrapartum and postnatal care plans in line with the local maternal medicine network's (MMN) management and escalation protocol. The local team will consist of, at a minimum: • epilepsy nurse specialist or neurologist • maternal medicine obstetrician (see national service specification for maternal medicine networks) • obstetric physician (subject to local availability)	Partially implemented	Joint clinical in York, remote offer in Scarborough. Inconsistent across sites.	Regional epilepsy guideline approved last month, need to adopt locally and develop local SOP in line with care bundle requirements. Process to be develop to triage women after first contact with pregnancy to ensure case review and triage within 14 days of first NHS care contact. Implementation to include accessible / translated PILs.
3.2 Women requiring more complex epilepsy care should be referred by the local epilepsy in pregnancy team to a maternal medicine network (MMN) multidisciplinary team (MDT) who can oversee and – where necessary – lead the provision of care.	Fully implemented	Referral process in place.	

Element 4: Maternal Mental Health

Intervention	RAG	Comments	Actions
4.1 As part of routine emotional wellbeing screening, women should be invited to self-administer	Not implemented	Currently not self-administered. Embedded at booking 25-28 weeks but not 31-	Digital midwife liaising with colleagues / system C regarding updates to BadgerNet which may support self-administered

the Whooley questions ahead of the: • booking, 25–28 week and 31-34 week antenatal appointments • 10–14 day postnatal appointment		34 weeks and 10-14 day PN. Not currently in the audit plan.	Implementation plan to be scoped including accessibility / translated materials to ensure equity.
4.2 When a woman responds positively to either of the Whooley questions or there is concern, she should be invited to complete a further assessment using the Edinburgh Postnatal Depression Scale (EPDS). Where appropriate, this could be by self-administration.	Not implemented	EPDS not implemented, GAD-7 and PHQ-9 currently utilised. No EPDS capability in BadgerNet.	Digital midwife liaising with colleagues / System C regarding BadgerNet updates to include EPDS. Implementation plan to be scoped.
4.3 If a woman screens positive using EPDS (scores 13 or above in total or 2 or above on self-harm) or there is clinical concern, allow sufficient time in the same appointment to offer the woman a compassionate conversation to explore needs, discuss care options, agree next steps and receive referral to appropriate services if indicated.	Partially implemented	Robust referral pathway following completion of GAD-7 / PHQ-9 but EPDS not currently in use. Compassionate conversations embedded and positive feedback received from service users around PNMH support.	Implementation of EPDS as above including updates to guideline / staff training. Protected time in appointment settings to be scoped.

Element 5: Obstetric Haemorrhage

Intervention	RAG	Comments	Actions
5.1 Measure cumulative blood loss for all births in community and secondary care settings. This includes ensuring access to key resources including: • scales – available at all births with swab weight chart to record and assess blood loss accurately	Partially implemented	Measurement of blood loss well embedded in hospital settings. Community teams do not have specific scales. Proformas are embedded.	Confirmation of drapes, weight charts and scales in every labour room Implementation of process in community settings.

• under-buttock blood collection drapes for assisted vaginal births • access to an obstetric haemorrhage emergency kit – that is, a trolley or grab bag for all births and postnatal settings • documentation tool for individual patient records to be updated in real time			
5.2 Standardised definition and reporting of postpartum haemorrhage (PPH) and points of escalation by cumulative measured blood loss: by 500mL loss* and ongoing bleeding: for community births, escalation and help sought, with plans made for immediate transfer to secondary care. in secondary care, midwife in charge and the first-line obstetric and anaesthetic staff should be alerted by 1,000mL loss,* senior midwife, obstetrician (ST3 equivalent or above) and anaesthetist should all be present and managing as an obstetric emergency by 1,500mL loss,* consultant obstetricians should be informed, with attendance required if bleeding ongoing, unstable or deteriorating	Partially implemented	Definitions and escalation process in current guideline Embedded into PROMPT.	Definitions and escalation in line with MCB has been incorporated into PPH guideline which is currently out for comments ahead of the maternity audit and guideline group in June (Local variation in escalation – consultant informed at 1000mls). Implementation of drills to be considered in addition to mandatory training.

standardising reporting of PPH at 1,500mL* * Clinical judgement should be used to escalate earlier if required, taking into consideration the woman's individual risk factors that may lead to an earlier deterioration and the skill mix of the clinical team attending.			
5.3 Multidisciplinary team (MDT) case review should be undertaken for all women with significant bleeds (>2L) and all cases of cryoprecipitate and fibrinogen concentrate use within a month.	Partially implemented	Case reviews completed for all cases >1500mls PPH >1500mls data reported to the maternity assurance gro up each month. PPH working group implemented.	Compliance with reviews within 1 month to be reviewed. Named QI leads and ongoing haemorrhage improvement programme to be implemented.

Report to:	Board of Directors
Date of Meeting:	24 June 2026
Subject:	Infection Prevention and Control Annual Report (1st April 2025 – 31st March 2026)
Director Sponsor:	Joe Hague, Chief Nurse/Director Infection Prevention and Control
Author:	Sue Peckitt, Deputy Director Infection Prevention and Control Chris Beard, Consultant in Medical Microbiology/Infection Prevention and Control Doctor Katrina Blackmore, Consultant in Medical Microbiology/Infection Prevention and Control Doctor

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

☒ To provide timely, responsive, safe, accessible and effective care.
☐ 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 Infection Prevention and Control Annual Report for 2025-26 outlines the Trust's performance against national Healthcare Associated Infection thresholds, noting exceedances in Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia, E.coli, Pseudomonas aeruginosa, and Klebsiella bacteraemia, while remaining below thresholds for Clostridioides difficile (CDI) and Meticillin sensitive Staphylococcus aureus (MSSA). The report details governance improvements, targeted initiatives,

antimicrobial stewardship priorities, water safety concerns, and ongoing quality improvement plans to reduce infection rates and enhance patient safety across the Trust.

The Infection Prevention and Control (IPC) team have been active with several initiatives this reporting period, including:

- Urinary catheter point prevalence survey and improvement plan
- Supporting the Trust Water Safety Plan
- Various capital projects
- Management of respiratory Virus Infections and supporting operational flow.
- Delivering the Trust IPC improvement plan.

Recommendation:
The Board is asked to note the trust performance with regards to HCAIs and acknowledge the actions being taken to reduce the incidence of avoidable HCAI's.

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

Meeting/Engagement	Date	Outcome/Recommendation
Patient Safety and Clinical Effectiveness Sub-Committee	10/06/2026	Approved
Quality Committee	16/06/2026	

Infection Prevention and Control 2025/26 Annual Report

1. Introduction and Background

The Health and Social Care Act 2008: code of practice on the prevention and control of infections (Department of Health, 2015) stipulates the importance of the Director of Infection Prevention and Control (DIPC) reporting regularly to the Board of Directors. This annual report for 2025/26 updates the committee of progress and risks for 2025/26, highlights HCAI performance for the trust and includes activity to prevent and control the spread of infection within the Trust.

This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving patient safety and the quality of patient experience, as well as striving to reduce the risk of infections.

2. The infection Prevention and Control Team (IPC Team)

The Infection Prevention and Control (IPC) team have provided a dynamic service over 2025/26, responding to operational pressures and emerging infections as they arose.

The Head of IPC position has been vacant since January 2024, despite several recruitment drives. The part time Deputy Director Infection Prevention and Control has been providing additional cover during periods of increased pressure and discussions are on-going as to the possible options for this post.

A band 7 position became vacant in September 2025 due to retirement of the postholder. The recruitment process has commenced.

A band 5 training position became vacant in February 2026, the recruitment process will commence in Q1 2026/27

2.1 Infection Prevention and Control Governance

The Infection Prevention Strategic Assurance Group (IPSAG) meets monthly, one month care group focused, one month strategic focused, and reports to the Patient Safety and Clinical Effectiveness Sub-Committee (PSCE) and the Quality Committee.

Care Group Infection Prevention and Antimicrobial Stewardship (AMS) groups are now established and running monthly. These are a formal sub-group of the Care Group Governance and Management Board. Their focus is to understand their IPC/AMS performance and deliver a Care Group specific HCAI/AMS improvement plan.

Internal Audit has reviewed the governance and effectiveness of IPC meetings; the final report has returned an opinion of significant assurance (see Appendix 1). This is a good outcome given that the care group IPC/AMS had been in place for approximately 15 months at the time of the audit. Recommendations for improvement are currently being implemented and include:

- Introduction of a standardised approach for action follow up, closure and embedding of learning within the care group meetings.
- Introduction of a clear escalation process for non-attendance at care group meetings.
- The care group meetings require formal sign off at IPSAG of their terms of reference.

The IPC Board Assurance Framework was refreshed in February 2026 and approved at the Strategic IPSAG on 16th February 2026. An overview is included in Appendix 2 for information.

A Trust IPC improvement plan has been developed in conjunction with the Care Group Associate Chief Nurses and the Corporate Nursing Team; it was presented to IPSAG in October 2025 and approved. The document is dynamic and an updated plan is included in Appendix 3

3. Current Position/Issues

This report highlights the Trust performance against the national Healthcare Associated Infection (HCAI) threshold and the high-level actions that are being taken to reduce incidence of infection. HCAI annual thresholds run 1st April to 31st March, the 2025/26 thresholds focus on reducing CDI and gram-negative blood stream infections. The document detailing the HCAI thresholds can be accessed via this link: https://www.england.nhs.uk/wp-content/uploads/2021/08/PRN00150-NHS-standard-contract-202526-minimising-clostridioides-difficile-and-gram-negative-bloodstream-infect.pdf . The threshold for CDI, *E. coli* bacteraemia and *Pseudomonas aeruginosa* bacteraemia remained the same as the previous year (144, 170 and 16 cases, respectively). *Klebsiella* bacteraemia had reduced by 25 cases to 43 cases for the year.

Whilst Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia is not detailed with the NHS Contract document, the Trust agreed to continue to focus on their reduction and monitor them against a 5% annual reduction. This was a True North objective and a Trust priority.

This report gives oversight of the quarter 4, year end, performance and current issues impacting on Infection Prevention and Control (IPC).

3.1 *Clostridioides difficile* Infection (CDI) Performance:

The Trust attributed annual threshold for 2025/26 was set by NHS England at 144 cases. This includes community-onset healthcare-associated (COHA) and healthcare-onset healthcare-associated (HOHA) cases in patients aged over 2 years. Definition of a COHA case is the specimen is taken in community or by day two following admission, but patient has been discharged from the Trust within previous 28 days. These cases are attributed to the ward that the patient was previously discharged from.

The Trust ended the year at 129 trust attributed cases; COHA =46;HOHA = 83, **15 cases under the threshold and 26 cases less than the previous year.** This is the lowest number of Trust attributable cases in 5 years, with the highest number of cases being recorded in 2024/25, as demonstrated in Appendix 4 figure 1

The attribution of Trust cases 2025/26 by Care Group is as follows: Medicine 76, Surgery 36, CSCS 12 and Family Health 5. 60% of the cases are attributable to York Hospital, 35% to Scarborough and Bridlington Hospitals and 5% to Community Units. Figures 2 and 3 in Appendix 4 demonstrate the cumulative monthly Trust attributed cases against trajectory. Unfortunately, we experienced an increase of cases in March 2026 which are being reviewed currently. Appendix 4, figure 4 shows the cumulative rate per ward area, with ward 33 having the highest number of cases at 9.

At year end, the Trust is **above the national monthly CDI rate per 100 000 bed days**, as shown in Appendix 4, figure 5 and the increase in cases reported in March 2026 can be clearly seen . Figure 6 demonstrates that the Trust has the highest annual rate of CDI per 100 000 bed days of comparable regional Acute Trusts. Figure 7 taken from the UK Health Security Agency Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026 shows that despite the Trust being under the annual threshold we are still reporting high numbers of CDI cases, only second to Leeds Trust. However, in the latest published NHS Oversight Framework (quarter 3 data) the Trust is scored at 1 for CDI. This is better than any of our comparable regional Acute Trusts as demonstrated in Appendix 4 figure 8. The metric is calculated in a 12-month rolling count of CDI and where the organisation is at or below the threshold level a score of 1 is awarded, a score between 2.00 - 4.00 is awarded based upon the distance from the threshold, the lower rate is better

All Trust attributed cases require a Patient Safety Incident Response Framework (PSIRF) review. With the Care Groups we have revised the PSIRF process and have commenced a weekly multi-disciplinary review meeting. At the time of the report production, we are refining the dashboard, action tracker and how lessons are shared across the organisation. Learning points identified include delays in sampling, hand hygiene compliance, antibiotic prescribing issues with suitability / course length, and delay in isolation. Improvement actions are being re-iterated with all the care groups via the IPC/Antimicrobial Stewardship (AMS) meetings.

Actions taken within 2025/26 to reduce the incidence of CDI have included:

- The IPC team have continued to undertake fundamental practice audits which include CDI control measures compliance, hand hygiene compliance, commode and bedpan cleanliness. Where areas do not meet the compliance standards, face to face education is provided and follow up audits conducted. There is a process embedded for escalations should timely improvements not occur which includes the review of data within the care group IPC/AMS monthly meetings and escalation to IPSAG as required. The audit data can be seen in Section 5, table 2, improvement work will continue throughout 2026/27.
- Additional IPC support and education have been provided to Ward 33 which had the most cases at 9, with 1 case in quarter 1 and quarter 2, 3 cases in quarter 3 and 4 cases in quarter 4. Ribotyping has been undertaken; it currently indicates that the cases are not all linked. An Incident Control Group has met, and an improvement plan is in place with the ward supported by the care group. There has been increased education with the ward staff, and it has been noted that there was a significant increase in stool sampling in January 2026. We will continue to work with the ward and monitor improvements.

- Additional IPC support and education have been provided to Holly ward who have had 7 cases attributed to them. These have been sporadic across the year with 1 case in April, May, November, December, March and 2 cases in August. Following the increased incidence of CDI in August an IPC in depth audit was completed and the ward has made the required improvements, including a kitchen refurbishment and improving storage of equipment and cleanliness. The pharmacy team have been supporting antibiotic prescribing, and all cases are reviewed using a PSIRF approach and discussed within the Care Group meetings.
- The Trust did not achieve a proactive Hydrogen Peroxide Vapour (HPV) decontamination programme within the year for all in-patient areas due to the lack of decant facilities across the sites, however we have, where possible deployed deep cleaning/HPV during ward moves and refurbishments or capital builds. The requests for reactive deployments for HPV or Ultra-Violet (UV) following cases of infection have been monitored throughout the year and when pressures have meant one of these options was not able to be deployed, a risk assessment has been undertaken by the IPC team and Site Co-ordinators and a suitable manual decontamination undertaken. All decontamination deployments are recorded by the Domestic Services Team and reported via the Cleaning Standards Group and escalated to IPSAG if appropriate.

3.2 *Staphylococcus aureus* bacteraemia:

3.2.1 Meticillin Resistant Staphylococcus aureus (MRSA):

There have been 7 Trust attributed MRSA bacteraemia reported in 2005/26 against a zero-tolerance objective, a deterioration from the annual position of 2024/25 of 5 cases. 57% of the cases were attributed to York Hospital and 43% attributed to Scarborough and Bridlington Hospitals.

The wards with a case of MRSA bacteraemia attributed to them are highlighted in Appendix 4 , Figure 9. All 7 cases have undergone a multidisciplinary team post infection review (PIR).The lessons and actions identified in each case are being enacted via the responsible care group and where appropriate wider Trust actions are being supported by the IPC team. These lessons and improvement actions include:

- Documentation of wound care
- Documentation and management of peripheral intravascular lines
- Hand hygiene compliance
- Communication of results and treatment request with General Practitioner and other providers related to one case which was shared attribution.

The Trust national monthly MRSA rate per 100 000 bed days is shown in Appendix 4, figure 10. Figure 11 demonstrates that the Trust has the **highest annual rate** of MRSA bacteremia per 100 000 bed days of comparable regional Acute Trusts. Figure 12 taken from the UK Health Security Agency Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026 shows that the Trust is reporting high numbers of MRSA cases, only second to Leeds Trust. The latest published NHS Oversight Framework (quarter 3 data) the Trust is scored at 3.6 for MRSA bacteremia as demonstrated in Appendix 4 figure 13. The metric is calculated over a 12-month rolling count of MRSA bacteremia. Organisations with zero cases of MRSA will receive a score of 1, the remaining organisations are scored between 2.00 - 4.00 based on ranked absolute number of cases, lower value is better.

3.2.2 MSSA:

There has been a total of 81 Trust attributed cases of MSSA bacteraemia for 2025/26 against an agreed internal target of 82 cases. Of the 81 cases; COHA =43; HOHA = 38 with 46 cases (57%) attributed to York Hospital, 33 cases (41%) attributed to Scarborough hospital and 2 cases (2%) being attributed to the community sites. 62% of the cases were attributed to the Medicine Care Group, 21% of the cases were attributed the Surgery Care Group, 14% were attributed to the CSCS care group and 3% of the cases were attributed to the Family Health Care Group.

MSSA bacteraemia reduction was a Trust priority for 2025/26, and the Trust agreed an improvement plan aiming for a 5% reduction on the previous year's incidence of 92 cases. The Trust achieved a **12% reduction** which must be recognised as a success due to the efforts of the ward staff and care groups to deliver the Trust Improvement plan actions. Appendix 4, figure 14 demonstrates that the Trust attributed MSSA bacteraemia cases 2025/26 were the lowest in 4 years but above the 2021/22 incidence.

Appendix 4, Figure 15 demonstrates the monthly Trust attributed cases against trajectory and Figure 16 demonstrates that the Trust has the highest annual MSSA bacteraemia rate per 100 000 bed days with comparable regional Trusts. Figure 17 shows the cumulative rate per ward area, with ward 31 having the highest number of cases, with 5 since April 2024. These have been investigated by the care group using a PSIRF approach and an MSSA improvement action plan has been implemented, which is overseen by the care group IPC/AMS meeting. The remaining are being reviewed within the weekly Infection review meetings and the learning incorporated into the Trust improvement plan.

The Trust national monthly MSSA rate per 100 000 bed days is shown in Appendix 4, figure 18. Figure 19 demonstrates that the Trust has the **highest annual rate** of MSSA bacteremia per 100 000 bed days of comparable regional Acute Trusts. Figure 20 taken from the UK Health Security Agency Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026 shows that the Trust is reporting high numbers of MSSA cases, with only 3 Trusts reporting higher than ourselves.

Actions taken within 2025/26 to reduce the incidence of MRSA/MSSA bacteraemia have included:

- The MSSA cases have all been recorded on Datix and the care groups are investigating these cases; feedback will be provided via the care groups IPC/AMS meetings.
- A standard operating procedure for MSSA case reviews which details the governance route for these cases has been approved at IPSAG and is now being implemented.
- Reducing MSSA bacteraemia by at least 5% was a focus of improvement in 2025-26 and a Trust MSSA operational improvement plan was introduced focusing on invasive device management and documentation, MSSA suppression therapy compliance, recognition of patients at risk of developing a bacteraemia and managing them appropriately.
- The Trust IPC improvement plan included in Appendix 2 focuses on 4 key improvement categories of: education and professional standards, clean and appropriate Healthcare environment, device related HCAI and surveillance of HCAI.

- A peripheral cannula Trust wide peripheral cannula compliance audit, has been undertaken at the end of quarter 4 and a task and finish group are undertaking improvement work, including reviewing the standardisation of products used across the Trust in quarter 1 and 2 of 2026/27.

3.3 Gram Negative Blood Stream Infections (GNBSI):

3.3.1 *E. coli* bacteraemia:

There has been a total of 187 Trust attributed cases in 2025/26. The Trust is **17 cases over the annual threshold** of 170. Of the 187 cases COHA=118 HOHA=69. Appendix 4, Figure 21 demonstrates that despite being over the annual threshold, the Trust improved upon their 2024/25 incidence by 9 cases, but the previous 3 years were all a lower incidence rate.

The attribution of Trust cases to end of quarter 4 2025/26 by Care Group is as follows: Medicine 89, Surgery 46 are attributed to the Surgical Care Group, CSCS 34 and Family Health 13. 57% of the cases are attributed to York Hospital, 33% attributed to Scarborough and Bridlington Hospitals and 10% attributed to Community Units. The Haematology/Oncology unit at York Hospital has the highest number of cases with 11 cases, as demonstrated in Appendix 4 Figure 22.

The Trust is **above the national monthly *E. coli* bacteraemia rate per 100 000 bed days** for the whole year except for February 2026 demonstrated in Appendix 4, figure 23. The Trust has the highest annual *E. coli* bacteraemia rate per 100 000 bed days with comparable regional Acute Trusts, as demonstrated in Appendix 4, Figure 24. However, in the latest published NHS Oversight Framework (quarter 3 data) the Trust is scored at 2.6 for E. coli bacteremia, as demonstrated in Appendix 4, figure 25. The metric is calculated in a 12-month rolling count of E. coli bacteraemia and where the organization is at or below the threshold level a score of 1 is awarded, a score between 2.00 - 4.00 is awarded based upon the distance from the threshold, the lower rate is better.

Figure 26, taken from the UK Health Security Agency Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026 shows that the Trust is reporting high numbers of E. coli cases, with only 3 Trusts reporting higher than ourselves.

3.3.2 *Klebsiella* bacteraemia:

There has been a total of 78 Trust attributed cases in 2025/26. The Trust is **35 cases over the annual threshold** of 43. Of the 78 cases COHA=37 HOHA=41. This is a deterioration on the 2024/25 position where 46 Trust attributed cases were reported.

The attribution of Trust cases at the end of quarter 4 2025/26 by Care Group is as follows: Medicine 42, Surgery 24 and CSCS 12. 74% of the cases are attributed to York Hospital, 24% are attributed to Scarborough and Bridlington Hospitals and 2% are attributed to the Community Hospitals.

Ward 35 and 36 at York Hospital have the highest cumulative number of cases with 6 cases each attributed to them, as demonstrated in Appendix 3 Figure 27. The Trust is

above the monthly Klebsiella bacteraemia rate per 100 000 bed days for the whole year, except February 2026 as shown in Appendix 4, figure 28, and has the highest annual Klebsiella bacteraemia rate per 100 000 bed days with comparable regional Acute Trusts as demonstrated in Appendix 4, figure 29.

Figure 30 taken from the UK Health Security Agency Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026 shows that the Trust is reporting high numbers of Klebsiella cases, with only 2 Trusts reporting higher than ourselves.

3.3.3 *Pseudomonas* bacteraemia:

There has been a total of 32 Trust attributed cases in 2025/26. The Trust is **16 cases over the annual threshold** of 16. Of the 32 cases COHA=21 HOHA=11. This is a deterioration on the 2024/25 position where 26 Trust attributed cases were reported.

The attribution of Trust cases at the end of quarter 4 2025/26 by Care Group is as follows: Medicine 11, Surgery 10 and CSCS 11. 69% of the cases are attributed to York Hospital, 31% are attributed to Scarborough and Bridlington Hospitals.

Haematology and Oncology have the highest cumulative number of cases with 5 cases attributed to them, as demonstrated in Appendix 4 Figure 31. The Trust is **above** the monthly Klebsiella bacteraemia rate per 100 000 bed days for most of the year, as shown in Appendix 4, figure 32, and has the highest annual Pseudomonas bacteraemia rate per 100 000 bed days with comparable regional Acute Trusts as demonstrated in Appendix 4, figure 33.

Figure 34 taken from the UK Health Security Agency Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026 shows that the Trust is reporting high numbers of Pseudomonas cases, with only 2 Trusts reporting higher than ourselves.

The Trust is **above the national monthly Pseudomonas bacteraemia rate per 100 000 bed days** as shown in Appendix 3, figure 22 and 23, and the highest annual Pseudomonas bacteraemia rate per 100 000 bed days with comparable regional Acute Trusts as demonstrated in Appendix 3, figure 24

Actions taken within quarter 4 2025/26 to reduce the incidence of GNBSI bacteraemia have included:

- A task and finish group supported by the QI team has been established following the point prevalence audit of catheterised in-patients. The key areas identified for improvement are the introduction of the “HOUDINI” catheter protocol, consistent use of fixation devices and refreshing the urinary catheter care plans.
- A Trust IPC improvement plan included in Appendix 3 focuses on 4 key improvement categories of: education and professional standards, clean and appropriate Healthcare environment, device related HCAI and surveillance of HCAI.

4. IPC Training

The IPC team continue to deliver IPC training with face-to-face training in classroom settings and clinical areas in both a reactive manner, in response to observed practice during ward and department visits, and proactively, such as the response to the high levels of respiratory viruses over the winter and preparedness to respond to emerging infections. The IPC team has continued the intensified clinical education on back to basics, including planned educational sessions for all staff groups throughout the year.

The team continue to provide Healthcare Assistant training within the academy and are now supporting the registered staff training and medical staff induction programmes. This is an excellent opportunity to deliver scenario based training and practical application of fundamentals of IPC.

The mandatory IPC training Trust compliance has remained static over the year and is recorded as 88% (against a target of 90%). Care Groups are aware of compliance rates via the IPC dashboards and are being asked to drive improvement.

A focus on Aseptic Non-Touch Technique (ANTT) training continued as a key element on reducing bacteraemia rates. Compliance has remained relatively static, with the ANTT theory recorded at 89% and the practical compliance at 83%. Care Groups are aware of compliance rates via the IPC dashboards and are being asked to drive improvement via the IPC/AMS meetings. The IPC team continue to collaborate with the Clinical Educators to promote ANTT and invasive device management, including VIP scoring, “scrub the hub” and device removal when no longer required.

High Impact Actions

The team have continued to embed the **high impact actions** introduced during the 2024/25 Chief Nurse’s Year of Quality. This includes:

1. Bare below the elbow and effective hand hygiene
2. Appropriate use of Personal Protective Equipment (PPE)
3. When to take stool samples
4. Decluttering the clinical areas, including linen management
5. Effective aseptic non-touch technique.

The team continue to use innovative approaches including ward walk rounds with visual aids, fun quizzes, conversation points, campaigns, awareness sessions, new information posters and prompt cards and de-clutter days.

