York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 29th July 2026
Time: 9:00am – 12:30pm
Venue: Boardroom, 2nd Floor Admin Block, York Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 24 June 2026** To be agreed as an accurate record.	Chair	Report	6	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	19	
6.	**Colleague's Story** To consider.	Fliss Durrant and James Pickup - Apprenticeship Team	Verbal	-	9:05
7.	**True North Report** To review the report.	Chief Executive	Report	20	9:15
8.	**Chair's Report** To review the report.	Chair	Report	38	9:25

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	40	9:30
10.	**Quality Committee Report** To receive the July meeting summary report.	Chair of the Quality Committee	Report	85	9.45
11.	**Resources Committee Report** To receive the July meeting summary report.	Chair of the Resources Committee	Report	To follow	9.55
12.	**Well-Led Action Plan Q1 Progress Report** To consider the report.	Chief Executive	Report	91	10:05
13.	**Trust Priorities Report (TPR)** July 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	138 143 189 204 215 223	10:15
Break 11:00					
14.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	240	11:15

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Freedom to Speak Up (FTSU) Quarterly Report** To consider the report.	FTSU Guardian	Report	245	11:25
16.	**Trust response to post death care and key actions following the Fuller enquiry** To consider the report.	Medical Director	Report	251	11:40
17.	**Maternity and Neonatal Report** 17.1 The National Maternity Review: Amos Final Report and Recommendations 17.2 Nottingham Review Findings, Conclusions and Esstential Actions 17.3 Maternity Feedback Survey 17.4 Perinatal Equity and Anti-Discrimination Programme (PEADP) 17.5 Bi-annual Maternity, Obstetric, Anaesthetic and Neonatal Workforce Report Quarters 3 and 4 To consider the reports	Chief Nurse - Executive Maternity Safety Champion	Report	268 282 307 311 318 326	11:50
18.	**Annual Complaints Report** To consider the report.	Chief Nurse	Report	356	12:00
19.	**Public Sector Equality Duty (PSED) Report** To consider the report.	Interim Director of Workforce & OD	Report	374	12:10
Governance					
20.	**Fit and Proper Persons Test (FPPT) Annual Report** To consider the report.	Associate Director of Corporate Governance	Report	378	12:20

Item	Subject	Lead	Report/ Verbal	Page No	Time
21.	**Q1 2026/27 Board Assurance Framework (BAF)** To consider the report.	Associate Director of Corporate Governance	Report	**381**	12:25
22.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
23.	**Time and Date of next meeting** The next meeting held in public will be on 30 September 2026 at 9.30am at Scarborough Hospital.				
24.	**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.				
25.	**Close**				12:30

Minutes
Board of Directors Meeting (Public)
24 June 2026

Minutes of the Public Board of Directors meeting held on Wednesday 24 June 2026 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.50pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Ms Rukmal Abeysekera
- Dr Lorraine Boyd (Maternity Safety Champion) *(Via Teams)*
- Ms Julie Charge
- 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
- Mr Mike Taylor, Associate Director of Corporate Governance

In Attendance:
- Ms Steph Williams, Head of Nursing, Cancer, Specialist and Clinical Support Services Care Group (For Item 6)
- Ms Jo Hadley, Deputy Director of Midwifery (For Item 15)
- Miss Oluwafumbi Olajide, Consultant Obstetrician & Gynaecologist and Guardian of Safe Working Hours (For Item 19)
- 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

- Ros Shaw, Elected Governor – Public
- One member of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

2 Apologies for absence

There were no apologies for absence.

3 Declaration of Interests

Dr Boyd declared that she had been appointed as a Non-Executive Director for Nimbuscare.

4 Minutes of the meeting held on 27 May 2026

The Board approved the minutes of the meeting held on 27 May 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.*
Mr Barkley suggested that the Patient Experience report recently presented to the Council of Governors should be circulated to the Board, to obtain feedback on whether this meets the request for a fuller, more rounded quarterly patient experience report rather than allocating time at a Seminar. The action was closed .

BoD Pub 64(25/26) *Add comparative figures from month to month in the National Operational Framework rank oversight in the TPR.*
This information had been added and the action was closed.