A Trust IPC study day was delivered in October 2025 at Malton Rugby Club with the theme of IPC ownership at ward and department level. There event was attended by circa 90 delegates and was well evaluated.

General Feedback

Feedback received has been mostly positive, with the overall opinion that the day was received well and pitched at an appropriate level for the staff in attendance.

Overall, how satisfied were you with the event?

4.47
Average Rating

Were your expectations of the event met?

4.44
Average Rating

Were the topics discussed relevant to your job role?

4.50
Average Rating

The IPC team are planning the annual IPC study day for the 6th of October 2026.

5. Infection Process Measures and IPC Audit Outcomes

The IPC team use data collected during planned ward and department audits to measure effectiveness of infection process measures which includes audit information on Hand Hygiene, Symbiotic Cleaning Scores, bedpan and commode cleanliness and CDI practice compliance. This is available in the care group dashboards located via this link Care Group Dashboards. Key points of note are listed in table 1 which shows that annual

compliance of 95% has not been reached for the CDI audits, improvements are being seen in hand hygiene compliance, commode and bedpan cleanliness compliance.

Hand hygiene audit data reflects audits carried out by the IPC Team, rather than those on Tendable.

Graphical demonstration of process measures for prevention of blood stream infection is currently being collated. It will include compliance with invasive device management including urinary catheters and IV cannulas.

Table 1 IPC Audit points of note – 95% or above is required for compliance					
Audit	Medicine Care Group Average compliance Current (previous quarter)	Surgery Care group Average compliance Current (previous quarter)	Family Health Care Group Average compliance Current (previous quarter)	CSCS Average compliance Current (previous quarter)	Trust Average Current (previous quarter)
CDI, Saving lives bundle	89%	86%	95%	91%	90%
Hand Hygiene **	91%	93%	94%	97%	94%
Commode cleanliness	94%	97%	93%	100%	96%
Bedpan cleanliness	99%	100%	98%	100%	99%

**Hand hygiene audits using IPC audit data not ward/department data.

6. Orthopaedic Surgical Site Infections (SSI)

The Trust continues to work on reducing the incidence of orthopaedic SSI. Appendix 5 details the Trust ongoing incidence versus the 2023/24 national incidence rate. The Trust quarter 4 data shows that it is above the 2023/24 national infection rate for total knee replacement in Bridlington, below the national infection rate for fractured neck of femur at York but at 0% infection rate for the other interventions and sites.

Post infection review meetings for any Orthopaedic surgical site infections take place within the Care Group with support from the IPC team; with lessons learnt being acted upon by the care group.

7. Outbreaks: Respiratory Virus Infection (RVI) and Norovirus

The RVI guideline, RVI screening guideline, the management plan for RVI in winter and RVI risk assessment and decision log were approved and published in September 2025. These documents detail patient screening and placement within the organisation, including the escalation to opening dedicated RVI cohort areas and de-escalation process, alongside a risk assessment and decision log to inform decisions regarding patient movement during operational pressures and formed part of the wider Trust Winter Plan 2025/26.

It has been recognised by Humber and North Yorkshire Integrated Care Board and NHS England that the Trust managed its winter RVI season much better than previously and our risk assessment tool and decision log was shared with other organisations as good practice. The Deputy DIPC has been invited by NHSE to present our approach to IPC management over winter 2025/26 and share our IPC improvement journey which is recognition of the hard work by all staff across the Trust to improve our IPC position.

The Trust has also been affected by Norovirus throughout 2025/26 which has resulted in bay and ward closures across the Trust. In quarter 4 there were 4 Norovirus outbreaks as detailed in the table below. The outbreaks were all managed within the Trust Management and Control of Outbreaks guideline and wards/beds were cleaned and re-opened as soon as safe to do so.

NOROVIRUS			
Dates closed and opened	Ward	Total patient affected	Total staff affected
17/01/2026 - 30/01/2026	Ward 35	18	5
20/01/2026 - 27/01/2026	Cherry Ward	5	0
25/02/2026 – 05/03/2026	BCU	12	0
23/03/2026 – 30/03/205	Ward 37	13	1

8. Antimicrobial Stewardship (AMS)

The AMS team continues to work to optimise the use of antimicrobials at the Trust, to improve patient outcomes, safety and reduce risk of antimicrobial resistance (AMR).

In November 2025 NHSE issued a call for action communication. The document outlined the NHS's strategic actions for antimicrobial resistance (AMR) management, including board-level reviews, performance benchmarking, risk assessments, and the establishment of three prioritized improvement areas with executive accountability and timelines by April 2026, supported by ongoing evaluations and reporting mechanisms. A group with representatives from Pharmacy, IPC, Consultant Microbiologists and care groups met and identified 3 priority areas which are for delivery in 2026/27:

1. Optimise the 'Start Smart' stage of antimicrobial prescribing

A full update of core AMS guidelines, including adult and paediatric treatment and ED antimicrobial guidance, and oral step-down recommendations is required to reflect national

duration reductions and local antimicrobial susceptibility data will be undertaken. Continued collaboration with the Trust EPMA team to support clinical decision making.
The Trust will reinstate routine blood culture pathway data collection, recognising feasibility constraints within the current system, and working with the patient safety team to optimise processes.

2. Improve IV-to-Oral Switch (IVOS) and 72-hour Antimicrobial Review

National guidance and ICB feedback identify IVOS as a key expectation for Trusts. Timely switch to oral therapy remains one of the most effective stewardship interventions for reducing length of stay, nursing workload, line complications, and antimicrobial resistance selection pressure.

Decisions relating to choice of oral stepdown option will be supported through the optimisation of local guidelines, to include empiric oral stepdown, along with improved blood culture pathway compliance enabling directed (narrower) therapy.

The Trust I 2026/27 will reinstate routine IVOS and ARK data collection and feedback, strengthen review processes, and increase visibility of antimicrobial review prompts within NerveCentre, contributing to safer, shorter, and more effective antimicrobial therapy.

3. Establish a Penicillin Allergy Delabelling (PADL) Programme

Penicillin allergy delabelling is nationally recognised as a high-value intervention, improving antimicrobial choice and reducing inappropriate broad-spectrum prescribing.

Introducing a structured, risk-stratified approach will allow the Trust to address a key driver of avoidable broad-spectrum antimicrobial use. This priority also positions the organisation to benefit from potential external innovation funding. Although full-service expansion is resource-dependent, initiating a scaled pilot is feasible within existing capacity and aligns with system-level ambitions.

A paper detailing these priorities and an action plan for delivery was prepared for approval and ongoing monitoring by IPSAG in April 2026.

9. Water safety

The Trust has a water safety policy to provide safe water and management of systems for all patients, staff and visitors.

The Water Safety Plan (WSP) outlines the operational arrangements and documents the Trust's approach in the effective management of water systems. The Trust Water Safety Policy and WSP has been developed and written in consultation with a Trust appointed independent external Authorising Engineer and agreed by The Trust at the Strategic Water Safety Group, IPSAG and Executive Committee.

The Nominated Director for the management of water safety is the DIPC and held by the Trust Chief Nurse. The DIPC receives reports from the Head of Safety and Security who chairs the Strategic Water Safety Group and reports through IPSAG every 2 months.

The Trust has in place a Consultant Microbiologist with responsibility for water and an Estates Responsible Person for water and a deputy at both main sites. The Deputy DIPC

is the water safety Responsible Person IPC and is required to monitor and report clinical surveillance regarding water safety. This has taken significant input from the Microbiologist and IPC throughout the year.

There is a programme of Augmented Care area water safety audits in place in line with water safety regulation and guidance.

Audit Yorkshire reviewed the governance arrangements for water safety within this year, and an improvement plan is in place. This includes the establishment of an operational water safety group to supplement the existing strategic water safety group and is being arranged in quarter 1 of 2026/27.

The main water safety concerns from an IPC perspective are:

- Scarborough UECC is subject to additional water safety group meetings to oversee and advise on the ongoing issues with the water quality, including variable water sampling results for total viable counts and chemical content.
- The water quality including high total variable counts on water sampling, delaying the opening of the Community Diagnostics Centre at Scarborough
- There are a high number of water outlet filters across the organisation due to high total variable counts on water sampling, The filters not only decrease water flow but also come with a high resource cost (product and manpower). When an outlet is fitted with a water filter an exit strategy should be in place but many of these areas have been operational with filters for a significant time with no resolution.
- The Estates team have been undertaking reviews of pipe systems, which over time have been added to as new developments have come on-line which makes them complex and challenging to manage. To replace old systems will require resource and planning to reduce the impact on operational services.
- The design of any new developments water systems should have the involvement of the Trust Estates Responsible Person for water at an early stage to reduce the impact on existing water systems. Over quarter 4 there has been increased engagement on new capital projects.
- The strategic Water Safety Group have been asked to consider a “water light” approach to new developments and refurbishments of existing areas, to reduce the number of water outlets and as such reduce the risk of water contamination due to little use at some outlets. The first area we have trialled this approach in is the SCBU at York and this is working well.

  Whilst the IPC team support the arrangements for water safety, the expertise for the physical water system sits within YTHFM Estates and Facilities team. We have a good working relationship with the team, but any further assurance should be sought through them.

10. Other IPC Activity

- Several capital schemes have been progressing with IPC involvement through the year. The team are working closely with the Capital Projects team and Estates teams regarding development of a clear Standard Operating Procedure for commissioning and sign off for new builds and refurbishments.
- IPC policies, Guidelines and Patient Information Leaflets continue to be reviewed and updated to reflect the National IPC manual. All documents are in date.

- The IPC team were closed involved with the digital team and the developments in preparation for the move to Nerve Centre in 2026. We continue to have active discussions with the digital team regarding the functionality of IPC Alerts and IPC documentation. We are keen to review the IPC module on Nerve Centre to determine if this will afford increased IPC control.

11. Summary

The overall HCAI performance for the organisation is showing signs of improvement, but we still have further improvements to make. The IPC team are committed to change their working practice and improve the delivery of the IPC service. The governance, ownership and accountability for IPC have been strengthened within the care groups, as demonstrated by the internal audit results. The IPC monitoring metrics are currently being reviewed to increase the assurance that the IPC team can provide to the organisation.

12. Next Steps

- Stabilise the IPC Team
- Deliver against the NHS England HCAI thresholds
- Develop new IPC awards to generate energy and competition into ward/department improvement
- Deliver IPC study day in October 2026
- Contribute to the Chief Nurse Year of Quality programme in September and October 2026
- Embed the HCAI PSIRF review process to make improvements for 2026/27 in relation to timeliness of reviews, ownership and completion of improvement actions by the care groups, and wider Trust feedback
- Progress the QI project for urinary catheter management
- Progress the development of a QI project for peripheral venous cannula management

Date: 30/05/2026

Appendix 1 Audit Yorkshire IPC improvement in Care Groups.

Executive Summary

Objective	The objective of this review was to review the actions instigated at the Care Group Infection Prevention and Control Improvement meeting against the agreed Terms of Reference (ToR) for the Group and assess the effectiveness of these measures with improving compliance with Infection Prevention and Control (IPC) standards.
Scope	The scope of this review evaluated the alignment of actions taken at Care Group IPC Improvement meetings with the agreed ToR and assessed the effectiveness of these actions for contributing to improved compliance with IPC standards. Our review considered the robustness of action tracking and closure, the quality and accessibility of supporting documentation, and the impact of implemented measures on IPC performance. Evidence was gathered through review of meeting minutes, action logs, compliance audits, and related documentation, with particular focus on governance arrangements, escalation processes, and the dissemination of learning across care groups.
Opinion	
 **Significant Assurance**	We have provided an overall opinion of **Significant Assurance**. The Trust has established comprehensive governance frameworks for infection prevention and antimicrobial stewardship, supported by robust Terms of Reference, structured reporting lines, and regular compliance audits. Action logs and dashboards are routinely used to monitor performance, escalate issues, and share learning across care groups. The Trust demonstrated a strong commitment to learning and quality improvement, with clear evidence of escalation pathways, regular review of compliance data, and the sharing of best practice across the Care Groups. The proactive use of audit findings to inform targeted interventions, alongside the structured dissemination of learning, supports a culture of accountability and responsiveness. Whilst the systems in place are well designed and generally effective, the audit identified several areas for improvement, including the need for formal approval and ratification of some Terms of Reference (ToR), more consistent tracking of actions prior to closure, and enhanced documentation of supporting evidence. These issues do not represent fundamental control failures but highlight opportunities to further strengthen governance assurance and continuous improvement. Continued focus on addressing the identified areas for development will further enhance the effectiveness and resilience of the Trust's infection prevention and control arrangements.
Recommendations	
Major	**0**
Moderate	**5**
Minor	**4**
Key Findings	
	• Whilst all groups operate under comprehensive ToRs, several current versions remain marked as "Draft" with no explicit evidence of formal approval or annual review by the relevant committee. This presents a minor risk to governance assurance. • Sample testing across the Care Groups found that, in some instances, evidence of action closure was not available or not systematically stored in a central, accessible location. Some actions remained open across multiple meetings, and supporting documentation was often obtained via direct requests to staff rather than from a shared repository. • Although medication incidents, missed doses, and errors are reviewed and documented, learning is not always embedded through

3

	targeted training or process change, leading to repeat incidents and missed opportunities for prevention. • Persistent issues with inconsistent attendance and engagement at strategic meetings, especially within Antimicrobial Stewardship Groups, risk weakening governance and delaying key actions. • Minutes and outputs from specialty governance meetings are not always captured or linked to the IPC Group, limiting assurance over the decision making process and weakening the audit trail.
	• Care Groups may wish to introduce thematic reviews to identify trends across wards and embed continuous monitoring of hand hygiene and environmental compliance. Linking audit outcomes to targeted training and standardising IPC dashboard reporting would help ensure consistency and support improvement. • Care Groups may wish to regularly review IPC key performance indicators to ensure they remain relevant and challenging, reflect current risks and guidance, and drive meaningful improvement. This should include identifying and addressing any gaps in existing metrics.
	• All Care Groups and the Infection Prevention Strategic Assurance Group (IPSAG) operate under detailed ToRs that align with Trust-wide priorities and national standards, with clear reporting arrangements and escalation pathways. • ToRs and supporting documents are distributed to all relevant members, with evidence of structured dissemination and robust approval processes at IPSAG. • Regular compliance audits are embedded within governance frameworks, with results routinely reported and used to inform targeted interventions and training. KPI dashboards are standing agenda items, enabling trend analysis, benchmarking, and prompt escalation of issues. • Audit results, checklists, and improvement plans are communicated to relevant staff, with processes in place to support transparency and promote learning across teams. Meeting minutes and action updates are consistently produced and circulated.

Appendix 2 IPC Board Assurance Framework

The purpose of the NHS England IPC Board Assurance Framework (BAF) is to provide an assurance structure against which the Trust can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NICPM), the Health and Social Care Act 2008:code of practice on the prevention and control of infections and other related disease specific IPC guidance issued by the UK Health Security Agency (UKHSA). The framework is not compulsory, but it is recommended to be used by organisations to demonstrate compliance with IPC standards.

The IPC BAF is divided into 10 sections:

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of services users and any risks their environment and other users may pose to them.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
4. Provide suitable and accurate information on infections to patients/service users/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion
5. Ensure early identification of individuals who have or at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmission of infection to others.
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation precautions and facilities.
8. Provide or secure adequate access to laboratory/diagnostic support as appropriate.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

The 2025/2026 self-assessment of the IPC BAF has been undertaken, and the overall results demonstrate that the Trust is partially compliant with 14 elements and fully compliant with 40 elements as demonstrated in Figure 1 and 2.

Figure 1: Overall compliance with the IPC BAF.

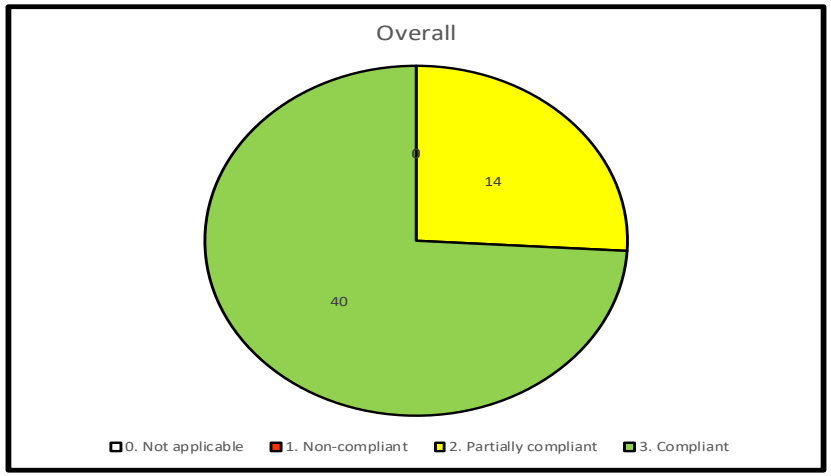
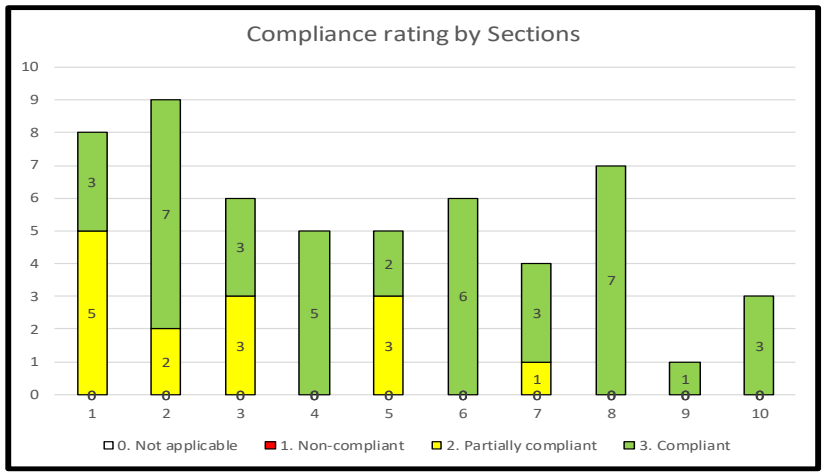


Figure 2: Compliance with the IPC BAF by section.



The areas where more work is required to achieve compliance are:

Area of improvement required / issue	Actions being taken	Deadline
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of services users and any risks their environment and other users may pose to them.		
1.3 Embedding learning from IPC reviews across the Trust	Revised PSIRF process commenced and an actions/ lessons learnt dashboard is being introduced for dissemination through the Care Groups.	May 2026
1.4 The Trust implements, monitors and reports adherence to the NIPCM	The NIPCM is not fully implemented but all policies/guidelines refer to NIPCM. A review of wider implementation will be undertaken within the coming 12 months as policies and guidelines are reviewed and reported via IPSAG	January 2027
1.5 The National Infection Prevention and Control Manual (NIPCM) states that the Trust should have epidemiological/surveillance systems capable of distinguishing patient case(s) requiring investigation and	New laboratory system implemented in September 2025. Nervecentre going live in February 2026.	December 2026

control. The Trust relies on the IPC team manually extracting data from multiple patient data systems which is prone to human error and accuracy is not assured	Discussions on-going with Trust IT regarding the ability of Nervecentre to support and enhance IPC surveillance. Draft Business Case for ICNet awaiting outcome of the above	
1.6 Hierarchy of Controls (HOC) Audits need repeating for 2026	Programmed for commencement in April 2026	September 2026
1.8 Local dynamic risk assessment based on HOC audits	Programmed for commencement in April 2026	September 2026
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.		
2.1 Compliance with the National Cleanliness Standards	YTHFM are currently revising the Cleaning Standards Policy including the escalation process for non-compliance. Planned for presentation to the March 2026 IPSAG for approval	March 2026
2.5 Planned preventative maintenance (PPM) programme for buildings and care environment In development of new build or refurbishments	PPM programme has insufficient resources to address all areas of concern. A priority list has been developed and is kept under review. Delays in undertaking these refurbishment leads to further degradation of the environment. IPC Team are involved with new builds/refurbishment but a checklist to evidence involvement and meeting requirements is being drafted for supporting standardisation and evidence	On-going March 2026
3. Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.		
3.4 Mandatory training only for new pharmacists and F1s, not other staff groups Qualitative data collection for surgery, medicine and family and community care groups	To review education for prescribers and nursing staff. Medicine and surgery planning data collection - identifying resident doctors to support as rolling audit within their programme	TBC by Pharmacy
3.5 Antibiotic Course length data not included in reporting data	Total quantity used is included as a surrogate To consider retrospective review of course lengths for common infections once Nerve Centre implemented	October 2026

3.6 Lack of comprehensive data to measure adherence to good AMS practice	Care Groups to identify residents to support data collection	April 2026
5. Ensure early identification of individuals who have or at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmission of infection to others.		
5.1 Isolation facilities are not always available for patients with or suspected to have an infection	The Trust already has a risk assessment and isolation priority process in place. IPC alerts are placed on CPD and will transfer into Nerve Centre. Single room review daily with Site Team and IPC Monitor for onward transmission of infection.	To continue
5.2 Patients have an ongoing assessment of infectious status; however isolation facilities are not always available for patients with or suspected to have an infection	The Trust already has a risk assessment and isolation priority process in place. IPC alerts are placed on CPD and will transfer into Nerve Centre. Single room review daily with Site Team and IPC Monitor for onward transmission of infection.	To Continue
5.3 There have been some occasions of limited communication regarding infectious status of a patient between ward/department areas despite having appropriate documentation available for use. Operational pressures can impact on timely information sharing	Non-compliance is dealt with in the moment and included within IPC training.	To Continue
7. Provide or secure adequate isolation precautions and facilities		
7.2 Single rooms are always in demand and despite prioritisation there are occasions when access for a patient with or suspected of having an infection is delayed	The Trust already has a risk assessment and isolation priority process in place. IPC alerts are placed on CPD and will transfer into Nerve Centre. Single room review daily with Site Team and IPC Monitor for onward transmission of infection	To Continue

Appendix 3: Trust HCAI improvement Plan

Improvement plan - corporate Decembe

Appendix 4 HCAI performance data 1st April 2025 to 31st March 2026

Figure 1 Trust attributed Clostridioides difficile cases 1st April 2021 to 31st March 2026

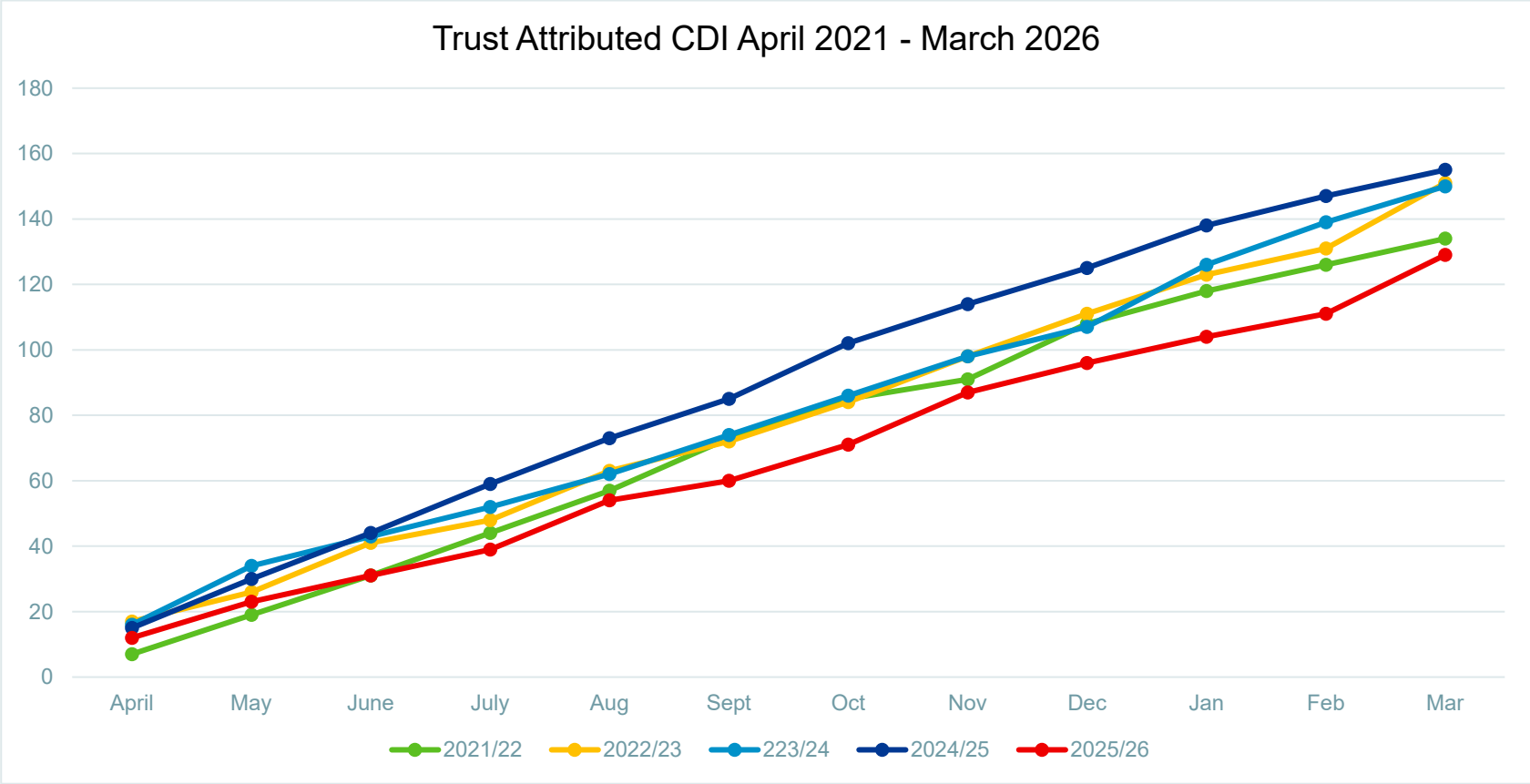


Figure 2: Cumulative Trust attributed Clostridioides difficile against trajectory

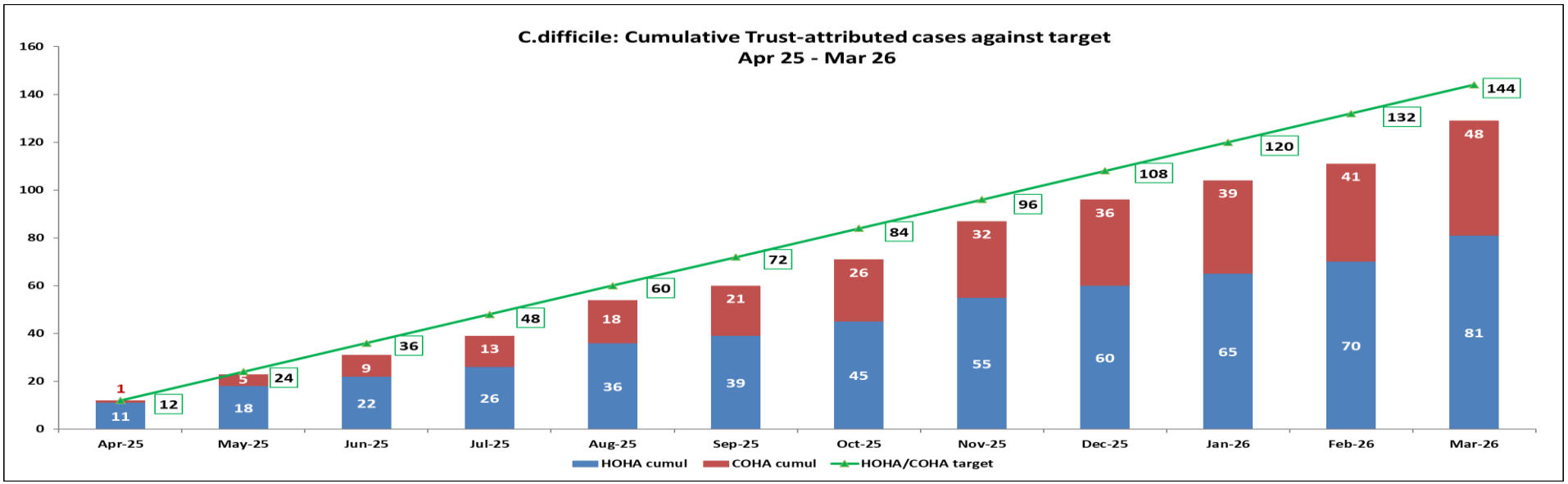


Figure 3: Cumulative Trust attributed Clostridioides difficile cases

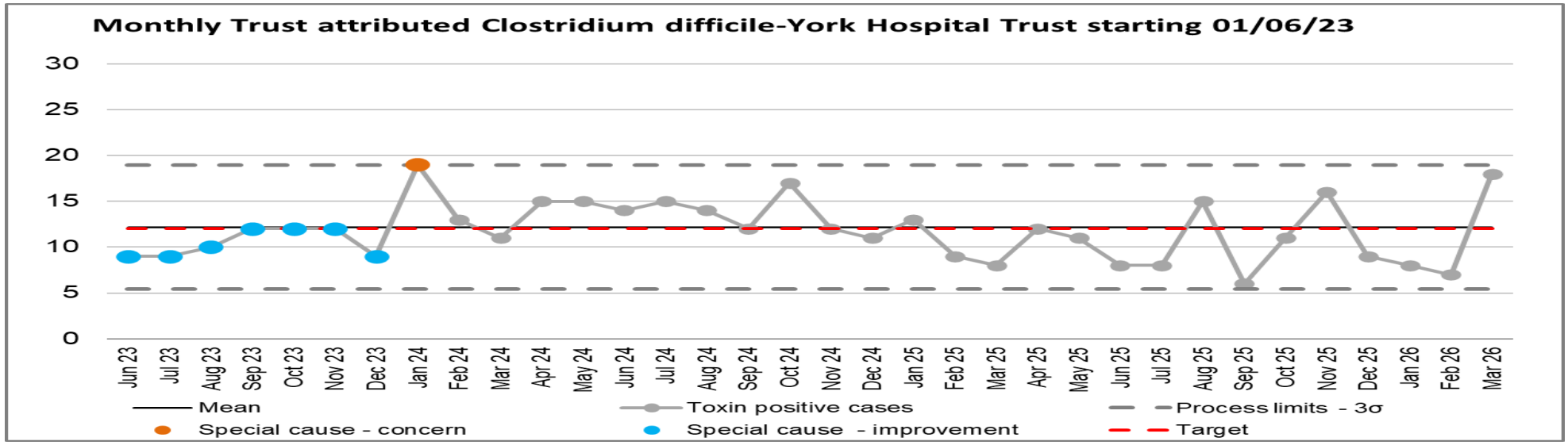


Figure 4: Cumulative Trust attributed Clostridioides difficile by area from April 2025

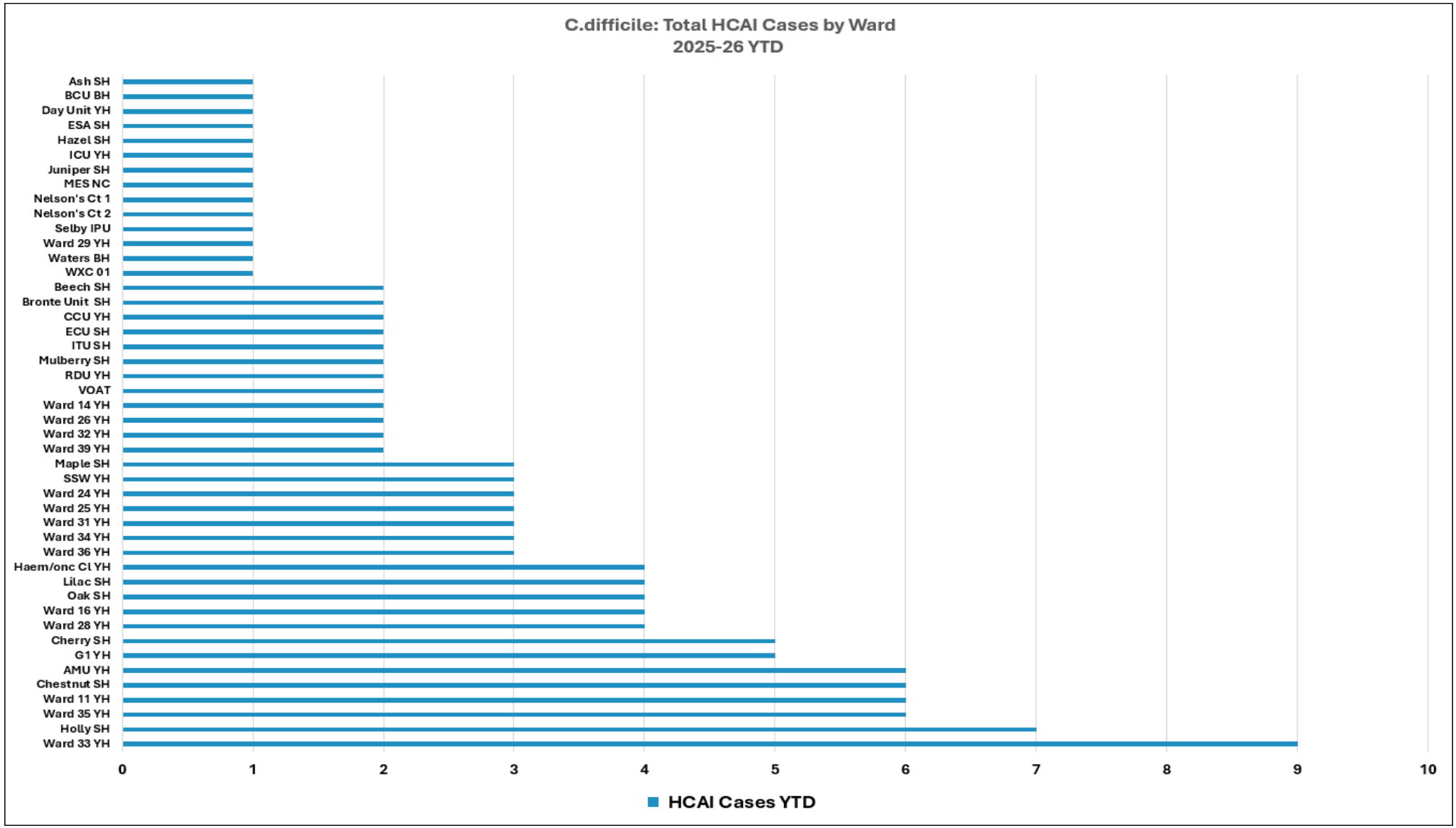


Figure 5: Clostridioides difficile national comparative rates per 100,000 bed days & day admissions monthly rate

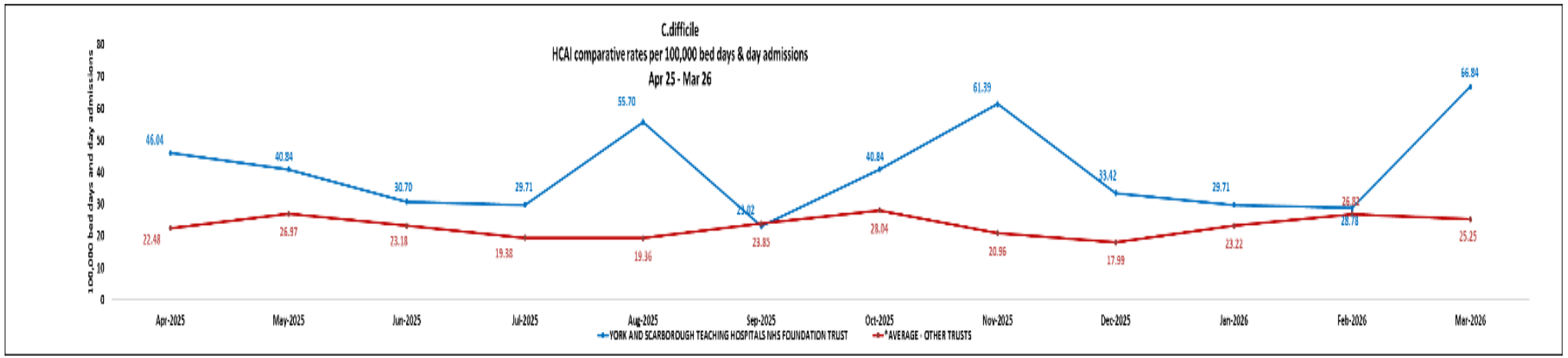


Figure 6: Clostridioides difficile regional comparative rates per 100,000 bed days & day admissions monthly rate

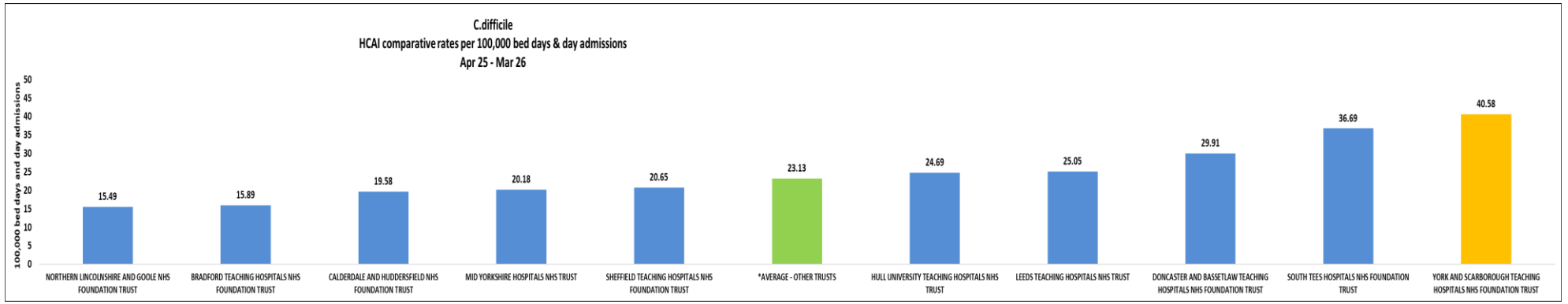


Figure 7: Clostridioides difficile UKHSA Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026

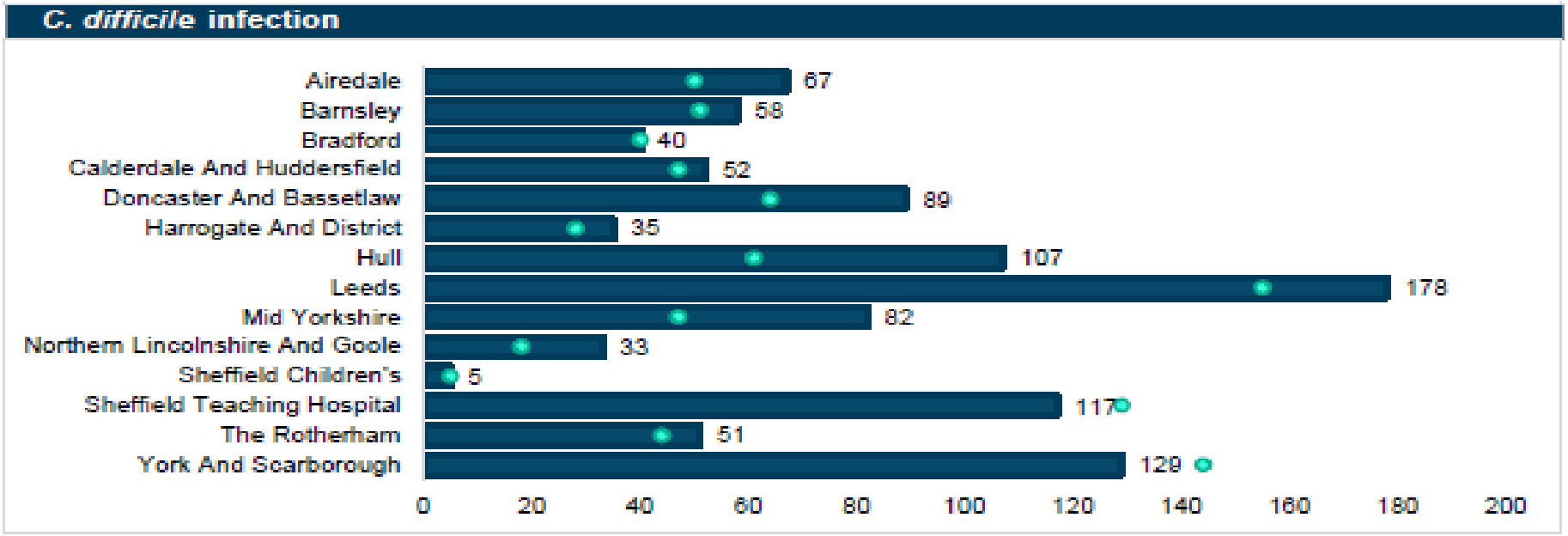


Figure 8: NHS Oversight framework Q3 ranking of the Trust and comparable regional Acute Trusts.

Metric	Trust	Q3 Metric Score (lower is better)
Rate of C.difficile infections	York and Scarborough Trust	**1**
	Sheffield Teaching Hospitals	**2.12**
	Leeds Trust	**2.22**
	South Tees Hospitals	**2.41**
	Calderdale and Huddersfield	**2.87**
	Doncaster and Bassetlaw Teaching Hospitals	**3.13**
	Hull Trust	**3.57**

	Mid Yorkshire	3.78
	Northern Lincolnshire and Goole Trust	3.88

Figure 9: Cumulative Trust attributed MRSA by area from April 2025

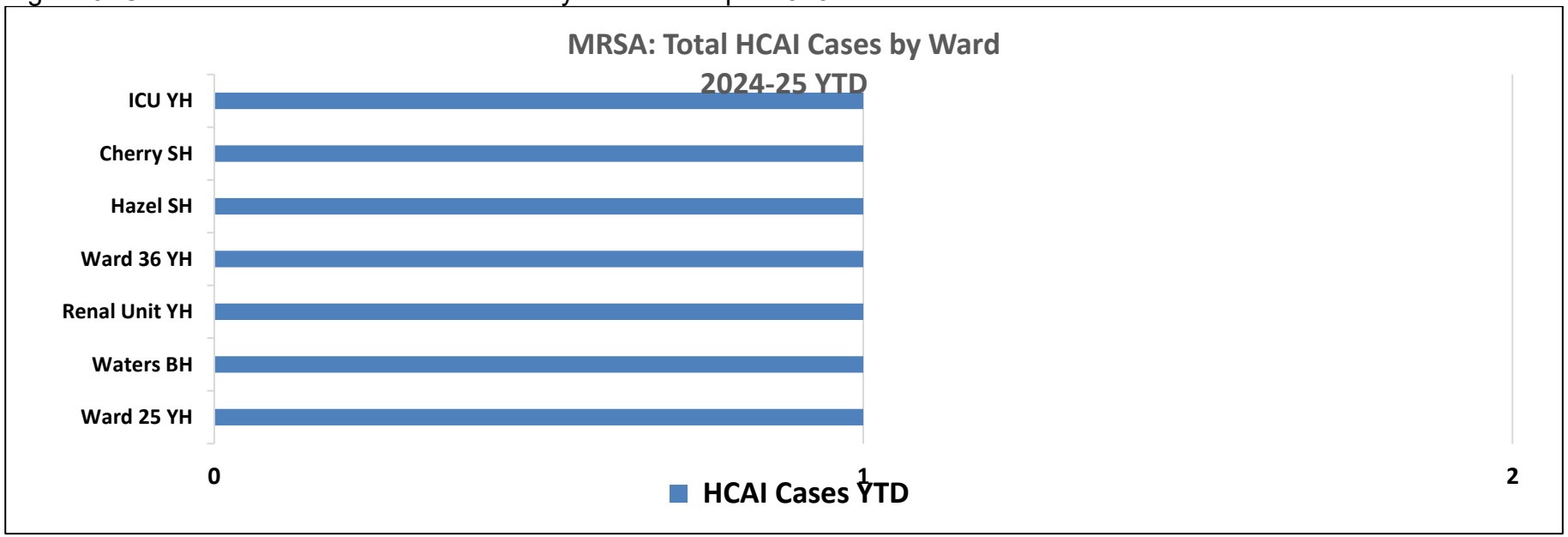


Figure 10: MRSA national comparative rates per 100,000 bed days & day admissions monthly rate

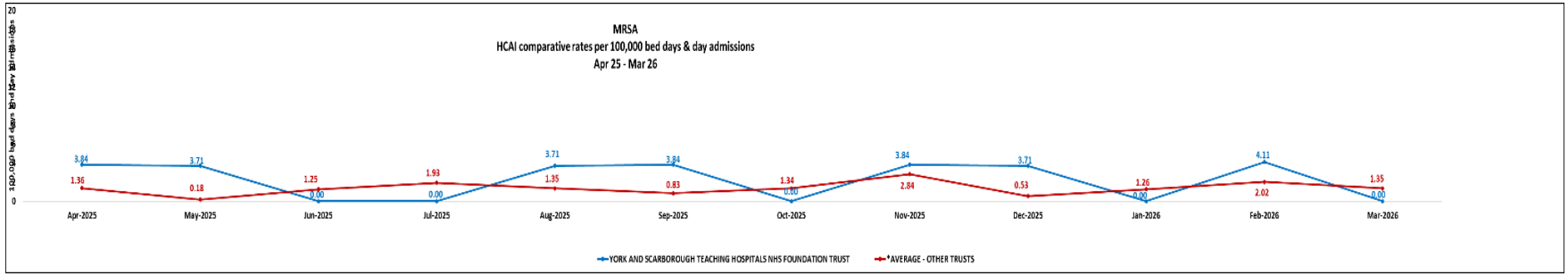


Figure 11: MRSA regional comparative rates per 100,000 bed days & day admissions monthly rate

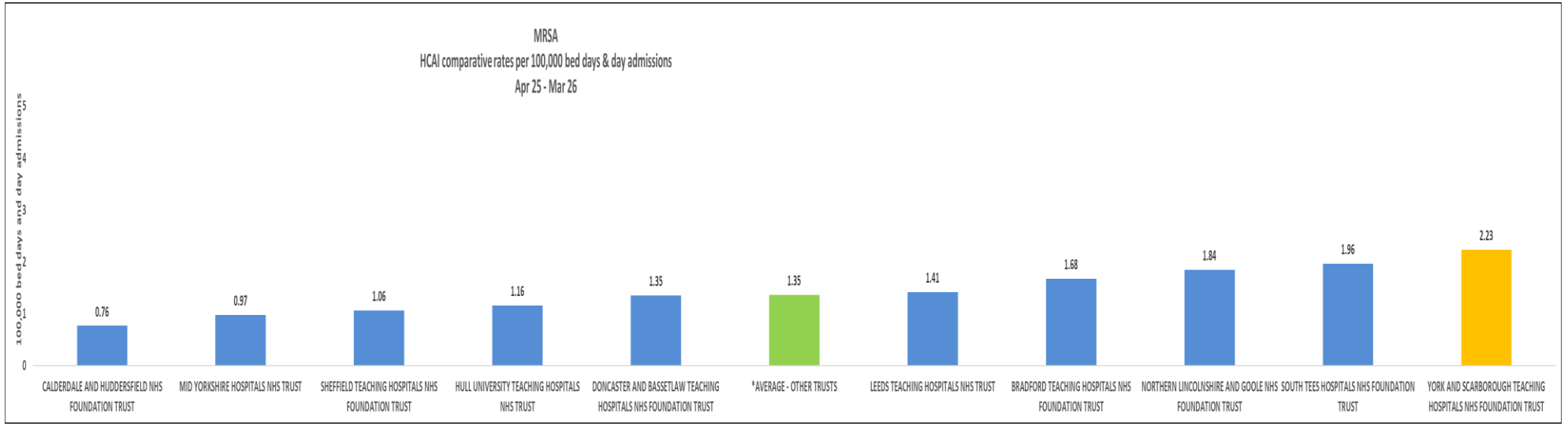


Figure 12: MRSA bacteraemia UKHSA Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026

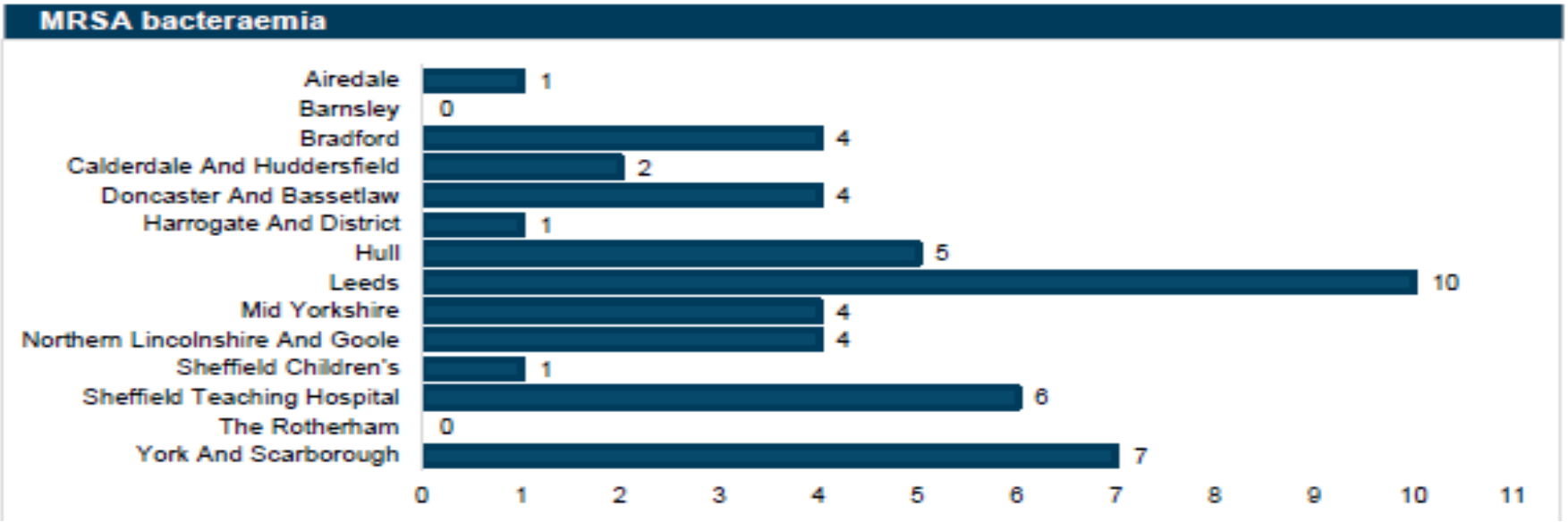


Figure 13: NHS Oversight framework Q3 ranking of the Trust and comparable regional Acute Trusts.