BoD Pub 70(25/26) *Bring a recommendation for the True North metrics for 2026/27 to the next meeting.*
A revised set of True North metrics had been discussed at the recent Board Development Seminar and would be presented formally to the Board in July.

BoD Pub 73(25/26) *Present an improvement plan for 2-hour Urgent Community Response compliance.*
Ms Hansen reported that compliance with the 2-hour Urgent Community Response (UCR) standard had improved to just under 85%. Breach validations were undertaken to identify themes and trends and there was also robust clinical triage all of referrals to ensure that UCR was the correct pathway. Ms Hansen referenced the forthcoming new community model which would increase community resource further and support compliance with the UCR standard.
The action was closed.

BoD Pub 76(25/26) *Consider including crude mortality trends within the Learning from Deaths report.*
The information was included in the appendix to the report under Item 18. 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 suggested that the results of the audit which was being undertaken should be presented to the Quality Committee first. Mr Barkley agreed but observed that the key assurance for the Board was evidence of improvement in the metrics. Ms Hansen noted that performance against metrics was reported to the Resources Committee. The action was therefore closed.

BoD Pub 04 *Include a graph in the TPR showing actual WTE compared with the plan.*
The graph had been included in the report. The action was closed.

BoD Pub 08 *Add further detail to midwife vacancy and recruitment table in the report.*
The detail had been added. The action was closed.

6 Patient's Story

Ms Williams joined the meeting to share with the Board the work which had been undertaken to improve patient experience with the introduction of bedside handovers. Following a pilot project last summer, bedside handovers had been rolled out across the Trust in November. The focus was on better communication with and involvement from patients about their care. Ms Williams explained how this improved patients' experience and shared feedback data.

Comments and questions were invited.

Miss Smith was very encouraged by this work and asked Ms Williams and Mr Hague how it might be used to ensure that patients were treated more promptly, for example in undergoing diagnostic procedures, which would link to the Trust's future work to eliminate corridor care.

Mr Taylor asked if there had been any barriers to introducing the bedside handovers. Ms Williams explained that some, more inexperienced, staff were nervous of discussing care with patients as they felt they lacked clinical knowledge. Mr Taylor observed that the most valuable discussions with patients were non-clinical ones. He queried whether the use of the bedside handover might lead to earlier discharges. Ms Williams agreed that there was potential for this as it allowed patients the opportunity to express their readiness to go home.

Ms Grantham asked if there were any next steps in terms of improving communication. Ms Williams advised that there was an idea to have pictures of thermometers on wards for patients to register how they were feeling. Mr Hague added that there was also a suggestion to expand ward rounds to include families and carers.

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

7 True North Report

Miss Smith reminded the Board that a new set of True North metrics would be presented in July; these linked to organisational priorities. Referring to the report, Miss Smith highlighted:

- in relation to the Staff Survey metrics, progress was being made towards initiating the Big Conversation; this was fundamental to the success of the Continuous Quality Improvement (CQI) programme and the elimination of corridor care;
- in terms of the Urgent and Emergency Care metrics, the Emergency Care Standard continued to improve and the percentage of patients waiting more than 12 hours in the Emergency Department continued to reduce although both metrics had been temporarily impacted by the introduction of Nervecentre; Miss Smith flagged the high number of attendances to the Emergency Departments (ED) and challenges to hospital security;
- the cancer Faster Diagnosis Standard continued to be a focus for the Trust;
- the percentage of patients waiting less than 18 weeks for elective treatment was improving month on month and was ahead of trajectory; there were however significant challenges presented by an increase in referrals from primary care; there were certain specialties for which rapid action was needed to manage the demand;
- there had been a reduction in the number of Category 2 pressure ulcers and there were ongoing discussions with the ICB on how these were reported in the community; there was a 20% reduction target for 2026/27;
- Tranche 2 of the new EPR was planned for August 2026 and planning for Tranche 3 was underway; the implementation of Tranche 1 had been managed and delivered excellently;
- the Trust would announce its CQI partner very soon.

Mr Floyd noted that the number of bed days lost to patients with No Criteria To Reside was rising. Miss Smith responded that the rise was linked to the capacity of Community Services to support patients at home. Ms Hansen added that the Trust was working with external partners but there was an increasing number of cases where care homes would not receive residents with certain conditions back from hospital. The programme to eliminate corridor care would also focus on patients with No Criteria To Reside. Miss Smith noted that it would be useful to discuss this whole area at a Board seminar.