Metric	Trust	Q3 Metric Score (lower is better)
Proportion of MRSA bacteraemia cases	Calderdale and Huddersfield	**2.28**
	Sheffield Teaching Hospitals	**2.66**
	Doncaster and Bassetlaw Teaching Hospitals	**3.01**
	Northern Lincolnshire and Goole Trust	**3.23**
	Mid Yorkshire	**3.44**
	Hull Trust	**3.44**
	York and Scarborough Trust	**3.60**
	Leeds Trust	**3.72**
	South Tees Hospitals	**3.79**

Figure 14: Trust attributed MSSA bacteraemia cases 1st April 2021 to 31st March 2026

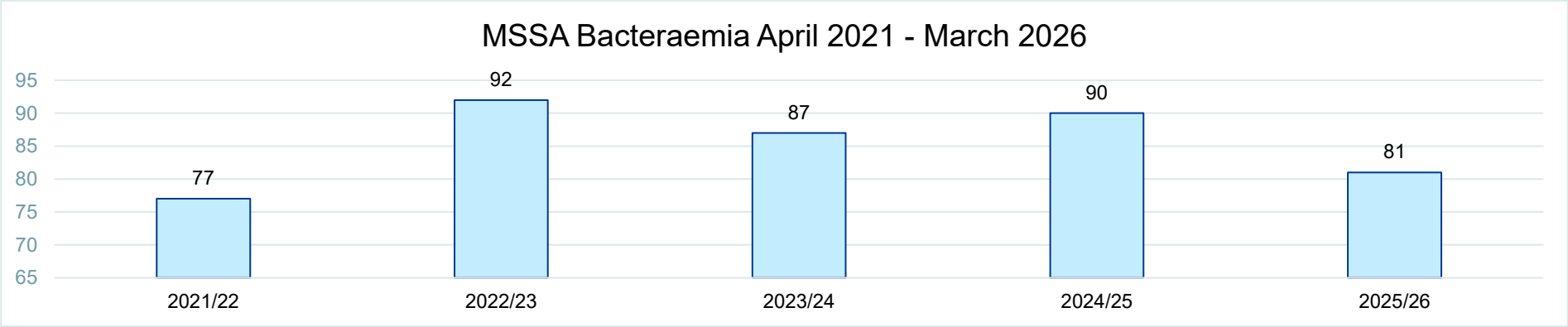


Figure 15: Cumulative Trust attributed MSSA Bacteremia against trajectory

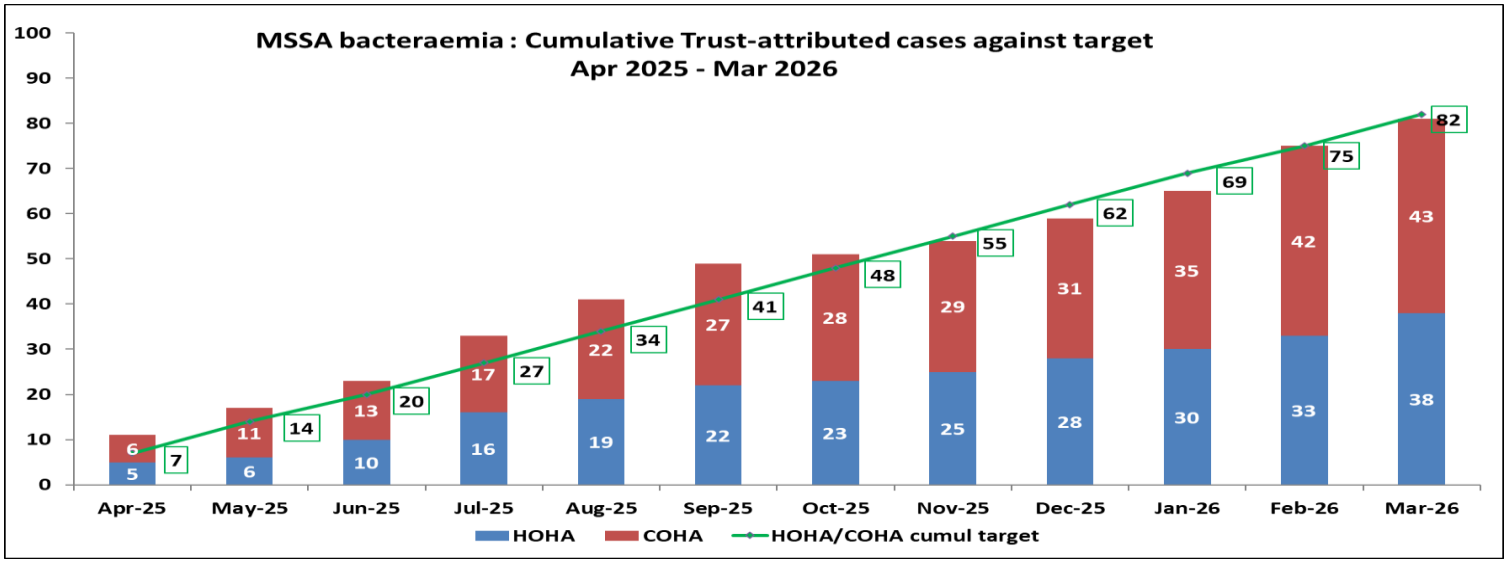


Figure 16: Cumulative Trust attributed MSSA Bacteremia cases

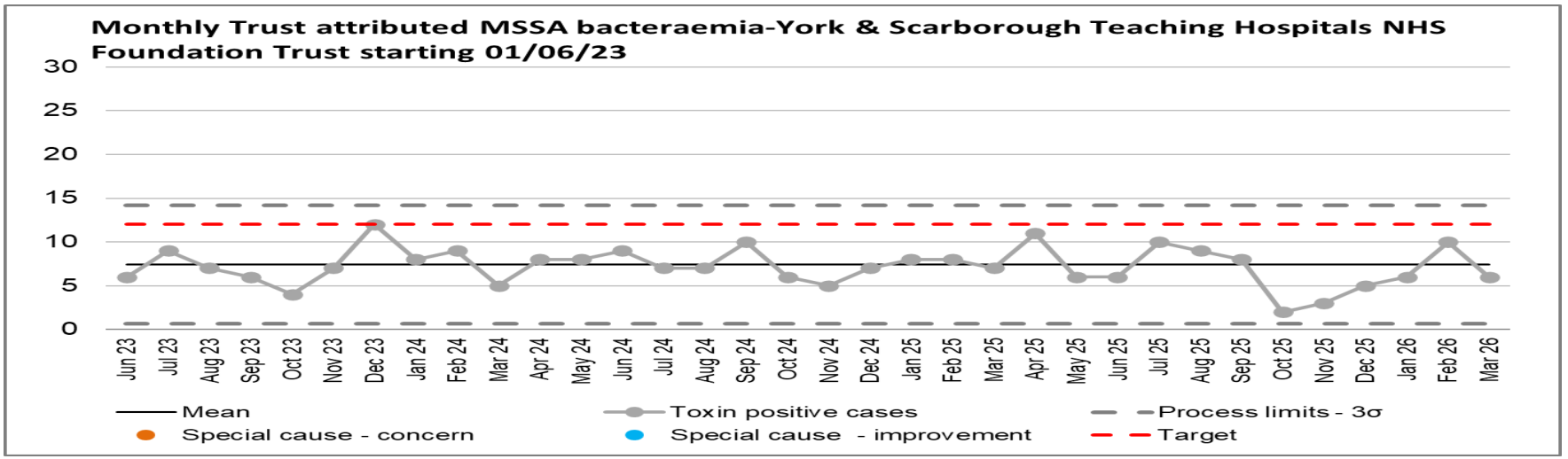


Figure 17: Cumulative Trust attributed MSSA Bacteremia cases by area from April 2024

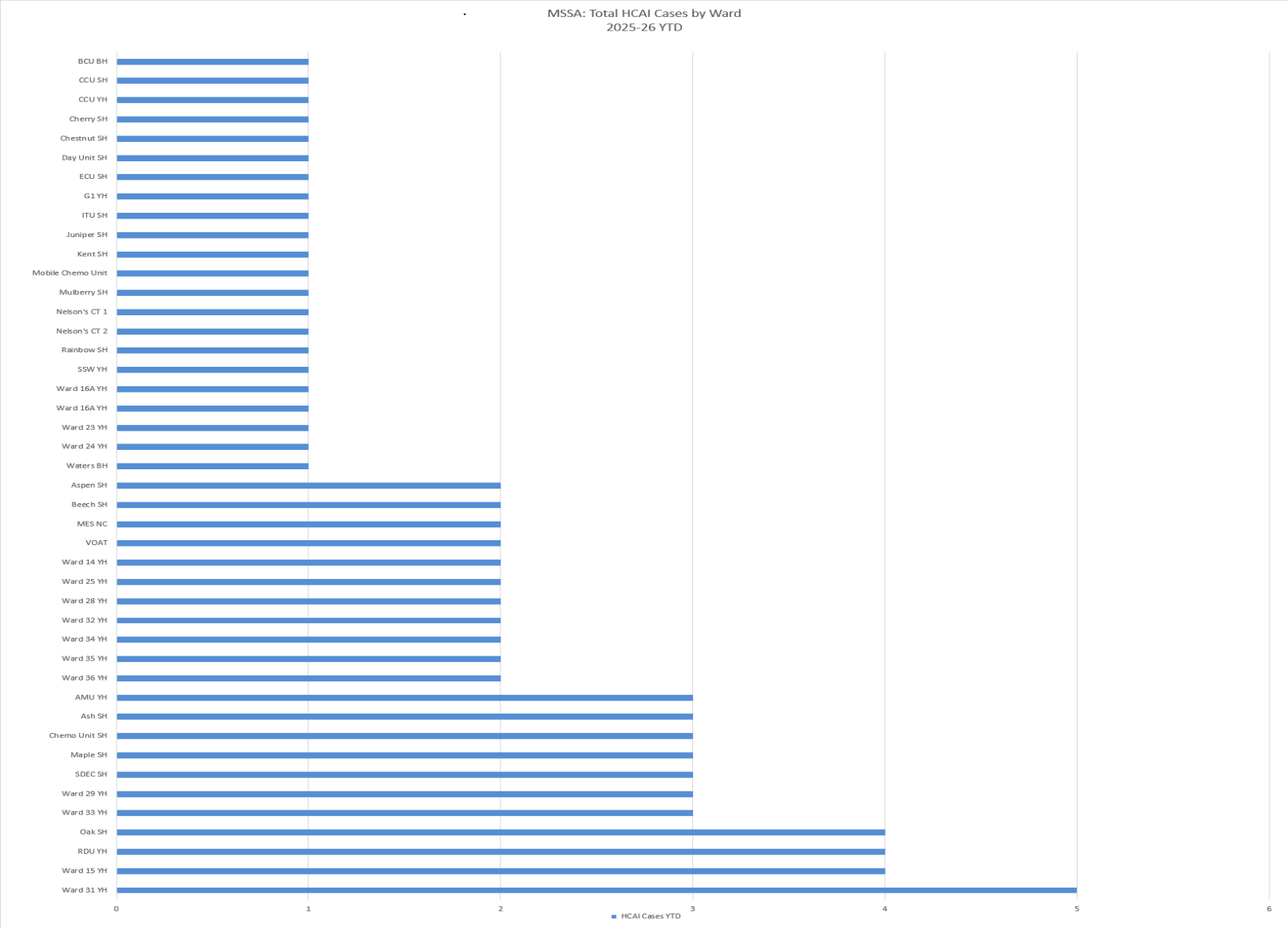


Figure 18: MSSA national comparative rates per 100,000 bed days & day admissions monthly rate

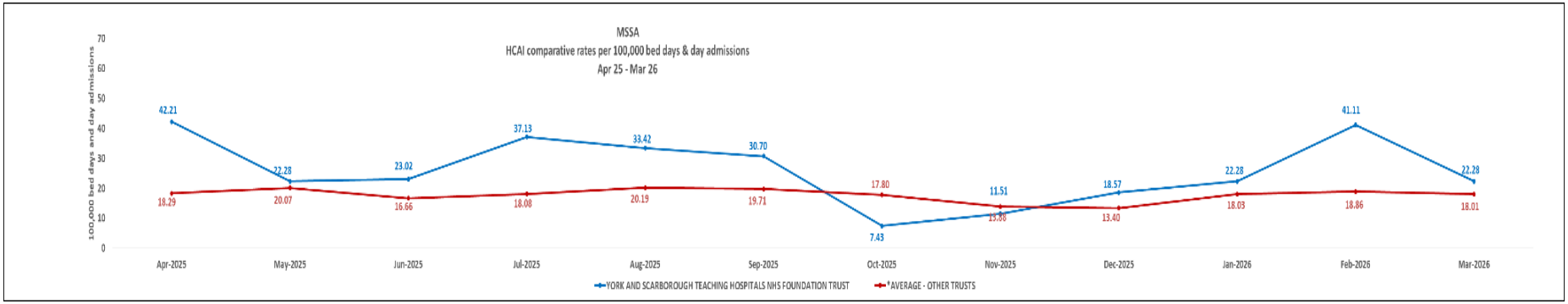


Figure 19: MSSA regional comparative rates per 100,000 bed days & day admissions monthly rate

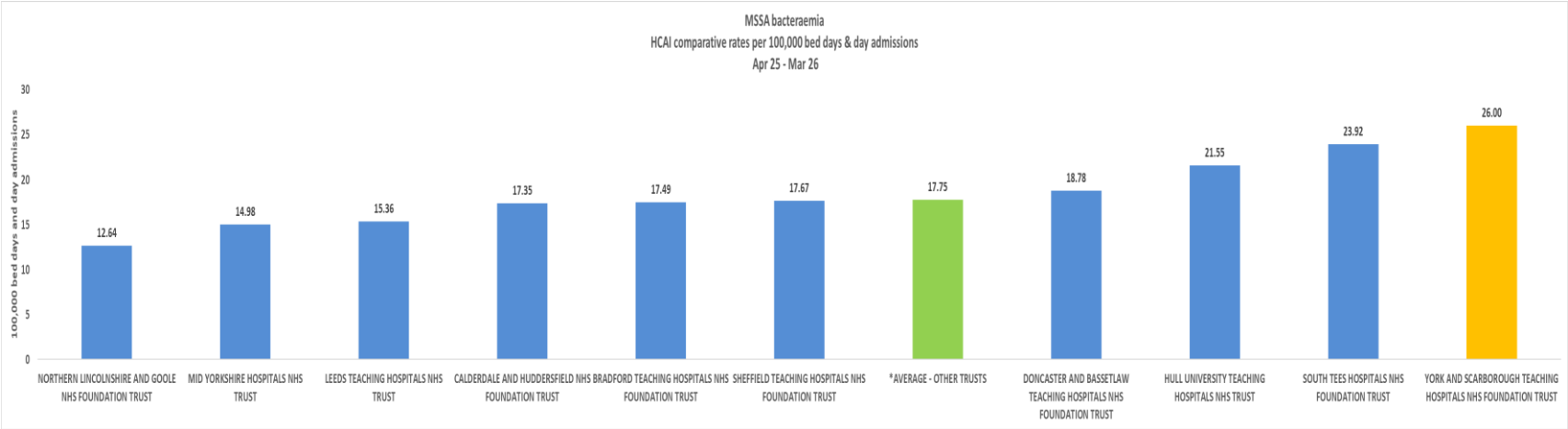


Figure 20: MSSA bacteraemia UKHSA Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026

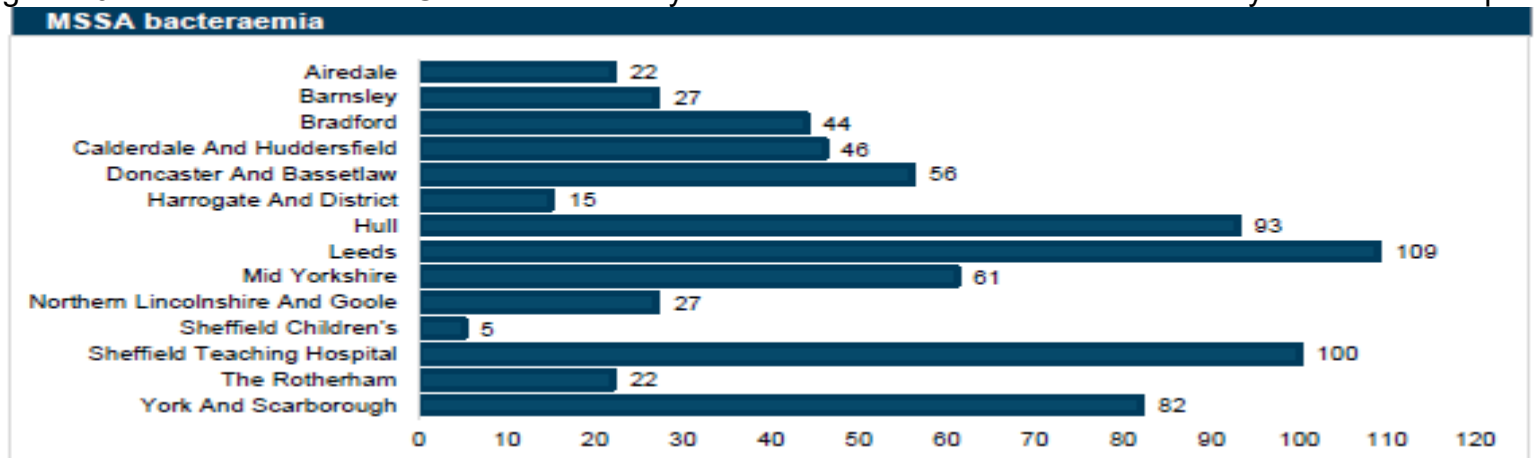


Figure 21: Cumulative Trust attributed E. coli Bacteremia cases by area from April 2025

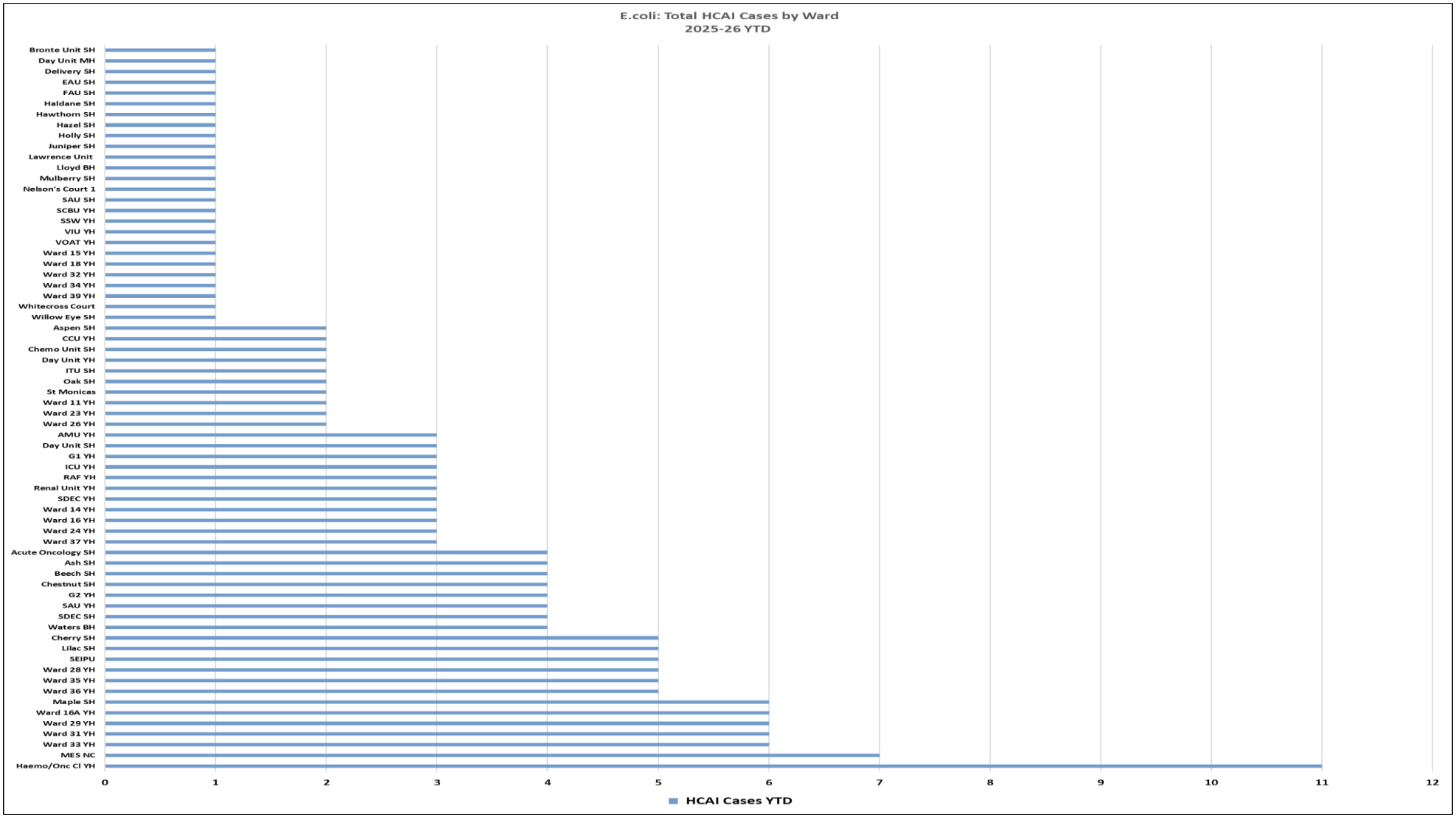


Figure 22: Trust attributed E.coli bacteraemia cases 1st April 2021 to 31st March 2026

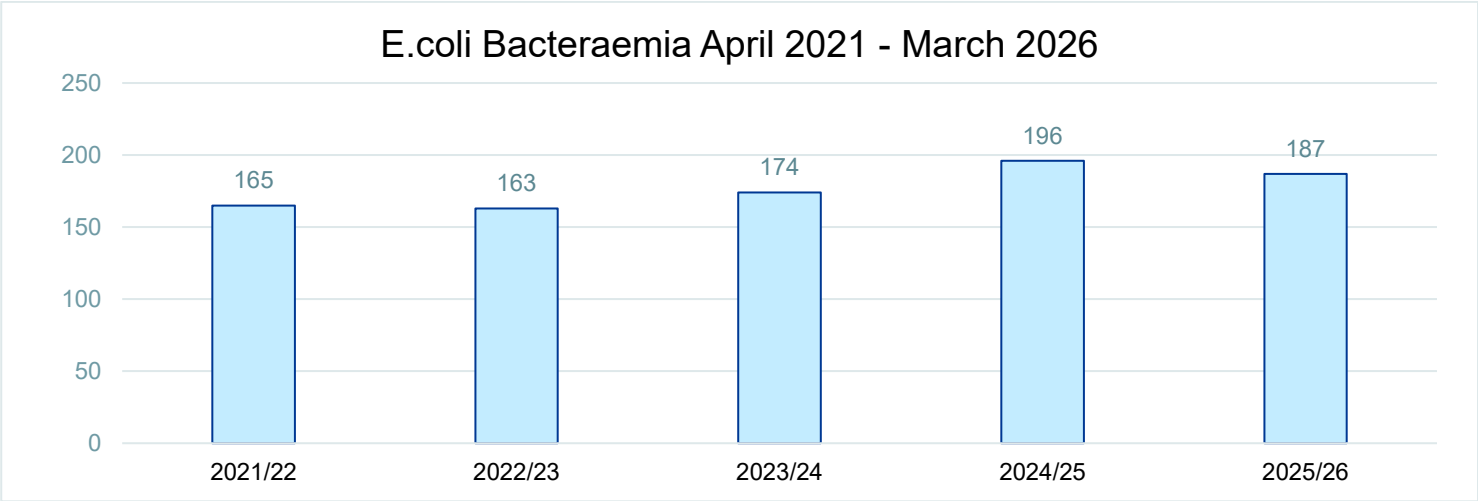


Figure 23: E. coli national comparative rates per 100,000 bed days & day admissions monthly rate

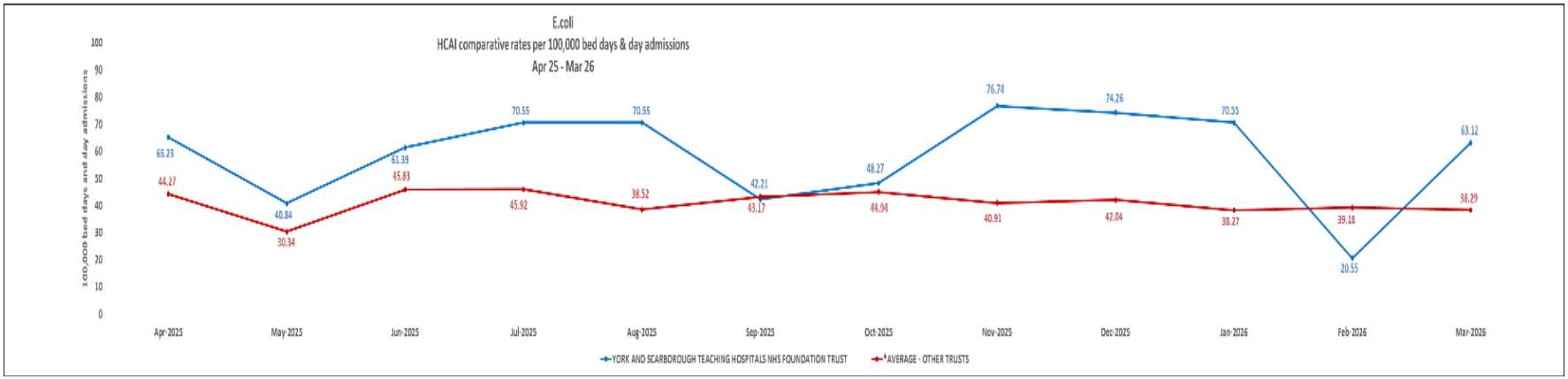


Figure 24: E. coli regional comparative rates per 100,000 bed days & day admissions monthly rate

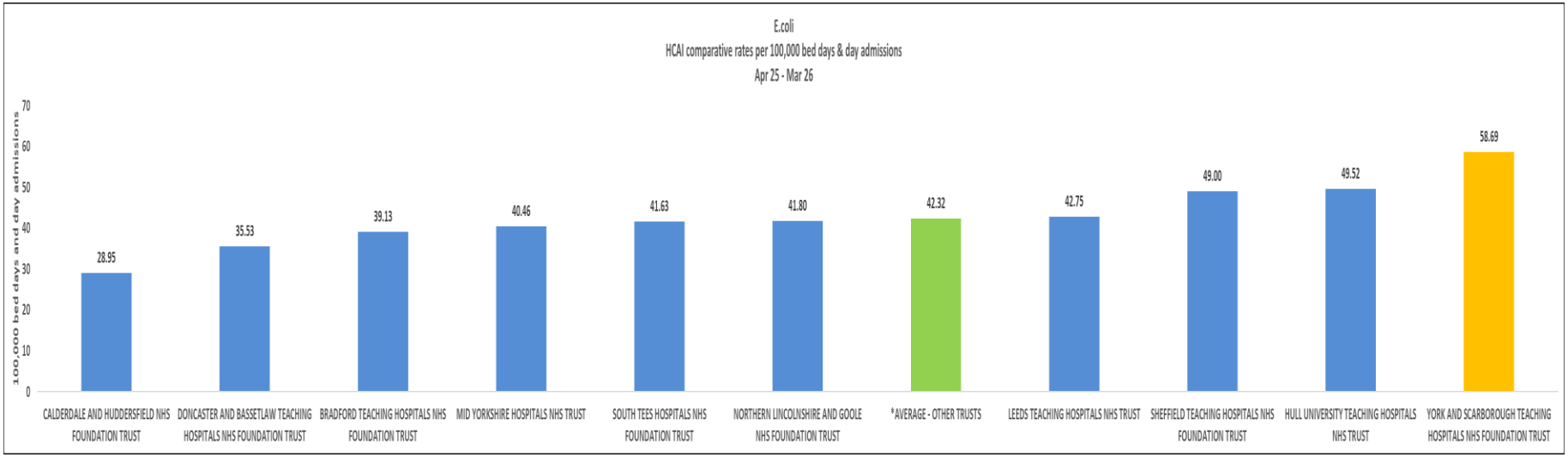


Figure 25: E. coli bacteraemia UKHSA Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026

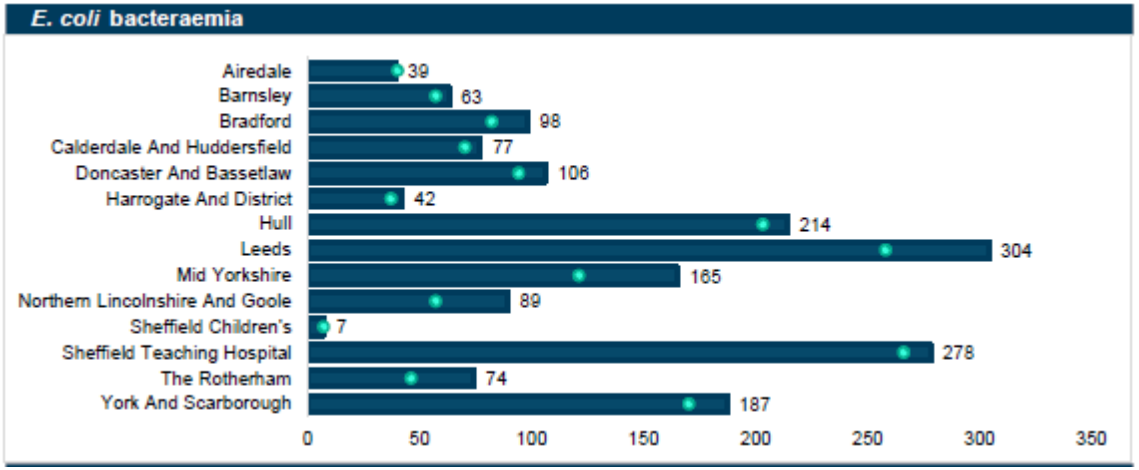


Figure 26: NHS Oversight framework Q3 ranking of the Trust and comparable regional Acute Trusts.