In response to a comment, Miss Smith advised that the format of the True North report would be informed by the CQI programme.

Referring to the Productivity and Efficiency Group update, Mr Barkley asked Ms Hansen about her confidence in achieving a year-end target for Patient Initiated Follow Up (PIFU) of 6.6%, which translated to an increase of 0.2% each month. Ms Hansen was confident that the year-end target would be achieved but not with a sustained increase through the year. The Director of the Surgery Care Group had been appointed to lead a working group which would work with specialties. Ms Hansen noted that the level of trust in the PIFU needed to be increased. She hoped to see significant improvement at the end of Quarter 2. Mr Hawkins confirmed that there had been another rise in PIFU usage in June to 5.1%.

In response to a question, Ms Hansen explained that outpatient utilisation encompassed utilisation of time within a clinic, that is, how many patients were seen and whether the clinics ran to time, and also the clinic schedule for the week. Both were a focus for review and improvement. The team was also looking at the availability and use of clinic rooms.

In response to Mr Barkley's question, Ms Hansen explained that there was new national guidance around the use of CT and MRIs in diagnostics against which the Trust benchmarked well. The data would be presented to the Resources Committee in due course.

Mr Taylor observed that, whilst the new Extended Emergency Medicine Ambulatory Care (EEMAC) areas in ED were not classified as corridor care, patient feedback suggested that this was how they were perceived by some. It was noted that this perception might result from the delays still being experienced in Urgent and Emergency Care, but the NHS England definition of corridor care was specific. Ms Hansen added that the new EEMAC and Emergency Assessment Unit (EAU) had significantly improved waiting times.

8 Chair's Report

The Board received the report.

Mr Barkley reported that he had received a draft proposal for a Board Development programme, which he would consider and then bring his recommendation to the Board.

9 Chief Executive's Report

Miss Smith presented her report and highlighted the visit of the King to the Sir Robert Ogden Macmillan Cancer Support Centre at York Hospital. Miss Smith paid tribute to Mrs Brown's and Mr Norman's team for the work in preparing for the visit and commented that the new facility was wonderful example of what could be achieved when charities, partners and NHS organisations worked together with a shared purpose .

Miss Smith reported that she had continued to spend time with colleagues across the Trust. She had spent time at Bridlington Hospital and had met with colleagues regarding the Bridlington Care Unit. The engagement process relating to the proposed closure of the Unit was ongoing. Miss Smith highlighted the Bridlington Surgical Hub optimisation week which been used successfully to significantly increase the number of elective procedures carried out.

Miss Smith referenced the recently published Lord Mann review into tackling racism and antisemitism within the NHS and noted that the Anti-Racism Group would review the report and its recommendations in detail.

Finally, Miss Smith reported that the annual Long Service celebrations had been very successful and she drew attention to the nominations for Star Awards attached to the report.

Mr Taylor recommended to Board members an article in the Health Service Journal on the challenges of decommissioning services.

10 Quality Committee Report

Dr Boyd summarised the key escalations from the meeting of the Quality Committee on 16 June 2026. The Committee had received the Quality Account and recommended it to the Board for approval, and had approved an amendment to its terms of reference requested by the Board. Dr Boyd observed that reports to the Committee evidenced inconsistency of practice and standards across the organisation which was an area for improvement. Dr Boyd also highlighted palliative care as an area of concern: the capacity of the team was

insufficient to provide a consistent level of care across the Trust's catchment area. Dr Boyd commented that the Board should consider more oversight of the service.

Finally, Dr Boyd made reference to the establishment of a Spina Bifida clinic in Scarborough, through the collaboration of paediatricians, paediatric urology, physiotherapy and the Shine charity. Early feedback on the service was very positive.

11 Resources Committee Report

Ms Grantham highlighted the main discussion points from the meeting of the Resources Committee on 23 June 2026. The Committee's focussed reviews had covered the Referral to Treatment (RTT) waiting list position, the Waste Reduction and Productivity (WRAP) programme and the financial position, and opportunities for digital transformation.

With reference to the RTT focussed review, Ms Grantham reported that there had been an improvement in the percentage of patients waiting less than 18 weeks for treatment but there was still improvement needed in other metrics. The Committee has asked for more visibility of the improvement plans.

Ms Grantham reported that the Trust was behind its financial plan in Month 2 and the Committee had discussed what strategic actions would be needed to recover the position. The Committee heard that senior leaders had met to discuss opportunities identified in the KPMG report.

The Committee had received the quarterly assurance paper from YTHFM: the focus continued to be on reducing sickness absence and improving the cleaning standards. The Sustainability report and the first report with details of ongoing major capital projects were also received. Ms Grantham noted the successes described in the Sustainability paper.

Ms Grantham advised that the paper describing opportunities for digital transformation had provoked discussion on the Trust's priorities for investment. The Committee had agreed that a wider Board discussion would be valuable. Mr Hawkins noted that the main opportunity for transformation was in the current project to replace the Electronic Patient Record (EPR) of which Tranche 3 would be transformational for staff and would empower patients through better communication. The challenges to digital transformation lay in the constrained financial environment. Miss Smith highlighted the volume of work which would be needed to prepare for a safe implementation of Tranche 3 of the EPR.

Ms Hansen advised that the Committee had noted concerns around the growth of the Total Waiting List and had discussed the drivers of this. Ms Hansen was, however, confident of reducing the number of patients waiting more than 52 weeks for treatment.

12 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen highlighted that Urgent and Emergency Care metrics had met the trajectory, despite the change in processes which accompanied the introduction of the new EPR, and there was certainly capacity for further improvement once the new processes were embedded.

Ms Hansen reported that diagnostic performance was ahead of trajectory, with 76% of patients being seen in under 18 weeks; this had resulted from a focus on patients waiting the longest and had been achieved despite delays to related capital projects as there were successful mitigations in place.
Cancer performance against the Faster Diagnosis Standard (FDS) and the 62-day standard continued to improve: the 62 Day Treatment Standard was ahead of trajectory in April, and was the best position in 12 months, but the FDS remained off trajectory. There would be deep dives of tumour sites as part of the improvement work.

Ms Hansen cautioned that the total waiting list remained the main challenge and the Trust was working with partners to address demand. Ms Hansen highlighted the national direction towards a Single Point of Access for elective care, but this needed a significant amount of work to implement. There was a structural gap between demand and capacity for some specialties, for example the Pain service, and discussions with commissioners to address this were continuing. Other services, for example, oral surgery were impacted by workforce constraints relating to difficulties in recruiting appropriately skilled staff. Pathways in some specialties were also being reviewed.

Ms Hazelgrave noted the sharp decrease in the percentage of admissions of Type 1 patients attending ED. Ms Hansen explained that the deployment of a senior clinician at the front door was supporting this reduction. It was noted that, with the implementation of the new EPR, a new Type 5 category referring to non-admitted patients had been introduced. Mr Barkley observed that the key metrics were the number of non-elective patients admitted for one night or more and the number of bed days occupied by patients with a length of stay of 1 day or more.

Mr Barkley drew attention to the increase in the number of ambulance handovers taking over 45 minutes. Ms Hansen agreed that this metric had deteriorated which was disappointing, and work was underway to identify the reasons. She advised that the department was experiencing record numbers of attendances and the Trust was working with the Yorkshire Ambulance Service to identify alternative pathways.

Mr Barkley highlighted the number of zero day length of stay non-elective admitted patients, which at 1826 was high considering that patients accessing Same Day Emergency Care were not included. Ms Hansen would investigate further.

Action: Ms Hansen

Mr Barkley noted the specialties that were exceeding their FDS target and asked whether they were receiving due credit for their performance. Ms Hansen responded that the Trust could do better at praising teams for performance.

Mr Barkley asked if the Trust held data on the number of GP referrals per thousand patients by GP practice. Ms Hansen explained that this analysis work was in progress.

Mr Barkley queried the significant gap between the actual number and the trajectory for outpatient first attendances. Ms Hansen responded that some appointments had been used for cancer patients as a priority and there had also been a focus on appointments for patients experiencing long waits. There had also been a reduction in additional activity due to financial constraints.