Metric	Trust	Q3 Metric Score (lower is better)
Proportion of E.coli bacteraemia cases	Doncaster and Bassetlaw Teaching Hospitals	**1.0**
	York and Scarborough Trust	**2.26**
	Sheffield Teaching Hospitals	**2.30**
	Hull Trust	**2.63**
	Leeds Trust	**2.98**
	Calderdale and Huddersfield	**3.00**
	South Tees Hospitals	**2.74**
	Mid Yorkshire	**3.41**
	Northern Lincolnshire and Goole Trust	**3.76**

Figure 27: Cumulative Trust attributed Klebsiella Bacteremia cases by area from April 2025

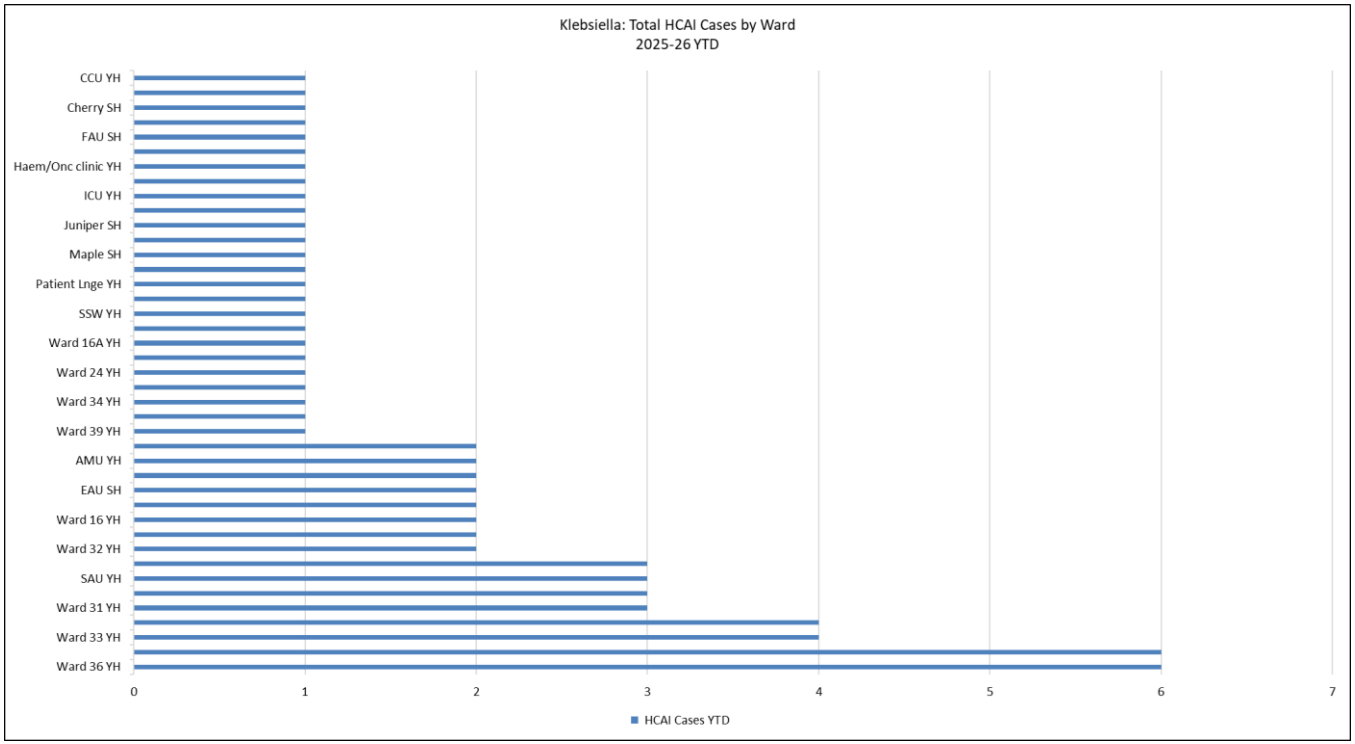


Figure 28: Klebsiella national comparative rates per 100,000 bed days & day admissions monthly rate

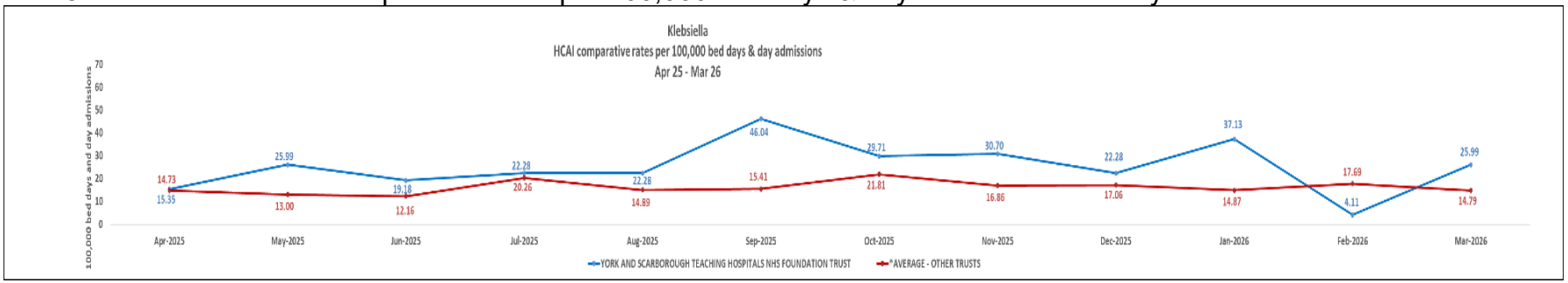


Figure 29: Klebsiella regional comparative rates per 100,000 bed days & day admissions monthly rate.

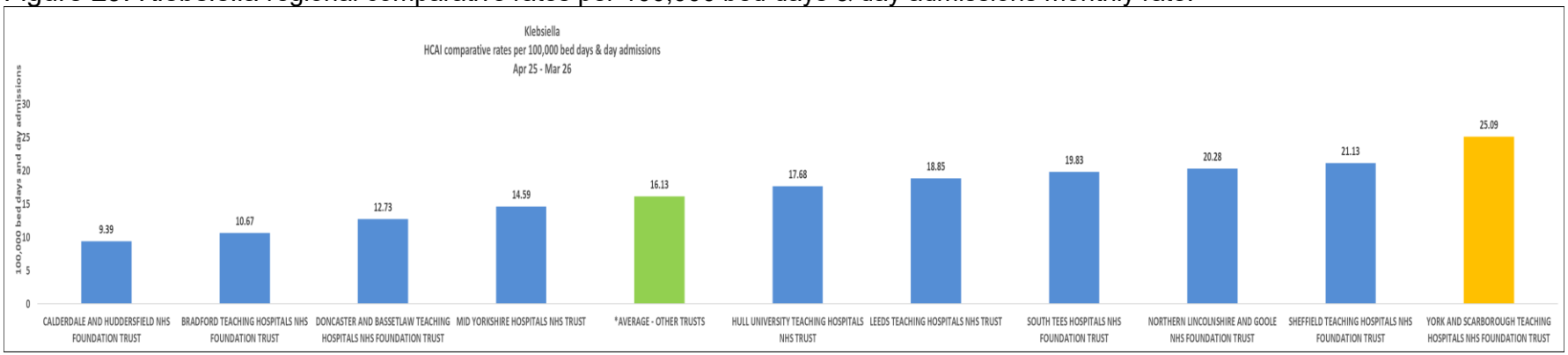


Figure 30: Klebsiella bacteraemia UKHSA Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026

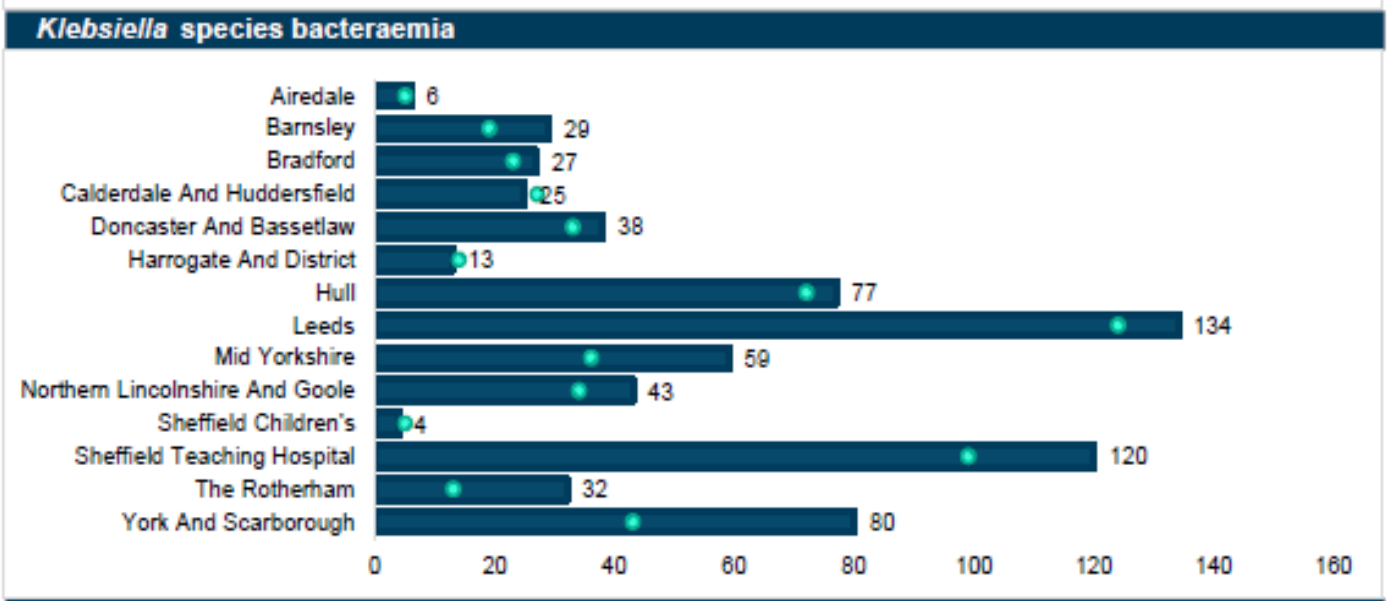


Figure 31: Cumulative Trust attributed Pseudomonas Bacteraemia cases by area from April 2025

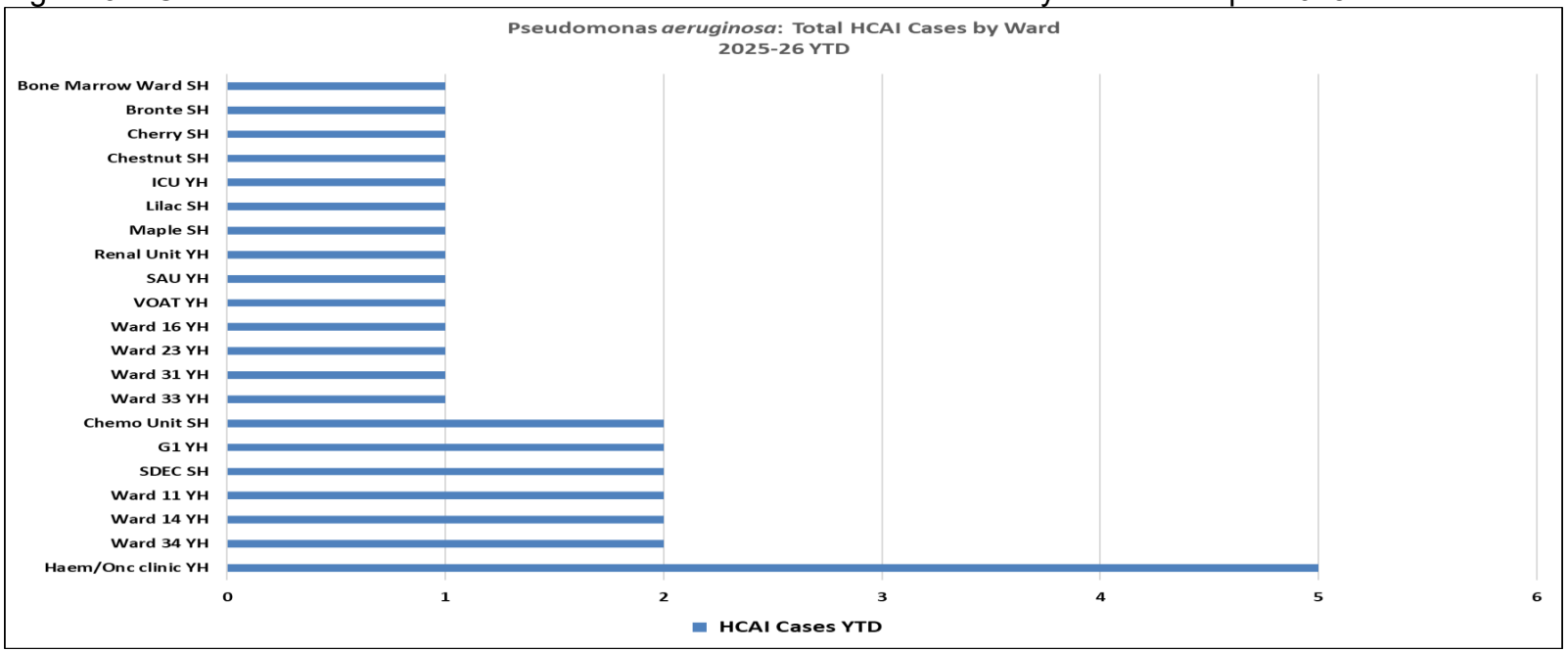


Figure 32: Pseudomonas national comparative rates per 100,000 bed days & day admissions monthly rate

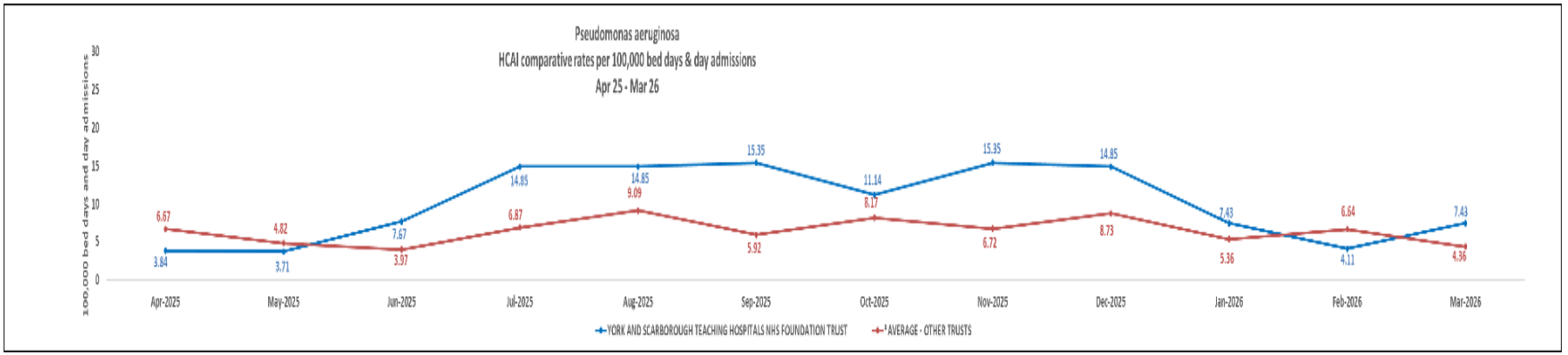


Figure 33: Pseudomonas regional comparative rates per 100,000 bed days & day admissions Monthly rate

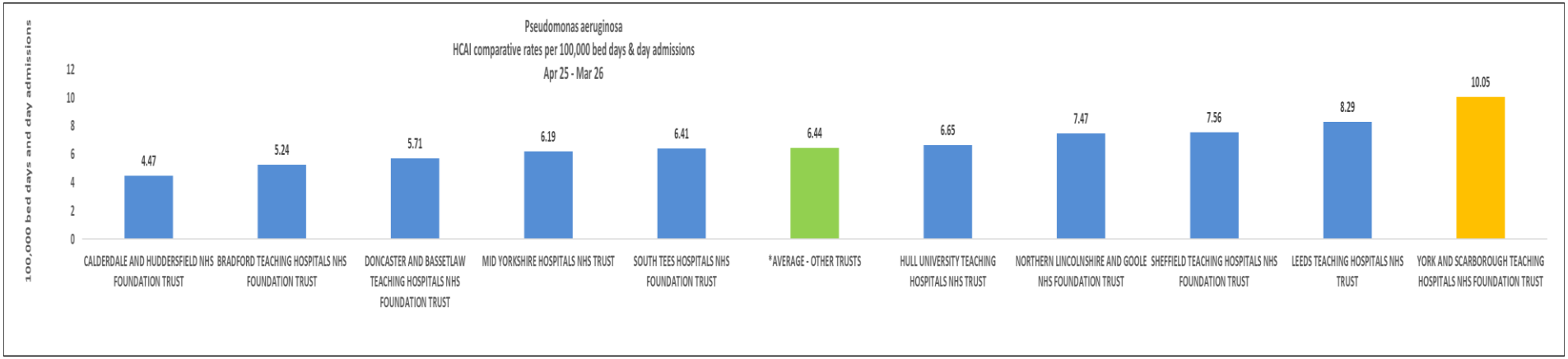
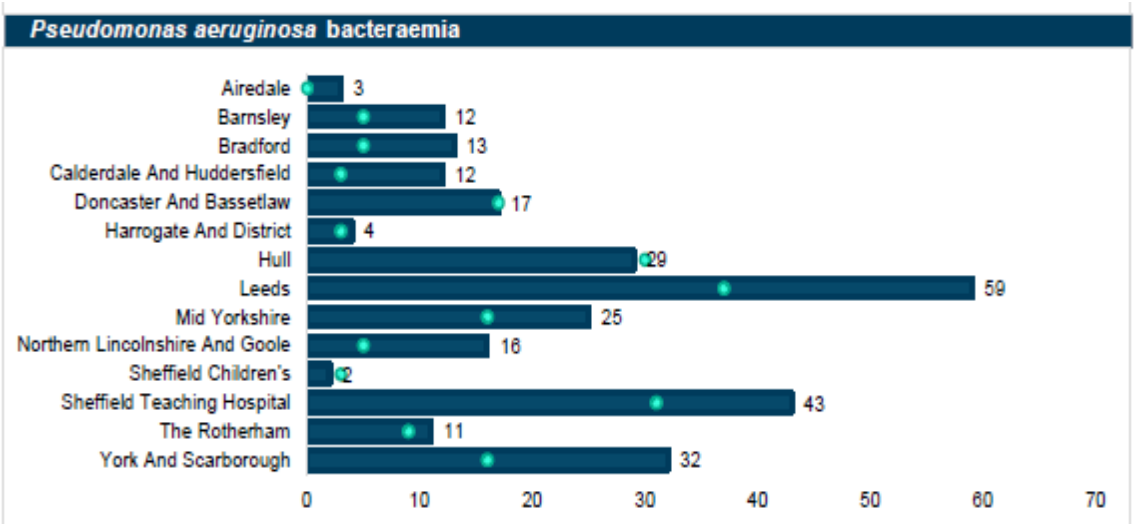


Figure 34: Pseudomonas bacteraemia UKHSA Mandatory Healthcare Associated Infection Monthly Surveillance report for March 2026



Appendix 5

Orthopaedic surgical site infection surveillance report

York and Scarborough Teaching Hospitals NHS Foundation Trust

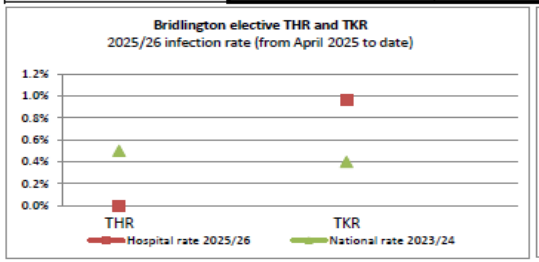
Report to the end of Mar-26

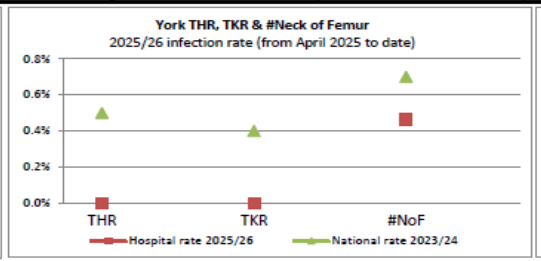
Actual number of infections - cases reported in month of inital surgery

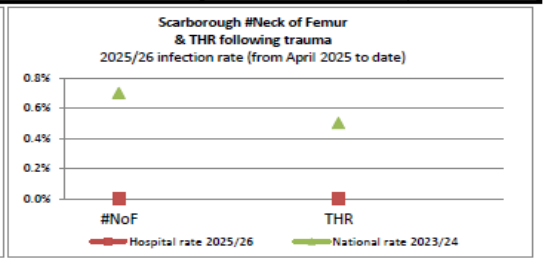
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Bridlington (Hips)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of operations	20	41	45	28	32	46	41	17	31	21	27	23	372
Bridlington (Knees)	2	0	1	0	0	0	0	0	0	0	1	0	**4**
Number of operations	39	30	31	45	27	35	55	24	25	32	35	37	415
York (Hips)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of operations	21	14	13	26	20	17	21	16	19	19	20	23	229
York (Knees)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of operations	17	19	18	13	13	18	17	9	13	18	10	19	184
York (#NoF)	0	0	0	1	0	1	0	0	0	0	0	0	**2**
Number of operations	46	35	31	39	40	34	32	35	42	41	27	30	432
Scarborough (#NoF)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of operations	19	20	34	30	29	22	30	26	26	29	29	37	331
Scarborough (THR)	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of operations	3	3	2	9	4	4	5	2	7	4	7	5	55

Infection rate to date (number of infections/number of operations)

	Bridlington		York			Scarborough	
	THR	TKR	THR	TKR	#NoF	#NoF	THR
Hospital rate 2025/26	**0.00%**	**0.96%**	**0.00%**	**0.00%**	**0.46%**	**0.00%**	**0.00%**
Hospital rate **2024/25**	0.80%	0.74%	0.46%	0.62%	0.00%	0.31%	1.82%
Hospital rate **2023/24**	0.33%	0.30%	0.62%	1.22%	0.69%	0.00%	0.00%
Hospital rate **2022/23**	2.07%	1.06%	1.42%	0.00%	0.47%	0.00%	3.85%
National rate 2023/24	0.5%	0.4%	0.5%	0.4%	0.7%	0.7%	0.5%







Infections may not be identified within the reporting month therefore data may change. New infections will be added when identified.
Post Infection Review may determine that a case does not fit the reporting criteria and will be removed from the figures

Report to:	Board of Directors
Date of Meeting:	24 June 2026
Subject:	10 Point Plan: Improving Resident Doctors' Working Lives
Director Sponsor:	Dr Karen Stone, Medical Director
Author:	Rachael Snelgrove, Head of Medical Education

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:
This report provides assurance on the Trust's initial self-assessment against the NHS England 10 Point Plan (10PP) to improve Resident Doctors' working lives. It confirms that good progress has been made in a number of areas, including appointment of named Resident Doctor leads, implementation of exception reporting reforms, early reimbursement of study leave expenses, and arrangements to support recognition of statutory and mandatory training on rotation.