Quality and Safety

Mr Hague reported that the Trust was over the year-to-date threshold for E.Coli, MSSA and pseudomonas bacteraemia. A deep dive of improvement plans would be undertaken

with a view to initiating a step change. The Trust was under the year-to-date threshold for C.Difficile but there was still work to do to improve the position further.

In terms of Category 2 pressure ulcers, the Trust had not achieved the monthly trajectory. Mr Hague provided an update on the work to reduce the number of pressure ulcers. A stretch target of 20% had been agreed for 2026/27. The number of complaints received by the Trust in May was similar to the April number, however, there had been a deterioration in response times.

Dr Stone highlighted the good work associated with medication incidents in terms of reviewing and communicating the learning. The two Patient Safety Incident Investigations referenced in the report were now complete and had significant actions arising from them.

Mr Barkley thanked the team for the excellent executive summary.

Maternity

There were no comments or questions on this section.

Workforce

Ms Larcum advised that, whilst the monthly sickness absence rate had reduced, this was not sufficient to impact on the annual rate which was above plan at 5.4%. There were proactive plans in place to support colleagues to remain at work and reactive plans to manage sickness absence.

Ms Larcum reported that the turnover rate remained below trajectory. The overall vacancy rate had increased as establishments had been added to budgets. Ms Larcum noted that the vacancy rate for Health Care Support Workers was on a downward trajectory. She referred to the additional workforce information added to the report which had been reviewed by the Resources Committee. The overall headcount was reducing according to the plan.

Referring to the table of planned and actual Whole Time Equivalent totals for each staff group, Mr Barkley asked if the increase in the NHS infrastructure staff group was related to the EPR implementation. Ms Larcum would check.

Action: Ms Larcum

Digital and Information Services

Mr Hawkins reported that there had been a first incident of downtime associated with the new EPR; this had been a national incident. Mr Hawkins advised that the EPR had a business continuity function which had proved valuable.

Mr Hawkins referred to the number of calls to the helpdesk in May which had been mitigated by the deployment of floorwalkers and online help functions to support the introduction of the new EPR. He also highlighted excellent compliance with the deadlines for responses to Freedom of Information and Subject Access Requests.

There was discussion on the introduction of Ambient Voice Technology (AVT) in ED which, in other Trusts, had been shown to benefit patients by reducing waiting times and also to contribute to improved job satisfaction for doctors who had adopted it. Ms Hansen advised that there were a number of clinicians in ED who had piloted AVT. Mr Hawkins added that the new EPR had an AVT function which would provide a better experience for staff. The challenge would be in demonstrating that the savings from using AVT would offset the investment required in licences. The Board would need to take a decision on the

investment. Dr Stone underlined the importance of educating and training clinicians to use AVT effectively should the decision to invest be made.

Finance

Mr Bertram reported that the current plan, which was for a year-end deficit of £22m, had not yet been formally approved by NHS England. In Month 2, there was a year to date deficit of £5m, a £0.9m negative variance to the planned deficit of £4.1m. £0.6m of this variance related to the costs of the resident doctors' industrial action for which there would be no external support. The WRAP programme had delivered £20.6m in full-year terms against the £61.6m target but was behind plan by £2.7m as at Month 2, in terms of monthly delivery. Mr Bertram advised that the cash position was £3m adrift of plan. This was a growing area of concern, and his team was already preparing a working capital submission and discussing the position with the regional team. Mr Bertram noted that a VAT repayment was awaited from HMRC which would boost the cash position.

Mr Bertram provided further details relating to the NHS England and ICB income variances. He noted the £1.1m cost pressure from high cost drugs and devices which he was hopeful would be offset by income from commissioners.

Mr Bertram drew attention to the new information in the report on the use of the investment reserve: this had been reduced by £3m to offset the overall deficit and by a further £2.7m to offset the WRAP shortfall over the first two months of the year. £1.7m had been drawn from the fund for activity related investments. Mr Bertram underlined that the WRAP savings must be accelerated to forestall any further use of the investment fund to offset underdelivery. Mr Floyd agreed that the use of the investment fund to offset the shortfall in the WRAP programme was not sustainable and drew attention to the number of medium and high risk schemes. He noted that the significant risk that the full WRAP target would not be delivered had been flagged by the Resources Committee and should be a matter for discussion by the Board. Ms Hazelgrave also highlighted the £5m overspend, and the risk to the cash position, and the need for a Board discussion on a course of action.