The self-assessment also identifies areas requiring further development, particularly ratification of an annual leave policy aligned to NHS England standards, stronger oversight of rota code of practice compliance across departmental rotas, and a clearer

monitoring framework for payroll errors linked to rotations. These priorities will form the next phase of implementation and ongoing assurance reporting.
Recommendation: The Board is asked to note the contents of the report and take assurance from the progress made to date, whilst supporting the proposed next steps to strengthen compliance, monitoring and governance in the areas identified for further development.

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

Meeting/Engagement	Date	Outcome/Recommendation

10 Point Plan to Improve Resident Doctors' Working Lives

1. Introduction and Background

The NHS England (NHS England) 10 Point Plan (10PP) was introduced in 2025 to improve Resident Doctors' working lives through a series of actions focused on wellbeing, rostering, annual leave, exception reporting, payroll, mandatory training and study leave processes. A local self-assessment has now been completed collaboratively by Medical Education, Medical Workforce Teams, Payroll and the Resident Doctor Peer Leads to establish the Trust's current position, identify areas of compliance and agree priorities for further improvement. The self-assessment is in Appendix One.

2. Considerations

Whilst early progress is evident, the main areas requiring continued executive attention are annual leave compliance, assurance on departmental rota practice, and the strength of monitoring arrangements for payroll and other workforce risks linked to rotations. These issues are important not only for standards of employment and training experience, but also for workforce retention, organisational culture and the Trust's ability to demonstrate robust governance against national expectations.

3. Current Position/Issues

The self-assessment demonstrates that the Trust has made meaningful progress against a number of the actions set out in the 10PP, although delivery remains variable across the different workstreams. Progress has been made in relation to leadership and governance, with named Senior and Peer Resident Doctor leads now in place and reporting arrangements established through existing committee and Board structures. Exception reporting reforms have been implemented at an early stage, supported by regular reporting through Resource Committee, Local Negotiating Committee (LNC) and the Resident Doctors Forum (RDF). In addition, the medical education team has adapted local processes to enable earlier reimbursement of study leave expenses, and the Trust has strengthened arrangements for recognition of statutory and mandatory training completed elsewhere, reducing avoidable duplication for Doctors rotating into the organisation.

There are a number of areas where further work is required to achieve full alignment with the national expectations. Whilst the Trust is broadly compliant with work schedule and rota publication standards for centrally managed rotas, assurance is less developed for rotas managed directly by individual departments and would benefit from a more consistent approach to monitoring and reporting. Annual leave arrangements remain a key area of non-compliance, with the Trust's Medical Annual Leave policy due for publication and some concerns within specialties regarding the ability for Resident Doctors to take leave. Similarly, there is not yet a fully established framework for monitoring payroll errors associated with rotations, and this will need to be strengthened to provide clearer oversight and earlier identification of issues.

Wider actions relating to rest facilities, lockers, protected breaks and self-directed learning also remain at varying stages of development, reflecting both local infrastructure constraints and the need for further cross-organisational engagement. Taken together, these issues indicate that the Trust has established a positive foundation for delivery but now requires a more formal implementation plan and strengthened assurance mechanisms to support sustained progress.

It should be noted there are multiple areas which affect Resident Doctor's working lives which are not covered within the 10 Point Plan actions. These include access to secure jobs and training places, pay and conditions and the intensity of work due to patient demand and staffing numbers. These issues have been the predominant focus of discussions regarding Resident Doctor Industrial Action. These are not covered within this assurance report on the 10 Point Plan and not all are within the responsibility and influence of the Trust. For Resident Doctor workforce planning and assurance within the Trust, Resources Committee receive a quarterly medical workforce report and an annual Medical Staffing Review is planned to report to Board in February each year.

4. Summary

In summary, the Trust has completed its initial self-assessment and has established a strong foundation for delivery of the 10PP. Key strengths include collaborative governance arrangements, appointment of Senior and Peer Resident Doctor leads, implementation of exception reporting reforms, and progress on study leave and mandatory training processes. The main priorities now are to finalise the annual leave policy, strengthen assurance around rota code of practice compliance and payroll errors, and develop a measurable implementation plan to support continued oversight through Resource Committee and Board reporting.

5. Next Steps

The next steps are to finalise and ratify the revised annual leave policy, agree a clear implementation plan against each relevant action within the 10PP, and strengthen local reporting arrangements for rota compliance and payroll accuracy. The Trust has appointed a Clinical Leadership Fellow in Improving Resident Doctors' Working Lives, a Paediatric ST5 who begins their fellowship year in August 2026 and will lead compliance with the 10PP and lead a number of projects to engage with Resident Doctors and improve their working lives. Progress will continue to be reported through Resources Committee, with onward assurance to the Board as required.

Date: June 2026

10 Point Plan to Improve Resident Doctors' Working Lives

York and Scarborough Teaching Hospitals NHS Foundation Trust

Self-Assessment Summary Report June 2026

Appendix One

Appendix One

Introduction

The 10 Point Plan (10PP) was introduced by NHS England in 2025, to create a safer, more supportive, and sustainable training environments. It recognises that high-quality patient care is directly linked to the wellbeing, development, and experience of doctors in training. By focusing on key areas such as rest facilities, rota design, supervision, flexible training, and access to wellbeing support, the plan sets out a structured approach to addressing long-standing challenges, ensuring Resident Doctors feel valued, supported, and able to thrive both professionally and personally.

The plan sets out 10 action points for individual trusts and NHS England to act upon. Progress is benchmarked locally and reported through Trust Boards.

10 Point Plan – York and Scarborough Self-Assessment

1. To improve the working environment and wellbeing of Resident Doctors

Summary

"Trusts are expected to take meaningful steps to improve the working environment for Resident Doctors. Issues will vary by location, so Trusts can adapt implementation to reflect local needs and operational realities in these and other areas: where possible, (provide designated on-call parking spaces) - the autonomy to complete portfolio and self-directed learning from an appropriate location for them - access to mess facilities, rest areas and lockers in all hospitals, including new builds - a 24/7 out-of-hours menu offering hot meals and cold snacks for staff" (10PP NHS England).

Actions achieved

<u>On-call parking</u>

York and Scarborough main sites have secure, on-site, staff parking for Resident Doctors who undertake shift work. For staff working nightshifts access to the York multi-storey is available free of charge, along with not needing to pay for staff parking on a weekend or after 6pm.

Parking at the York site is particularly challenging with it being a city centre hospital. Subsidised public transport and cycle route information is provided at Resident

Doctor induction and information is available in the Medical Education Centres and via the staff benefits webpage.

Mess facilities

Across both sites, the York and Scarborough Doctors' messes are vibrant and well-established communities that play a central role in bringing Resident Doctors together through the mess committees. The committees have coordinated a wide range of social and wellbeing activities, including monthly pay-day social events, an annual summer ball, and a popular Beach BBQ to welcome the incoming F1 doctors. Each mess also provides practical day-to-day support, with access to workstations, PCs and internet, and Resident Doctors are actively signposted to these facilities through Corporate Induction fayres and targeted communications once in post. Collectively, these coordinated efforts reflect active, committed mess committees that consistently create opportunities for connection, peer support and a positive wellbeing resource for Resident Doctors

24/7 catering – hot and cold

Hot and cold food is available on a 24/7 basis across both sites. During standard working hours, canteen facilities are available at each location, with out-of-hours provision supported by hot food vending machines situated within the canteen areas. Information on these facilities has been communicated to staff through posters displayed in the York Mess.

Access to Induction

All Resident Doctors are invited to attend a Corporate Induction day, providing them with a bespoke induction programme for Medical and Dental staff. For Residents who rotate at nationally set changeover dates, this occurs on their first day, for Residents rotating outside of these dates they attend the next induction date. Local inductions are undertaken by the relevant speciality teams, providing speciality specific orientation and information.

Psychological support

The Trust provides all Resident Doctors free access to all the benefits of being a Trust employee including access to psychological and wellbeing support.

There are also external free services for Resident Doctors in training through NHS England, and through the BMA, available to all Residents.

Feedback mechanisms to promote excellence

The Trust uses Greatix to promote sharing excellence along with the annual Learning, Education and Development (LEaD) awards to celebrate multiprofessional learners and educators.

Sexual Safety/harassment training

'Understanding Sexual Misconduct in the Workplace' Elearning is available on the Trust's learning management system, Learning Hub. This learning is not part of the Skills for Health Framework of transferable Elearning modules but is available for all staff to complete locally.

Actions ongoing

Rest areas and lockers

Both sites have an active Doctors mess which all Residents can access 24/7 with a valid ID badge. There are also wellbeing rooms on each site which are open to all staff.

There are currently no locker facilities available for Medical staff across the sites; it is recommended that consideration be given to introducing these to support the secure storage of personal belongings.

Self-directed Time (SDT)

At present SDT is not mandated across all speciality schools. Where SDT is available this can be undertaken from the Residents place of work or at home. Some specialities have been able to build SDT into rosters, whereas others are required to book this via the rota or clinical team. Work continues to support Residents to take SDT time.

Protected breaks

Ongoing actions to facilitate protected breaks for Resident Doctors, include strengthening rota design to ensure adequate staffing levels, promoting a culture that supports taking breaks, and monitoring compliance through exception reporting.

If a doctor misses' breaks on at least 25% of occasions across a four-week reference period, a fine may be levied and breaks monitoring is implemented through the Guardian of Safe Working Hours office.

2. Resident Doctor work schedules and rota information are in line with Code of Practice

Summary

"For all rotations going forward NHS England must provide at least 90% of trainee information to Trusts 12 weeks prior to rotations commencing. Trusts must use this information to ensure that Resident Doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken." (10PP NHS England).

Significant work has been undertaken in recent years to improve the design of Resident Doctor rosters and work schedules. In March 2026 there was agreement and publication of a new Standard Operating Procedure – "Resident Doctors Changeover – Medical Deployment, Finance and Departmental Responsibilities for Work Schedules and Roster Publication" to aid full compliance. Alongside this, the Executive Committee approved an annual process for reviewing Resident Doctor establishments in every specialty which is intended to improve collaboration between teams, timely review of rotas and identification of areas of concern regarding work schedule compliance, financial governance and patient safety.

Actions Achieved

The Trust is fully compliant with the required timelines of submission for work schedules and rota summaries for those rotas which are centrally managed, except when delays occur beyond the Trusts control e.g. communication delays from NHS England, awaiting confirmation of Less Than Full Time (LTFT) trainees non-working days etc.

Work schedules have undergone a review to ensure they are fully compliant, along with updating information to align to the Good Rostering Guide.

Actions ongoing

For those rotas managed by departments the SOP is shared with them as a reminder of the rota code of practice standards.

3. Resident Doctors should be able to take annual leave in a fair and equitable way which enables wellbeing

Summary

"It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery" (NHS England 10PP).

NHS England standards are:

- *Every Trust must have a specific published annual leave policy for Resident Doctors*
- *Leave must be approved or declined in a timely fashion with clear reasons*
- *Rotas must be flexible enough for Resident Doctors to take their full leave entitlement*
- *Where possible, every Resident Doctor should have the opportunity to take two consecutive weeks of leave which may be a combination of annual leave, rostered non-working days, and bank holidays*
- *Resident Doctors must be supported to take their annual leave allowance just like any other staff*
- *The guidance informs organisational and departmental policy and supports board reporting of annual leave practice for assurance*

Actions ongoing

At present we are not compliant with the minimum standards for annual leave.

The Trust is in the final stages of agreement and publication of a Medical Annual Leave Policy, which has not previously been in place. This policy includes clauses related to Resident Doctors which are in alignment with the standards set with the 10PP.

4. All NHS Trust Boards should appoint 2 named leads: one Senior leader responsible for Resident Doctor issues, and one Peer representative who is a Resident Doctor. Both should report to Trust Boards.

Summary

"Trusts should appoint a senior named lead for Resident Doctors' issues and a Resident Doctor Peer representative, to report to the Board. The senior lead will formally take on this responsibility within an existing role, supported by a national

role specification to be published by NHS England in September 2025. The Resident Doctor lead will act as a Peer representative and enable Trust Boards to hear directly from Resident Doctors themselves. They should be invited to attend Board level discussions on issues which specifically relate to improving Doctors' working lives. Boards should also ensure their Executive teams engage directly with Resident Doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses" (NHS England 10PP).

Actions Achieved

The Trust has appointed into all three roles outlined in the 10PP.

Two Resident Doctor Peer leads (RDPLs) alongside a Trust Senior Lead for Resident Doctor Experience (SLRDE) and a Non-Executive Director who is responsible for Resident Doctors.

Governance and reporting is through a bi-annual report submitted to the Board of Directors. In future this will be aligned with the formal surveys; National Training Survey (NTS), National Education and Training Survey (NETS) and staff surveys, mapping to the 10PP.

Collaboration has been established between the Peer leads and Senior lead, alongside medical education, medical deployment and payroll teams to ensure triangulation of data and transparency across all domains in the 10PP.

Actions ongoing

To establish regular meetings between the Resident Doctor Peer leads, medical education, medical staffing and payroll to proactively discuss and collaborate regarding concerns and queries raised by Resident Doctors. Strong engagement and accountability will ensure Doctors working lives are regularly reviewed, acting upon feedback and challenges escalated to the right forums.

Clear governance and reporting structures need to be refined further, including regular attendance by the Peer leads at Trust governance meetings.

5. Resident Doctors should never experience payroll errors due to rotations

Summary

"Every trust should: Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a Board-level governance framework to monitor and report payroll accuracy and begin national reporting as required" (NHS England 10PP).

The Trust is reliant on timely and accurate information being share with the trust from other organisations, host employers and NHS England to provide rotational placement information.

Actions ongoing

There is currently no mechanism for activity monitoring Resident Doctor payroll errors. Payroll errors are picked up and adjusted as soon as possible.
A clear monitoring and reporting framework for Resident Doctor payroll errors needs to be established alongside establishing a check and review process before the pay run following Resident Doctors' main rotation dates to help ensure errors are identified and corrected before payments are made.

6. No Resident Doctor will unnecessarily repeat statutory and mandatory training when rotating

Summary

"Comply with agreements set out in the MoU signed by all Trusts in May 2025 by ensuring acceptance of prior training. By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England" (10PP)

Actions Achieved

In 2025 the Trust signed the Recognition of Statutory and Mandatory training MoU. The MoU sets out the intention for all 262 NHS bodies in England to work together to reduce unnecessary repetition of training when staff move from one NHS body to another and allow for the recognition of mandatory training between them.
The Trust's Learning Management System (LMS), Learning Hub, has an interface with ESR which allows us to send and receive nationally mandated

statutory/mandatory training competencies for employees. This relies on other trusts either using ESR for recording their training competencies or having a similar interfacing function in place. Resident Doctor new starters receive an email from medical education asking for any evidence of previous nationally mandated statutory and mandatory training to be emailed across to the mandatory training team to ensure all possible completions are captured.

The Trust's Mandatory Training Oversight Group (MTOG) was established in April 2025 and is chaired by the Lead for Workforce Planning & Development. The group's main function is to manage a rigorous assurance process to receive proposals for Locally Mandated training topics and only approve those where there is a clear case for the investment of staff time justified by improved outcomes.

While nationally mandated statutory and mandatory training content, refresher intervals and target audiences are set centrally by NHS England, any training mandated locally by the Trust must go through a gateway approval process, with notional approval by MTOG before final sign-off by the Executive Board.

Actions Ongoing

Medical Education has established a robust system for monitoring statutory and mandatory training compliance among Resident Doctors in training. Further work is required to implement a clear escalation process for instances of non-compliance.

7. Resident Doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours

Summary

"A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025. The changes agreed simplify the reporting process for Resident Doctors, ensure they are being fairly compensated for the additional hours they are required to work, and will support the safety of their working hours" (NHS England 10PP).

The exception reporting reforms were designed to create a more transparent, supportive, and responsive approach to monitoring Resident Doctors' working patterns, training opportunities, and wellbeing. The reforms simplify the reporting process, strengthen accountability, and ensure concerns relating to working hours, missed educational opportunities, fatigue, staffing pressures, and patient safety are

addressed promptly and consistently. By improving oversight and encouraging a culture where reporting is actively supported, the reforms seek to enhance both the training experience and the overall working lives of Resident Doctors, while helping organisations identify themes, drive improvement, and maintain safe, high-quality care.

Actions Achieved

York and Scarborough Teaching Hospitals NHS Foundation Trust was identified as an early adopter of the reforms in January 2026, enabling local testing of the revised arrangements ahead of full implementation in February 2026.

Reporting mechanisms are in place with quarterly Guardian of Safe Working Hours reports submitted to the Trust's Resource Committee, alongside an annual Board report and a bi-monthly report presented at formal LNC meetings. Information on exception reporting is also included in the papers circulated to the Resident Doctors Forum (RDF).

Actions ongoing

The Board shall be responsible for providing annual reports to external bodies such as NHS England, Care Quality Commission, General Medical Council and General Dental Council as and when required.

8. Resident Doctors should receive reimbursement of course related expenses as soon as possible

Summary

"We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a Resident Doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred" (NHS England 10PP).

Study leave for Resident Doctors in formal training posts is administered through the national Accent Leave Manager (ALM) system. Under previous arrangements, approved expenses could only be reimbursed after attendance at the relevant course or event. The revised NHS England policy now permits eligible costs to be reimbursed in advance of attendance, thereby reducing financial burden on Resident Doctors.

Actions Achieved

Medical Education has revised its internal processes to align with the updated requirements, enabling Resident Doctors to reclaim eligible expenses at the earliest opportunity following expenditure. These arrangements are now operating effectively, and requests received to date have been approved and reimbursed in advance where appropriate.

Ongoing Actions

At present, reimbursement claims are submitted by an electronic form and processed by email to the Expenses Team. To strengthen accountability, transparency and administrative efficiency, Medical Education will transition all expense claims to the Trust's Easy Expenses system later in 2026. This change will also extend to Locally Employed Doctors and Senior Medical and Dental staff, ensuring equitable access to early reimbursement arrangements across the wider Medical and Dental workforce. Implementation will be supported by the introduction of the Senior Medical and Dental Study Leave Policy, which is scheduled for issue in late summer 2026.

While most elements of the plan require delivery at Trust and system level, points 9 and 10 are led and managed centrally by NHS England, recognising that they require national consistency and infrastructure.

9. We will reduce the impact of rotations upon Resident Doctors' lives while maintaining service delivery

"A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority" (NHS England 10PP).

10. We will minimise the practical impact upon Resident Doctors of having to move employers when they rotate

"NHS England is committed to extending the Lead Employer model to cover all Resident Doctors and Dentists in training. This change will eliminate the need for trainees to change employers with each rotation, reducing duplication and

administrative errors while improving continuity, efficiency, and the overall training experience. By October 2025, NHS England will: develop a comprehensive and financially sustainable roadmap, underpinned by a robust business case. This will include detailed recommendations on costing and funding, service catalogue requirements, and pricing models for national implementation. The roadmap will provide a clear framework for expanding Lead Employer arrangements across the system" (NHS England 10PP).

References

British Medical Association (BMA). *Fatigue and Facilities Charter; Fatigue and Sleep Deprivation*. [Link]

Health Education Yorkshire and the Humber. *Study Leave Guidance*. [Link]

NHS Employers (2016). *Doctors and Dentists in Training Terms and Conditions (England) 2016*. [Link]

NHS Employers. *Good Rostering Guide*. [Link]

NHS Employers. *Pay and Conditions Circulars for Medical and Dental Staff*. [Link]

NHS England. *10 Point Plan to Improve Resident Doctors' Working Lives*. [Link]

NHS England. *Guidance and Role Specification: Senior Lead for Resident Doctor Experience*. [Link]

NHS England. *Resident Doctors: Rota Code of Practice Compliance Data Collection*. [Link]

Report to:	Board of Directors
Date of Meeting:	24 June 2026
Subject:	Quarter 4 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Owen Bebb- Associate Medical Director for Patient Safety Alice Hunter- Patient Safety Specialist

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☐ Not Applicable

Summary of Report and Key Points to highlight:
This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:
  - Nationally mandated data

- Locally mandated data
- Quality account data

- Learning from deaths – themes, actions and escalations
  - LFD in March was stepped down in advance of nerve centre go live
  - Poor care was given to 1/13 SJCR's reviewed.

Metric	Result
Crude mortality	Crude mortality is 2.9% (December 2024 to Novemeber 2025) (12 month rolling HES data)
SHMI - NHS England[1]	SHMI for 12months (Jan 25 to Dec 25) for the whole trust is 0.88 down from 0.91 (Oct 24 to Sept 25)

[1] SHMI NHS England - Summary Hospital Mortality Indicator 12month rolling, NHSE SHMI dataset

Recommendation:
Patient Safety and Effectiveness Group to note the report and receive the escalations.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Learning from Death Group	11/05/2026	
Patient Safety & Clinical Effectiveness Subcommittee	13/05/2026	
Quality Committee	16/06/2026	

1. Y&SH NHS FT mortality rates

The references in section 6 provide details about the methodologies for measuring mortality and their context.

1.1 Crude Mortality - unadjusted

Crude Mortality rate is the percentage of patients that have died. The crude rate includes all deaths up to 30 days post discharge. The crude mortality rate is the sum of the in-hospital deaths and the out-of-hospital deaths against all provider spells. The rolling 12month trend is now decreasing compared previous 12month periods. The crude mortality rate (12-month rolling, December 24 to November 25) stands at 2.9%. It was 3.2% for December 23 to November 24.

Benchmarking of crude mortality against other Trusts is not recommended due to significant operational variations between Trusts. Instead, Trusts should monitor local trends comparing data from the same month or quarter each year. This takes account of seasonal variation seen locally and nationally. For our trust we see an increase in the winter months but overall there is a downward trend in crude mortality rates.

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust, including those receiving palliative care, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the Trust. It covers patients who died either while in hospital or within 30 days of discharge.

A standard approach is taken to ‘adjust’ the figures so that the England average is always reported as ‘1’. Values below 1 represent a better outcome, i.e. lower mortality, and vice versa.
Further information regarding the methodology can be found in the references towards the end of the report.

There is now one risk-adjusted mortality rate model.

- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.

The latest NHS-Digital Summary Hospital Mortality Index (SHMI) to November 2025 (covering December 24 to November 25) shows the SHMI was 0.8816. The SHMI in comparison to other Trusts is displayed below (Figure 1). We continue to see a decrease in SHMI for the same 12-month period ending November 24 the SHMI was 0.9638. The numbers in this period were for expected deaths 3470 and observed deaths 3060. These are similar to previous values.

The SHMI across both sites continue to reduce, with a bigger reduction seen in Scarborough. Scarborough is now 0.90 (previously 0.94), whilst York has reduced to 0.86 (previously 0.88). The overall value for the trust is now 0.88. Figure 2 shows the position of both sites in a funnel plot format, Figure 3 as box plot. You will note from the funnel plots that we are near the lower control limit and both sites sit below the national baseline.