Mr Bertram outlined the steps taken this year for better grip and control of the WRAP programme; these had resulted in tangible improvements to delivery but were not sufficient. Senior leaders had been working through key areas identified in the KPMG report. These needed to be added to the list of schemes, with Senior Responsible Officers and delivery leads identified. Mr Bertram reported that the Trust was now part of the Challenged Provider Programme and was in discussions with NHS England about external support for delivery of the WRAP programme.

Mr Barkley asked for clarity in the next report on where the £2.75m from the investment fund had been applied in the income and expenditure table. He also requested that future finance reports include a table showing expenditure against budget for each Care Group, directorate and the LLP.

Action: Mr Bertram

Mr Bertram confirmed that the use of the investment fund to offset the under delivery of the WRAP programme would impact on activity if not repaid.

Mr Barkley questioned the £0.4m spent on over activity when it was clear from the TPR that that activity was not being delivered. Mr Bertram explained that the activity plan for 2026/27 had been based on the 2025/26 tariff with an assumption about the cost uplift factor. The 2026/27 tariff had been released in April with fundamental changes in tariffs. Mr Bertram confirmed that the value of the activity had risen by more than inflation.

In response to Mr Barkley's question, Mr Bertram explained that the key driver of the operational pay overspend was medical and dental costs, particularly bank usage at premium rates. This was a focus for the WRAP programme.

13 Trust Strategy Scorecard

Ms Hansen presented the report and noted that the priorities identified by Miss Smith in her 100 day report reflected the strategic priorities which had already been identified in the Trust Strategy.

In response to Mr Floyd's query, Miss Smith agreed that the successes identified in the report could be more explicitly communicated to the organisation. Mr Taylor suggested that there should be greater reference to the Trust's external partnerships and, although it was difficult to identify suitable metrics to evidence progress, the Board needed to accept more accountability for partnership working. Ms Hansen suggested that partners could be asked for feedback. Mrs Brown responded that this had been undertaken as part of the Well-Led review. A stakeholder engagement plan had been developed and an evaluation of this could be completed. The Resources Committee was responsible for oversight of partnership working. Ms Hansen advised that a member of her team was now working for two days each week on better alignment with partners.

Mr Barkley thanked Ms Hansen for the well-written report.

14 CQC Compliance Update

The Board received and noted the report.

15 Maternity and Neonatal Reports

Ms Hadley, the newly appointed Deputy Director of Midwifery, was welcomed to the meeting.

Mr Hague presented the report and highlighted:

- a reduction in the rate of Post-Partum Haemorrhages (PPH) over 1500mls and improved compliance with PPH risk assessments at 36 weeks;
- recruitment of midwives to current vacancies was progressing well.

Service risks included:

- a decrease in compliance with completion of intrapartum PPH risk assessments; targeted work was underway to address this;
- the disestablishment of the Local Maternity and Neonatal System (LMNS) on 31 July; the ICB would assume a commissioning role but options to replace the service user role of the LMNS were being considered.

Miss Smith asked if appropriate support was in place for newly qualified midwives. Mr Hague had discussed this with the Director of Midwifery and was confident that the preceptorship was robust and the progressional points were clearly identified. The key challenge was in recruiting too many newly qualified midwives at one time.

Mr Barkley and Ms Hadley agreed that the LMNS had been key to engagement with stakeholders and that there should be a continuation in some form. Mr Barkley asked that an update on progress to a solution be brought to the Board in the next quarter.

Action: Ms Wells-Munro

15.1 Saving Babies' Lives Care Bundle

The Board received and noted the report.

Mr Barkley asked how Trust compared with peers in terms of compliance with the Care Bundle. Ms Hadley advised that, with 78% of the interventions fully implemented, the Trust was slightly behind peers, but actions were in place to address the outstanding elements.

15.2 Maternal Care Bundle Interim Review

Mr Hague advised that the Maternal Care Bundle had been published in January 2026. The paper described the internal interim review which had taken place before the publication of the national implementation tool. This had now been published and would be used to finalise priorities, timelines and develop an implementation plan.

16 Infection Prevention and Control (IPC) Annual Report

Mr Hague presented the paper, noting that it covered Quarter 4 data and as well as being the annual overview for 2025/26. The Trust had made credible progress in reducing Health Care Acquired Infections (HCAIs), notably with C.Difficile, and there had been an improvement in MSSA infections. Mr Hague referenced the internal audit of IPC governance which had returned an opinion of significant assurance and advised that the team had been asked to share their improvement work outside of the Trust.

Mr Hague noted that the Trust was still an outlier in relation to peers in terms of HCAIs in relation to patient bed days. Stretch objectives were in place for 2026/27. Mr Hague also highlighted the vacancies within the IPC team.

Mr Barkley expressed concern that the report lacked detailed reasons why the Trust benchmarked so poorly against others and what the solutions were to the root causes. Mr Hague acknowledged these concerns and agreed to report back to the Board.

Action: Mr Hague

Ms Abeysekera queried whether there was information about mortality rates in relation to HCAIs. Dr Stone responded that all incidents of infection were subject to review regardless of the outcome for the patient and a Structured Judgement Case Review would be undertaken if any concerns were raised by the review.

17 10 Point Plan: Improving Resident Doctors' Working Lives

Dr Stone presented the paper, noting that the 10 point plan was a national requirement. Progress in implementing the actions had been good thus far: Senior and Peer Resident Doctor leads were now in place, a Non-Executive Director lead had been appointed, exception reporting reforms had been implemented as well as recognition of prior learning to fulfil some statutory and mandatory training requirements. The Trust had also appointed a Clinical Leadership Fellow in Improving Resident Doctors' Working Lives who would begin in post in August. Dr Stone advised that there were still gaps in compliance relating to work schedules and rosters, and payroll issues. She drew attention to the Self-Assessment Summary Report attached to the paper.

Mr Barkley suggested that it would be valuable for the Board to hear from the Resident Doctor Peer leads (RDPLs) alongside the Trust's Senior Lead for Resident Doctor Experience (SLRDE). Dr Stone would progress this.

Action: Dr Stone

Ms Hazelgrave asked if any of the actions in the plan should be of concern to the Board. Dr Stone responded that the Trust needed to look beyond the 10 point plan to consider the experience of resident doctors working in the organisation. It was agreed that this would be considered when the RDPLs and SLRDE presented to the Board.

18 Q4 Mortality Report - Learning from Deaths

Dr Stone presented the report and highlighted the alert received by the Trust regarding its mortality rates in relation to the National Emergency Laparotomy Audit. The increased mortality rate had not been evidenced by the Summary Hospital-level Mortality Indicator (SHMI) tool so the team was analysing the coding to identify why the Trust was an outlier.

Dr Stone expressed some concern that the SHMI funnel plots may reflect inaccurate data and she had requested further analysis.

19 Guardian of Safe Working Hours Annual Report

Miss Olajide, Guardian of Safe Working Hours, presented the annual report from 2025/26. She highlighted a sustained increase in exception reporting across the year and persistent workforce pressures and rota gaps due to staffing gaps, rota design and operational pressures. Miss Olajide noted however that there was strengthened governance following early adoption of the national exception reporting reforms from January 2026.

Miss Smith noted that there may be opportunities for digital solutions to reduce pressure on the medical workforce.

In response to Miss Smith's query, Miss Olajide noted that current roster designs were often inappropriate for the service and needed additional staffing to function effectively. Dr Stone reported that a paper had recently been presented to the Executive Committee covering medical rostering and its oversight. Some issues with rosters would be caused by the design but some would require extra capacity which might be mitigated by the new EPR. She advised that solutions were in train which would support resident doctors. Dr Stone confirmed that the report from the Guardian would be triangulated with the 10 point action plan for resident doctors. It was positive that there was an increase in reporting as this would inform actions. Dr Stone observed that better oversight of rosters was needed to ensure that they were appropriate and there needed to be better assurance around the timing of issuing rosters, both of which had been covered in the paper presented to the Executive Committee. There were gaps in assurance around allowing time in rosters for training and educational opportunities.

Miss Olajide asked about the possibility of raising business cases to increase staffing levels. Mr Barkley responded that the financial constraints under which the Trust was operating would almost certainly prohibit this. Miss Smith added that any investment would need to be agreed by the Executive Committee.