Figure 1 SHMI(HES data) Funnel plots (in comparison with other Trusts (Dec24 to Nov25)

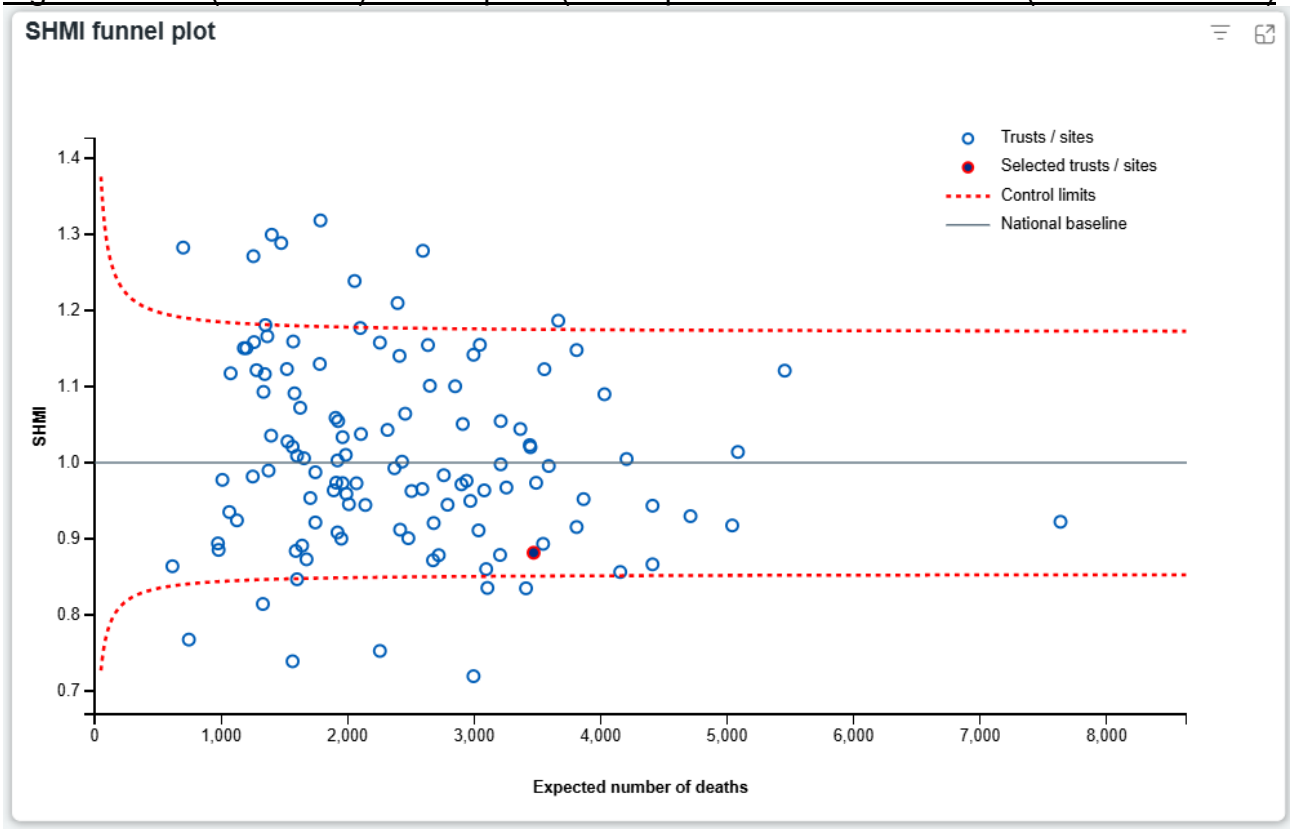


Figure 2 SHMI site comparison Dec 2024 to Nov 2025

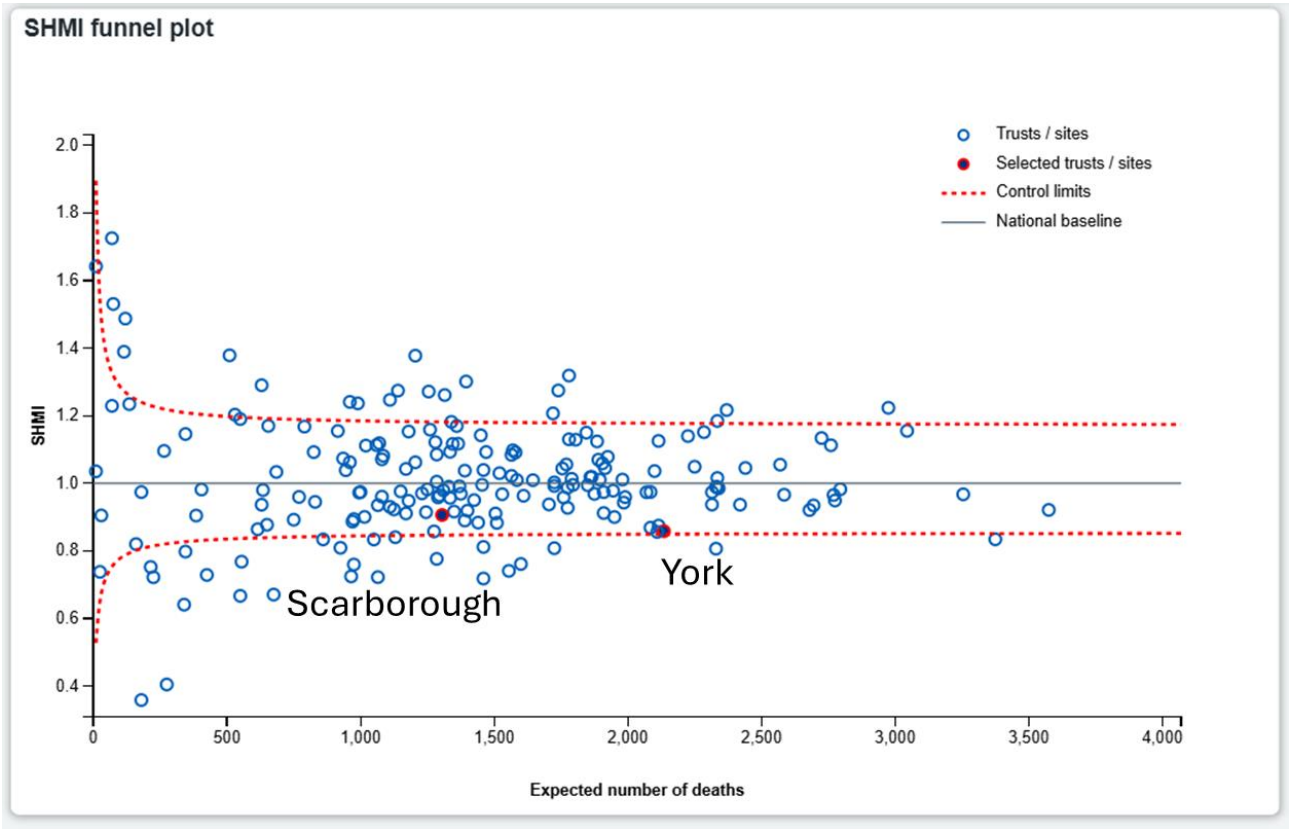
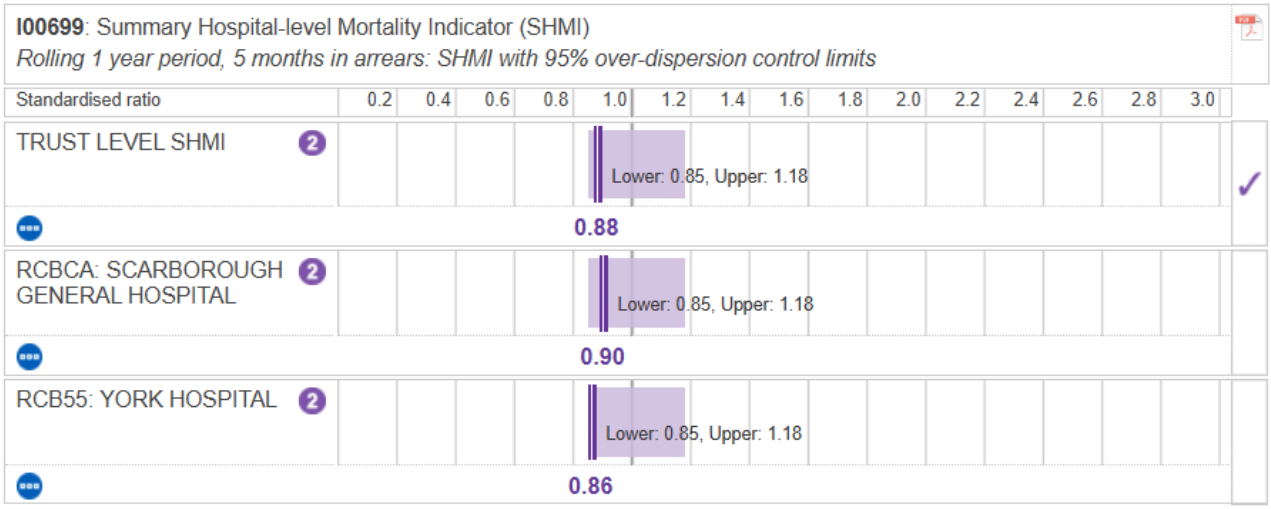


Figure 3 SHMI site comparison (12 month period)



2. Diagnostic groups contributing to our mortality rates

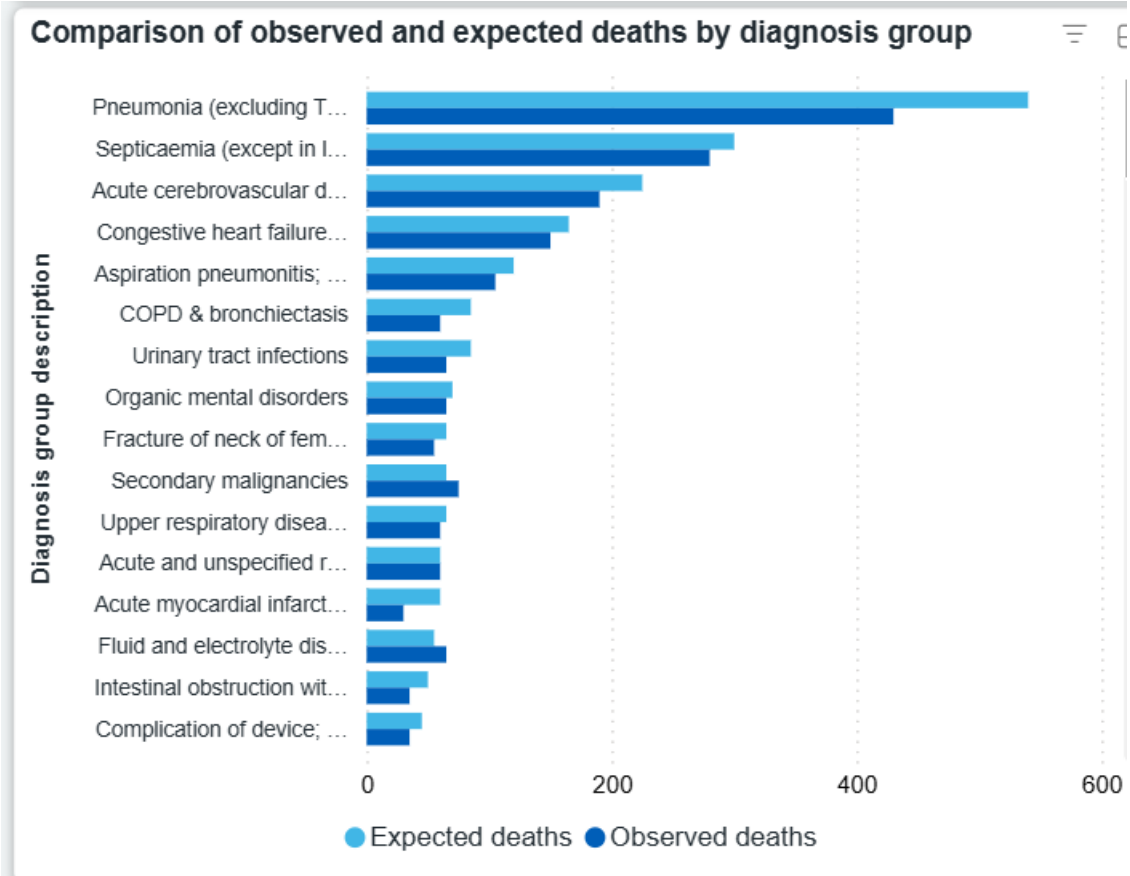
There are 144 diagnostic groups that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

The way in which coding is applied to patients that die in the Trust can significantly affect mortality statistics. The “depth of coding” (coding of co-morbidities as well as primary diagnosis) is important as it allows for more accurate calculation of the expected number of deaths that should be seen during a specific time period. Coding of the primary diagnosis will also affect mortality statistics in particular diagnostic groups. We continue to work with the coding team to understand how better to managing this reporting and we are using the learning provided from Trust mortality reviews via the Learning from Deaths process to triangulate our current mortality outliers and ascertain if any further investigation is required.

The most recent breakdown of differential SHMI for common diagnostic groups is displayed in Figure 4 below. At present there remain no diagnostic groups causing concern (all are at or below the expected level when adjusted for SHMI). There are more observed than expected deaths in secondary malignancies and fluid and electrolytes. Septicaemia which has been a key focus in the Trust and we now see more expected deaths than observed deaths in this group.

We have recently received an alert that our National Emergency Laparotomy Audit (NELA) mortality rates are higher than the national average. The nearest diagnostic category would be intestinal obstruction without hernia where there were 35 deaths against 50 expected. For cancer of colon it was 15 observed versus 25 expected. This is being investigated as a priority to determine why the NELA rates are higher than the national rates. The SHMI data may not accurately capture this cohort.

Figure 4: SHMI associated with various diagnostic groups (from HES data) for September 24 to August 25 (Top 16 by expected deaths)



3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

This section provides data and outcomes in line with the requirements of the:

- National Guidance on Learning from Deaths (National Quality Board, 2017)
- Trust's Learning from Deaths Policy
- Department of Health and Social Care NHS (Quality Accounts) Amendment Regulations 2017

Whilst the report focuses on quarter 3 data, some information is provided for quarter 1 and 2 for comparison.

3.1 Nationally mandated data and information

The data provided in the table below is mandated by the national LfD framework. A narrative on learning and actions is provided in section 4.

When reading the table, SJCRs are Structured Judgement Case-note Reviews; PSII are Patient Safety Incident Investigation. It should be noted that that PSIIs replaced SIs when the new PSIRF was introduced in December 2023.

Table 1 – National data summary

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Quarter 1 (25/26)			**Quarter 2 (25/26)**			**Quarter 3 (25/26)**			**Quarter 4 (25/26)**		
Total in-patient deaths (inc ED, exc community)	196	187	178	168	141	171	185	166	197	251	182	170
No. SJCRs commissioned for case record review[1]	5	7	3	2	2	5	5	9	2	3	7	3
No. PSII commissioned of deceased patients	2	2	2	0	1	1	1	1	0	1	2	0
No. deaths likely due to problems in care	See tables below			See tables below			See tables below			See tables below		

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 24/25).

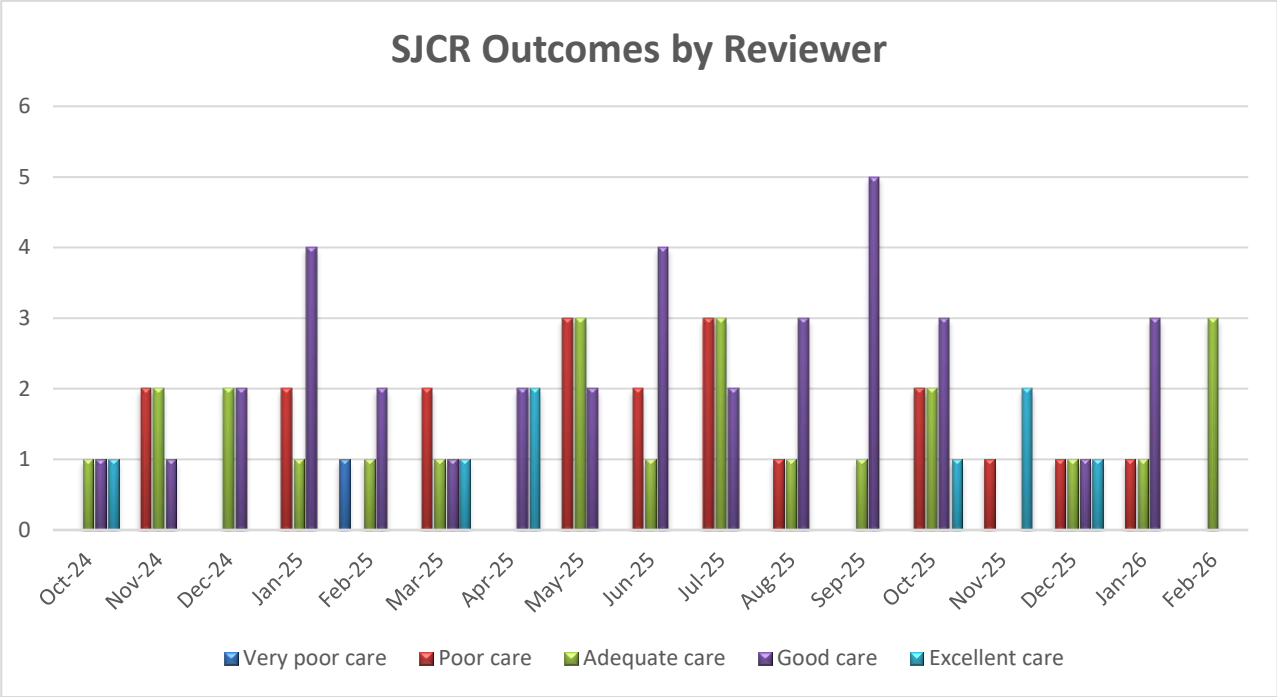
National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Figure 6 shows the outcomes of the SJCRs completed and reviewed during, Q1, Q2, Q3 and Q4 25/26:

- Figure 6 - the ‘overall score’ provides the rating from the Reviewer based on their assessment of care during the last admission.
- Figure 7 - the ‘degree of harm’ agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q4 8 SJCRs were reviewed (15 in Q3) NB there was no LfD in March:

Figure 6 – SJCR outcomes assigned by the Reviewer (overall score)



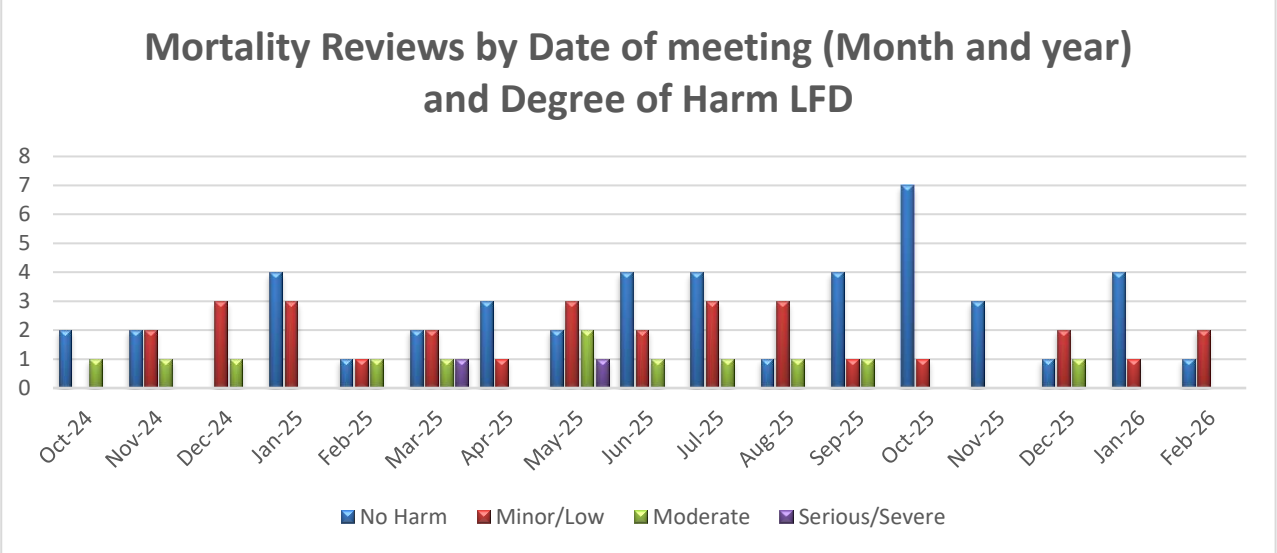
The Reviewer found there to be:

- Good care in 3/8 cases.
- Excellent care in 0/8 cases
- Adequate care in 4/8 cases
- Poor care in 1/8 cases
- Very poor care in 0/8 cases

The Poor care cases were all discussed at Q&S prior to LFD to ensure they were not potential Patient Safety Incident Investigations (PSII's).

The LfD group will decide on the level of harm for the SJCRs presented. The degree of harm levels is No harm, Minor, Moderate, Severe and Death.

Figure 7 – SJCR outcomes following review by LfD Group (degree of harm)



The Learning from Death Group agreed harm leading to death in 0 cases, severe in 0 cases, moderate harm in 0 cases, low in 3 of the cases and no harm in 5 cases.

3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance now Medical Examiners review all deaths; and the timely completion of structured judgement case-note reviews.

Data on progress of investigations at point of reporting (14/04/2026)

Overall no. of SJCRs open 40 (previously 34 as of 12/01/2026)

Figure 8 – Mortality Reviews by SJCR Status (date collected (14/04/2026)

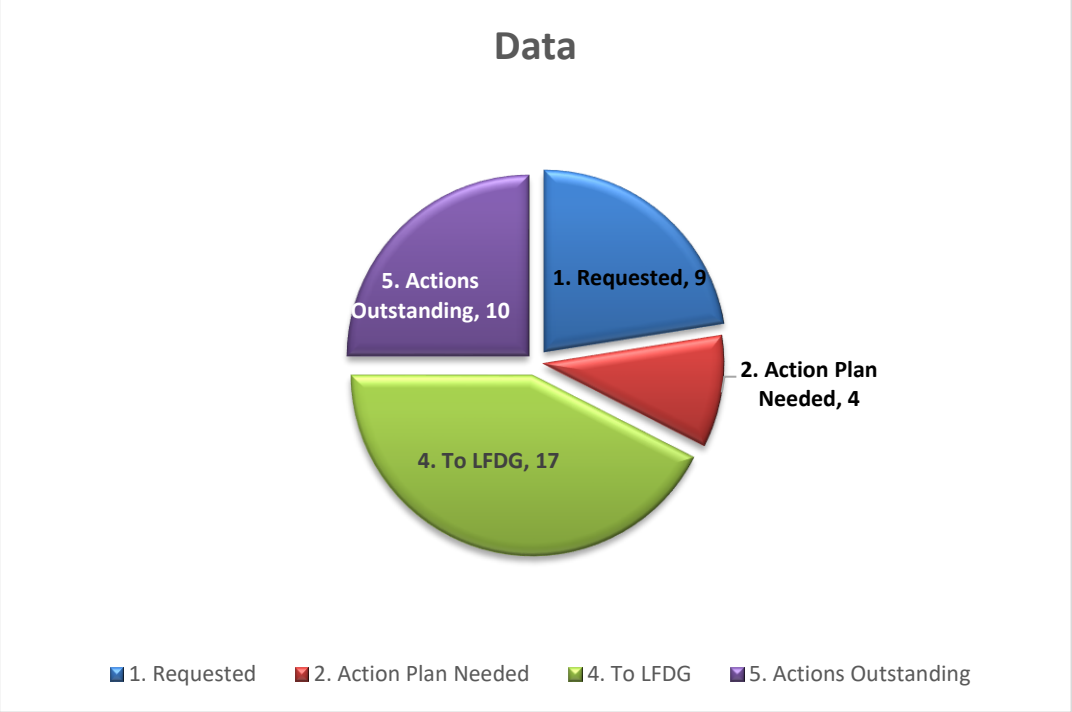


Table 2 - Status of open SJCRs

	Q1 (25/26)	Q2 (25/26)	Q3 (25/26)	Q4 (25/26)
Number under review	15	17	20	26
Awaiting action planning	5	5	3	4
Actions outstanding	8	12	11	10
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	8	5	4	4

The number of SJCR's more than 60 days overdue has decreased over the year, this has been evident since the increase in the number of trained SJCR investigators.

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure

requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 3 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2025/26. (please note that the numbering of these relate to the numbering dictated by the Quality Account Report which is why they differ from the rest of the report.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2024/25 but were investigated during 2025/26 and hence not reported in the 2024/25 Quality Account.

	Requirement	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
27.1	Total number of in-hospital deaths	561	480	548	603
27.2	No. of deaths resulting in a case record review or PSII investigation (requested reviews of patients who died in 24/25 or 25/26)	ME:561	ME:480	ME:548	ME:603
		SJCRS: 15	SJCRS:9	SJCRS:16	SJCRS:13
		PSII:6	PSII:2	PSII:2	PSII:1
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 24/25)	0	0	0	0
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 6	SJCR: 6	SJCR:	SJCR:0
		PSII:5	PSII:0	PSII:3	PSII:0
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0	0	0	0
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	0	0	0	0

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group

[2] Reviews completed in 2025/26 after the 2024/25 Quality Account was published

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

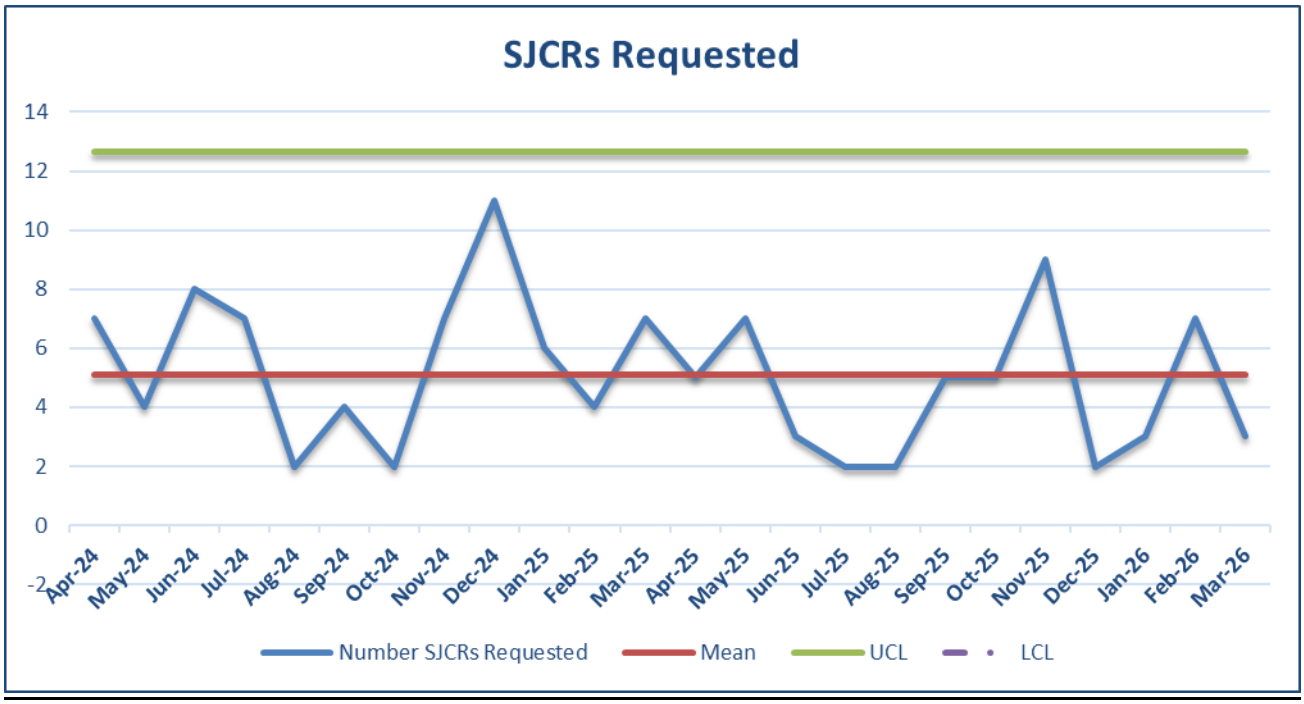
a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

Local PSII investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.
- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

Table 4 – SJCRs Requested



During Q4 of 25/26, there were 14 requested SJCRs. The numbers for the following quarters were: 15 in Q1 25/26, 9 in Q2 25/26, and 16 in Q3 25/26.

Table 5 – Source of request for SJCR

*It should be noted that there can be more than one source, however, to avoid duplication only the original inputted source is considered.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
SJCR Request Source	**Quarter 1 (25/26)**			**Quarter 2 (25/26)**			**Quarter 3 (25/26)**			**Quarter 4 (25/26)**		
Care Group	3	3	1	1	1	1	4	6	1	2	2	4
Learning Disabilities	1	2	2	0	0	2	1	3	1	4	0	1
Medical Examiner Review	0	0	0	1	0	1	0	0	0	1	0	0
NoK Concern/ Complaint	0	0	0	0	0	1	0	0	0	0	0	0
Elective Admission	1	1	0	0	0	0	0	0	0	0	0	0
Q & S	0	1	0	0	1	0	0	0	0	0	0	0
Initial Mortality Review	0	0	0	0	0	0	0	0	0	0	0	0

Table 5 presents the origins of SJCR requests for 2025/26. Most of these requests still come from Care Groups, with learning disabilities being the next most common source.

4.1 Themes from SJCRs considered by the LfD Group in Q4:

Case record reviews highlight issues related to quality of care, revealing patterns that help guide organisations' improvement efforts.
With the introduction of DCIQ and its mortality module, theme identification was updated. The mortality module uses the same themes as other DCIQ modules, enabling cross-comparison and data triangulation.

The themes are identified within the Learning from Deaths meeting. These themes identified are shown in Table 6.

Table 6 – Themes identified

Themes	25/26 Q1			25/26 Q2			25/26 Q3			25/26 Q4		
	Apr 25	May 25	Jun 25	Apr 25	May 25	Jun 25	Apr 25	May 25	Jun 25	Jan 26	Feb 26	Mar 26
Capacity/Demand	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Assessment	0	0	0	0	0	0	0	0	0	2	0	0
Communication/Documentation	2	4	2	2	4	2	2	4	2	0	1	0
Consent	0	0	1	0	0	1	0	0	1	0	2	0
Delayed Diagnosis /Treatment	0	0	0	0	0	0	0	0	0	2	0	0
Escalation	0	1	3	0	1	3	0	1	3	1	1	0
Guidance/Policies	0	0	0	0	0	0	0	0	0	0	0	0
No Themes Identified	2	1	2	2	1	2	2	1	2	1	0	0
Not listed (please specify)	0	1	1	0	1	1	0	1	1	1	0	0
Nutrition and Hydration	1	0	0	1	0	0	1	0	0	0	0	0
Pathways/Process	0	3	0	0	3	0	0	3	0	1	0	0
Patient Factors	0	0	0	0	0	0	0	0	0	0	0	0
Team Factors	0	0	0	0	0	0	0	0	0	0	0	0
Transfer Issue	0	0	1	0	0	1	0	0	1	0	0	0

The key themes identified in Q4 were varied clinical assessment, Consent and Delayed diagnosis/treatment being the most identified.

5.0 Escalations & Learning

5.1 Maternity update Q4

Current Position/Issues

Eligible losses in Q4 2025/2026 (appendix A)

There have been a total of four eligible losses reported to MBRRACE-UK via the PMRT in Quarter 4.
No reported cases met the criteria for an external investigation conducted by the Maternity and Newborn Safety Investigations (MNSI).

Summary of all losses closed in Quarter 4 (appendix B)

There have been four incidents closed in Q4. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby.
Grading of care provided to the mother before the death of the baby:

- 0 cases had no issues identified that would have had an impact on the outcome.
- 4 cases had issues identified that would have had no impact on the outcome
- 0 cases had issues that may have had a difference to the outcome.

Grading of care provided to the mother after the death of the baby

- 0 cases had no issues identified that would have had an impact on the outcome
- 4 cases had issues identified that would not have had an impact on the outcome

5.2 Learning from deaths group overview

5.21 End of Life update

End-of-life professional standards group.

- Bimonthly meeting started September 2024 and provides a 6 monthly update to PSCE.
- Ongoing plans to improve attendance and for care groups to attend with their own data, escalations and outcomes of complaints etc.

Key areas of progress:

- ReSPECT group now comes under the deteriorating patient group meeting.
- Palliative care team providing training to IMT doctors due to change in the regional training due to lack of funding.
- The team continue to lead on advanced communication training for band 6 and above.
- The trust partakes in the national care of the dying patient audit.
- There have been improvements in the use of the last days of life document.
- Datix themes around the care after death, and the mortuary teams are doing work with the wards to raise awareness.
- Palliative care champions in York had a visit to mortuary which was beneficial.

Key areas of risk:

- Need to improve around staff having earlier conversations with patients about their wishes.
- Improve the quality of ReSPECT documentation and what matters most to the patient.
- Not having a 7-day service on York site.
- Senior decision making around identifying end of life care.
- End of life education is not part of the mandatory training.

5.22 Medical Examiner update

The Lead ME attended to provide an update.

- 181 referrals for December, with some cases going directly to the coroner.
- Average time from death to receipt of referral is 3.6 days, noting a wide range (up to 34 days) and identified this as an area for improvement.
- 14 referrals rejected by the ME team, reasons for rejected death certificates, including incomplete or unclear documentation, spelling errors, use of abbreviations, and illegibility, all of which cause delays for bereaved families.

It was noted that training for doctors on death certification is minimal and mostly on-the-job, suggesting a need for better education and ownership within clinical teams.

The aim is this data will be included within the learning from deaths quarterly report.
It was raised that there is an upcoming Grand round that focusses on medical examiners, and it was suggested this data also be added and discussed.

6. Service developments

Quarterly updates from specialist groups, including the End-of-Life group, Nutrition and Hydration Group, and Deteriorating Patient Group are scheduled as per the table.

Group	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Nutrition Steering Group			✓			✓			✓			✓
Deteriorating Patient Group		✓			✓			✓			✓	
End of life		✓		✓		✓		✓		✓		✓
ME update	✓			✓			✓			✓		
Family health update		✓			✓			✓			✓	
SJCR training	✓		✓		✓		✓		✓		✓	
Actions			✓		✓		✓		✓		✓	

7. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -
   a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.
   b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
   c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.
   d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

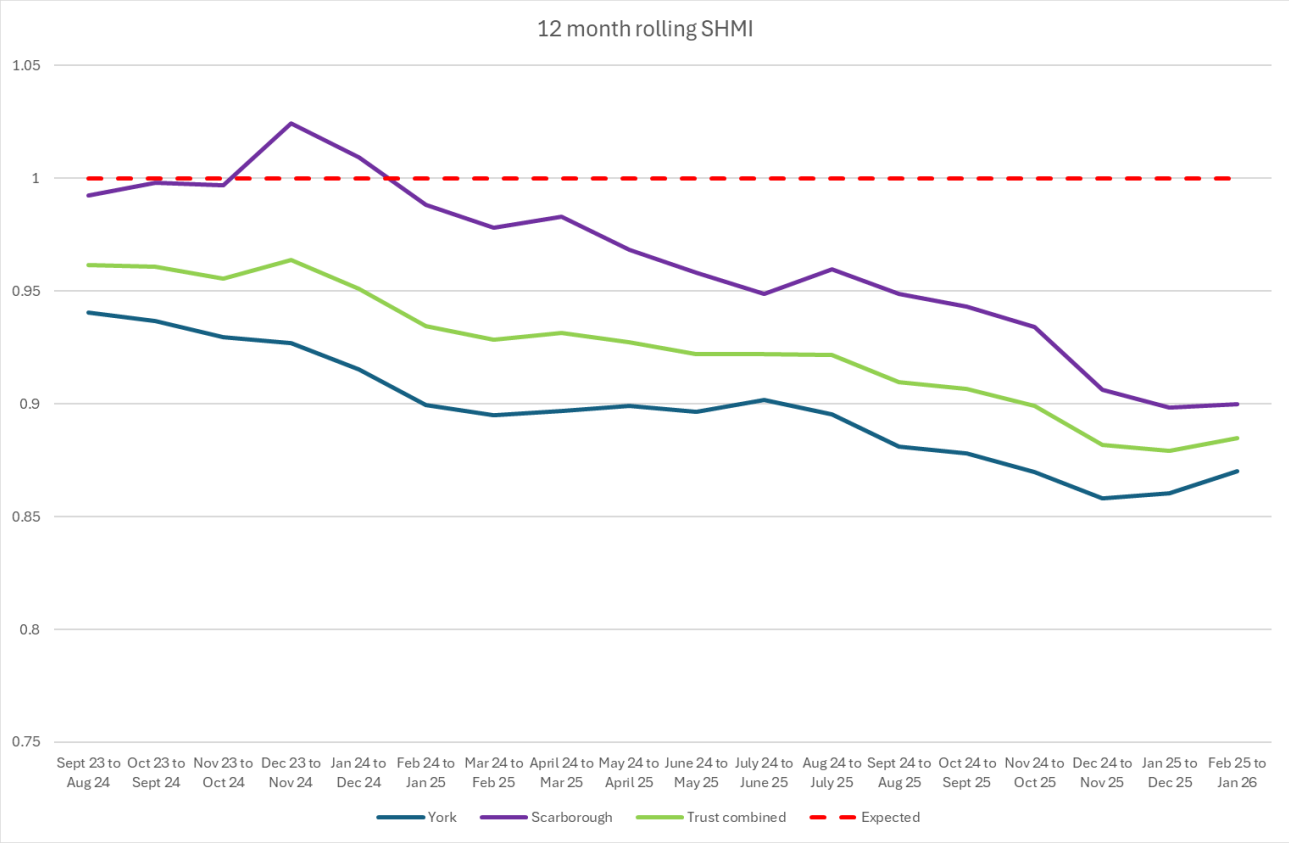
SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

Appendix 1

Figure 1 provides the 12 month rolling SHMI values for the last 18 reporting periods. The dotted red line is the expected value for the SHMI. York is represented by the blue line, Scarborough the purple and the green is the overall Trust value. Over the last 18 reporting periods covering September 2023 to August 2024 up to the most recent February 2025 to January 2026 we have seen a sustained decrease. The most recent reporting period does show a slight increase, but I would be concerned if the SHMI continued to fall as that would prompt us to look at the data as the expected deaths criteria may need revising.

Figure 1: 12 month rolling SHMI values.



Report to:	Board of Directors
Date of Meeting:	24 June 2026
Subject:	Guardian of Safe Working Hours 2025-2026 Annual Report
Director Sponsor:	Dr Karen Stone, Medical Director
Author:	Dr Oluwafumbi Olajide

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 Guardian of Safe Working Hours (GoSWH) is a statutory, independent role established to ensure compliance with contractual stipulations regarding safe working hours for Resident Doctors employed by the Trust and to provide assurance of this to the Board.

- Key themes in this annual report include:

- Sustained increase in Exception Reporting across the year, reflecting improved engagement alongside ongoing service pressures. Reporting increased markedly from Quarter 2 and remained high through Quarters 3 and 4.

- Persistent workforce pressures and rota gaps impacting safe working, wellbeing and training, evidenced by overtime/late finishes, missed breaks, breaches of the 13-hour maximum shift length and immediate safety concerns across both York and Scarborough sites.

- Strengthened governance following early adoption of national Exception Reporting reforms from January 2026, with improved timeliness of report review in Quarter 4; however, survey feedback indicates ongoing cultural and administrative barriers to reporting.

Recommendations:

- The Board is asked to note the report and support continued organisational focus on workforce capacity, rota resilience, reporting culture and the implementation of national exception reporting reforms.

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

No ☒ Yes ☐

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

Report History

(Where the paper has previously been reported to date, if applicable) N/A

Meeting/Engagement	Date	Outcome/Recommendation

1. Introduction and Background

This is the 2025/2026 annual report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training. The annual report is for 1 April 2025 to 31 March 2026 and summarises key findings from Exception Reporting data, matters escalated through the Resident Doctors' Forum (RDF), and themes arising from the GoSWH wellbeing survey undertaken during the year.

The primary role of the GoSWH is to ensure compliance with contractual stipulations regarding safe working hours for Resident Doctors employed by the Trust and provide assurance of this to the board.

All Resident Doctors are given access to the online Exception Reporting tool and can highlight variation in working hours, missed breaks, and missed training opportunities. From February 2026, NHS England introduced significant reforms to the Exception Reporting system. These changes are summarised in Section 2.2.

Resident Doctors now have the option to choose between time off in lieu (TOIL) or payment for additional hours worked and are also entitled to report any actual or threatened detriment related to Exception Reporting.

The Director of Medical Education has access to review reports related to training and supervision to ensure educational standards are maintained.

The GoSWH also holds the position of Chair of the Resident Doctors' Forum (RDF). The Forum has core representation from Medical Employment, Medical Deployment, Medical Education, Care Group management, Local Negotiating Committee (LNC) and the British Medical Association. It is open to all Resident Doctors working in the Trust.

2. Current Position/Issues

2.1 *Exception reporting trends*

A complete breakdown by Care Group and department is detailed in Table 1 of the Appendix. It is worth noting that the specialty recorded reflects the doctor's primary base but not necessarily where they worked the shift in question. This is usually the case in reports related to out-of-hours shifts.

A total of 621 Exception Reports were received in 2025/2026, representing a significant increase compared to 312 reports in 2024/2025 and 297 in 2023/2024 respectively. This increase reflects improved awareness and confidence in reporting, early adoption of national reforms, and sustained service pressures including staffing gaps and workload intensity.

Quarter 1 demonstrated comparatively lower reporting volumes, consistent with historical trends and likely reflecting the period during which Resident Doctors focus on portfolio completion in preparation for the Annual Review of Competence Progression (ARCP). However, a marked increase in Exception Reporting was observed from Quarter 2 onwards, with volumes remaining elevated through Quarters 3 and 4. This pattern indicates that the rise in reporting was not due to a transient period of operational pressure but rather reflects sustained demand and underlying workforce pressures across the reporting year.

The Medicine Care Group remained the highest contributor to Exception Reports, consistent with workforce size and service demand. In later quarters, reporting increased across multiple Care Groups and both sites, indicating broader system-wide pressures rather than isolated service issues.

Overtime/late finishes remained the most frequently reported category across the year, alongside missed breaks and increasing reports related to breaches of the 13-hour maximum shift length. There was also a continued rise in reports relating to missed training opportunities, inadequate clinical support, and rota-related pressures, reflecting the interaction between service demand, workforce capacity, and training delivery.

Immediate safety concerns were reported in each quarter, predominantly relating to staffing gaps, rota design and workload intensity. For the purposes of Exception Reporting, an immediate safety concern refers to situations where working conditions pose a risk to patient safety and/or the health, wellbeing or performance of the doctor, such as insufficient staffing, inadequate supervision or inability to take rest breaks.

All immediate safety concerns are reviewed directly by the GoSWH, with escalation through Care Group leadership and local governance processes, including Datix where required. Targeted actions include ongoing investigation of themes, follow-up with Care Groups, and regular engagement with Resident Doctors to support safe working. While immediate safety concerns are reviewed through Exception Reporting processes, there remains variability in the use of wider incident reporting systems, including Datix, where these would be expected.

Overall, the increase in Exception Reporting is interpreted as both:

- Positive, reflecting improved transparency and engagement
- Concerning, reflecting sustained workforce and workload pressures

In response, the GoSWH office undertakes regular thematic review, engages with Care Groups, maintains action logs, and uses Exception Reporting and Resident Doctors' Forum insight to inform workforce planning and service improvement. This includes contributing to organisational responses, with business cases developed or in progress within Medicine, Surgery and Family Health (Paediatrics) to address staffing and rota pressures. This approach ensures that Exception Reporting is used not only retrospectively, but as a proactive source of intelligence to inform organisational decision-making and service improvement.

Timeliness of Exception Report review varied during the year, with performance declining in Quarters 2 and 3 in the context of increased reporting volumes. Following implementation of national reforms and centralised processes from January 2026, timely review improved significantly, with the majority of reports reviewed within contractual timeframes by year end. However, the sustained volume of reports continues to present a challenge in maintaining consistently timely responses.

Exception Reports by quarter / Review times				
Quarter	**No. exceptions 2024/2025**	**Review times (within 7 days)**	**No. exceptions 2025/2026**	**Review times (within 7 days)**
Quarter 1	31	65%	56	73%
Quarter 2	93	22%	209	59%
Quarter 3	101	50%	179	56%
Quarter 4	87	43%	177	94%
Total	**312**		**621**	

2.2 *National Exception Reporting Reform*

The Trust adopted the reformed national Exception Reporting framework as an early adopter from 5 January 2026. Under the revised arrangements, Exception Reports are no longer routed through supervisors. They are managed through a centralised process with oversight by the GoSWH, supported by the Verification Manager, Director of Medical Education and relevant teams, improving consistency and organisational visibility of reporting.

The framework introduced defined timescales for the review of Exception Reports, alongside strengthened governance and accountability measures, including financial penalties for breaches such as delayed handling, restricted access to reporting systems, or concerns relating to confidentiality.

For clarity:

- Review refers to the timely assessment of an exception report, including initial evaluation and identification of required actions.
- Resolution refers to the point at which all necessary actions have been agreed and completed, which may require clarification, investigation or engagement with relevant stakeholders.
- Restricted access refers to barriers preventing doctors from using the Exception Reporting system.

Implementation of the national reform has been a significant focus for the GoSWH's Office and associated teams in Medical Education and Workforce during 2025–2026, requiring widespread changes to local processes, policy and systems, alongside engagement with Resident Doctors and stakeholders to support understanding and adoption of the revised arrangements.

2.3 *Resident Doctors' Forum (RDF)*

The Resident Doctors' Forum (RDF) remained a key mechanism for engagement, escalation and organisational insight during 2025–2026. Participation improved over the course of the year following targeted changes to meeting structure, communication and representation.

The following key themes were identified:

- Workforce pressure and rota resilience: Persistent concerns relating to staffing gaps, rota design and out-of-hours cover, particularly within Medicine, Surgery, Paediatrics and Emergency Care, contributing to workload intensity, missed breaks and Exception Reporting trends.
- Implementation of national Exception Reporting reform: The RDF played a central role in supporting communication, feedback and ongoing engagement following early adoption of the revised national framework.
- Access to training and educational opportunities: Ongoing challenges in accessing protected teaching and training due to service pressures and rota constraints, consistent with Exception Reporting data.
- Working environment and Resident Doctor experience: Issues relating to annual leave access, supervision and consistency of experience across specialties.

RDF discussions and Exception Reporting data have informed organisational action, including workforce planning and development of Care Group business cases to address staffing and rota pressures.

2.4 *Guardian Funds*

The Resident Doctor contract stipulates specific breaches to safe working hours, and rest should lead to a Guardian fine payable by the relevant Care Group. It also details how the fine should be calculated and shared between the affected doctor and Guardian. The use of Guardian funds is accessible to all Resident Doctors via the Resident Doctors' Forum.

During the 2025–2026 reporting period, there were 36 breaches of the 13-hour maximum shift length. Of these, six related to Locally Employed Doctors, for whom fines are not applicable. Of the remaining breaches, three did not result in fines due to either withdrawal of the report or inability to provide supporting evidence.

Guardian fines were therefore issued for the remaining 27 breaches, the majority of which related to excess working hours driven by service pressures. The predominant reasons identified included unreasonable workload, perceived staffing shortages, handover delays, and unavoidable operational pressures, with a small number attributable to the clock change.

Fines were levied across multiple Care Groups, indicating that breaches were not confined to a single service or site, but reflect broader workforce and operational pressures impacting safe working hours. The frequency and distribution of fines demonstrate recurrent breaches of contractual safe working hours requirements across multiple services, driven primarily by workforce pressures and service demand.

Guardian funds continue to be managed in accordance with contractual requirements, with a proportion ring-fenced for Resident Doctor facilities and the remainder available to support wellbeing initiatives through the Resident Doctors' Forum.

Guardian Funds: 2025/2026 activity

Detail	+/-	Balance
Opening balance on 1 April 2025		**£1,671.44**
(+) Guardian fines	+£1,522.40	£3,193.84
(-) Purchases made in this quarter	*- £457.14*	£2,736.70
Closing balance on 31 March 2026		£2,736.70

Ring-fenced funds	+/-	Available Balance
Purchase for York Doctors' Mess	*-£500.00*	*£2,236.70*
Available funds on 31 March 2026		**£2,236.70**

2.5 *GoSWH Wellbeing Survey*

A GoSWH wellbeing survey was undertaken during the 2025–2026 reporting period to capture Resident Doctors' experience of safe working, Exception Reporting, training and support. The survey received 44 responses.

Key findings from the survey were broadly consistent with Exception Reporting trends, reinforcing the following themes:

- Workload and staffing pressures: High workload intensity and rota gaps continue to impact safe working, rest breaks and overall wellbeing.
- Access to training and educational opportunities: Service pressures and rota constraints limit access to protected teaching and training.
- Reporting culture and barriers: While awareness of Exception Reporting is high, some respondents identified administrative burden and perceived cultural barriers in certain areas.
- Variability in experience across departments: Differences in supervision, access to breaks and support highlight inconsistency across services.

Overall, survey findings support Exception Reporting data in identifying sustained workforce pressures as the primary driver of unsafe working and reduced training opportunities.

3. Recommendations

The Board is asked to:

1. Note the sustained increase in Exception Reporting as both a reflection of improved engagement and an indicator of ongoing workforce and operational pressures.

2. Support continued focus on workforce capacity and rota resilience, recognising organisational actions underway within Care Groups, including business cases developed or in progress to address identified staffing and rota pressures.

3. Support a positive and consistent reporting culture, ensuring that Resident Doctors can raise concerns without barriers and that reports are reviewed and responded to in a timely and constructive manner.

4. Support the continued use of Exception Reporting data and Resident Doctors' Forum insight to inform workforce planning, rota design and service improvement.

5. Receive assurance on the ongoing implementation and impact of national Exception Reporting reforms, including timeliness of review and governance arrangements.

4. Summary

The 2025–2026 reporting period demonstrates a continued strengthening of reporting culture, with a significant increase in Exception Reporting providing improved visibility of Resident Doctors' experience.

This increased reporting reflects both greater engagement with the process and sustained workforce and operational pressures across the Trust. These pressures are evident across multiple Care Groups and are associated with staffing gaps, rota design challenges and workload intensity.

Immediate safety concerns have continued to be identified and reported through the Exception Reporting system, providing a mechanism for the escalation of risks relating to safe working. While this provides important visibility of safety concerns, there remains variability in the use of wider incident reporting processes, including Datix reporting, where this would be expected.

The early adoption of national Exception Reporting reforms has strengthened governance arrangements and improved the timeliness and consistency of report review. However, the sustained volume of reporting highlights the need for continued organisational focus on workforce capacity, rota resilience and consistency of experience across services.

Overall, Exception Reporting, Resident Doctors' Forum insight and wellbeing survey findings provide a consistent and robust picture of workforce pressures. The priority going forward is to ensure that this intelligence continues to inform targeted and sustainable organisational action to support safe working, training and wellbeing.

Date: 20 May 2026

Appendix 1: Exception reporting data for 2025-2026

Table 1: Exception reports by department			
Care Group/ department	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions open**
CSCS	**24**	**24**	
Haematology/Oncology	6	6	
Neurology	17	17	
Ophthalmology	1	1	
Family Health	**85**	**85**	
Obstetrics & Gynaecology	57	57	
Paediatrics	28	28	
Medicine	**342**	**342**	
Acute Medicine	20	20	
Cardiology	19	19	
Diabetes & Endocrinology	47	47	
Elderly Medicine	98	98	
Emergency Medicine	23	23	
Gastroenterology	45	45	
Rehabilitation Medicine	1	1	
Renal Medicine	26	26	
Respiratory	63	63	
Surgery	**170**	**170**	
Anaesthetics	8	8	
General Surgery	4	4	
General Surgery (Colorectal)	24	24	
General Surgery (Gastro)	3	3	
General Surgery (Upper GI)	8	8	
General Surgery (Urology)	34	34	
General Surgery (Vascular)	33	33	
Orthogeriatrics	2	2	
Trauma & Orthopaedics	54	54	
Total Raised	**621**	**621**	

Table 2: Exception reports by grade				
Grade	No. exceptions in **previous financial year**	Proportion of reports **financial year**	No. exceptions raised **this financial year**	Proportion of reports **this financial year**
F1	148	47%	310	50%
F2	15	5%	44	7%
CT1-2 / IM1-2/ ST1-2	114	37%	206	33%
IMT3/ ST3+	35	11%	61	10%
Total	**312**	**100%**	**621**	**100%**

Table 3: Exception reports by type				
Type	No. exceptions raised **24/25**	Proportion of reports **24/25**	No. exceptions raised **25/26**	Proportion of reports **25/26**
<11 hours rest between shifts	1	0.32%	1	0.16%
Difference in work pattern	4	1.28%	7	1.13%
Early start	0	0%	1	0.16%
Early start, late finish	0	0%	5	0.81%
Late finish	215	68.91%	419	67.47%
Late finish, >13-hour shift length	14	4.49%	36	5.80%
Late finish, difference in work pattern	0	0%	1	0.16%
Late finish, missed breaks	14	4.49%	30	4.83%
Late finish, missed breaks, >13-hour shift length	1	0.32%	1	0.16%
Missed breaks	27	8.65%	51	8.21%
Missed breaks, difference in work pattern	2	0.64%	2	0.32%
Late finish, missed breaks, inadequate supervision	0	0%	1	0.16%
Missed breaks, inadequate supervision	4	1.28%	2	0.32%
Missed breaks, missed clinic or theatre session	1	0.32%	0	0%
Late finish, missed scheduled teaching	1	0.32%	6	0.97%
Late finish, inadequate supervision	1	0.32%	0	0%
Late finish, missed breaks, missed scheduled teaching	1	0.32%	0	0%
Difference in work pattern, missed scheduled teaching	0	0%	1	0.16%
Inadequacy of rostered skills mix, missed breaks	0	0%	1	0.16%
Inadequate clinical support	0	0%	7	1.13%
Inadequacy of rostered skills mix	0	0%	4	0.65%
Inadequate supervision	11	3.53%	17	2.74%
Missed clinic or theatre session	3	0.96%	4	0.64%
Missed scheduled teaching	8	2.56%	18	2.90%
Inadequate clinical exposure	4	1.28%	3	0.48%
Raising concerns of suspected non-compliant rota pattern	0	0%	2	0.32%
Detriment or threat of detriment	0	0%	1	0.16%
Total	**312**	**100%**	**621**	**100%**

Table 4: Exception Reports (review time)				
	Reviewed within 48 hours	**Reviewed within 7 days**	**Reviewed in longer than 7 days**	**Still open**
FY1	141	110	59	0
FY2	10	16	18	0
CT1-2/ST1-2	52	67	86	0
IMT3/ST3+	22	14	24	1
Total	**225**	**207**	**188**	**0**

70% reviewed within 7 days (44% in 2024/2025)