Directors thanked Miss Olajide for her report and for her support for resident doctors.

Miss Abeysekera asked how the Board could be assured that the Medical Education programme was fit for purpose. Dr Stone responded that there was appropriate monitoring in place for undergraduate and postgraduate students which was reported to the Resources Committee.

20 Questions from the public received in advance of the meeting

Mr Barkley had received questions from a member of the public regarding its publicising of the National BAME Health and Care Awards, and he responded as follows.

He confirmed that neither the Trust nor the York and Scarborough Hospitals Charity had provided financial sponsorship or support to the National BAME Health and Care Awards. They had simply shared information about the awards, should any colleagues wish to enter. The Trust and the Charity took the same approach with any external other awards scheme which may be of interest or relevance to colleagues, including the Nursing Times Awards amongst others. The Trust had its own recognition schemes: the monthly Star Awards and the Annual Celebration of Achievement Awards, and these were open to all colleagues.

The Trust had used the term BAME, as this was the term used by the Awards organisers; the Awards were called the National BAME Health and Care Awards.

In relation to the question regarding whether the Trust had carried out due diligence with regard to the National BAME Health and Care Awards, it had not, as it was not deemed to be required.

21 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 29 July 2026 at 9am at York Hospital.

Item 5

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 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. Update 24.06.26: A revised set of True North metrics had been discussed at the recent Board Development Seminar and would be presented formally to the Board in July.	Jul 26 from Apr 26	Delayed
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
BoD Pub 10	24-Jun-26	12	Trust Priorties Report	Investigate why the number of zero day length of stay non-elective admitted patients is high	Chief Operating Officer		Jul-26	On Track
BoD Pub 11	24-Jun-26	12	Trust Priorties Report	Investigate the reasons for the increase in Whole Time Equivalent staff in the NHS staff infrastructure group	Interim Director of Workforce & OD		Jul-26	On Track
BoD Pub 12	24-Jun-26	12	Trust Priorties Report	Include in the next report, an indication of where the £2.75m from the investment fund is applied in the income and expenditure table and a table showing expenditure against budget for each Care Group, directorate and the LLP.	Finance Director		Jul-26	On Track
BoD Pub 13	24-Jun-26	15	Maternity and Neonatal Report	Bring an update to the Board on progress towards a solution towards continuing the work of the LMNS	Director of Midwifery		Sep-26	On Track
BoD Pub 14	24-Jun-26	16	Infection Prevention and Control Annual Report	Report to the Board on the detailed reasons why the Trust benchmarks so poorly against others in infection prevention and control, and the solutions to the root causes	Chief Nurse		Sep-26	On Track
BoD Pub 15	24-Jun-26	17	10 Point Plan: Improving Resident Doctors' Working Lives	Invite the Resident Doctor Peer leads alongside the Trust's Senior Lead for Resident Doctor Experience to present at a Private Board meeting	Medical Director		Jul-26	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

July 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’.

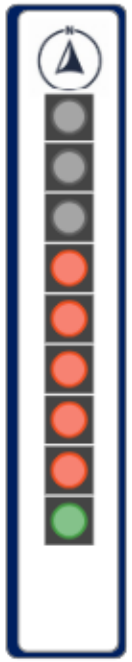
This is the single point of reference to measure our progress.

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 eleven key metrics for 2026/27 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)

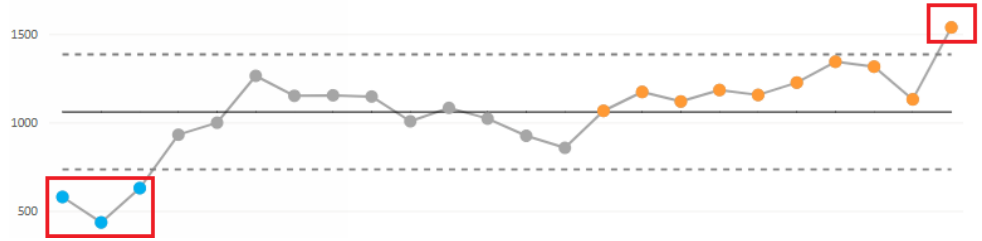
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

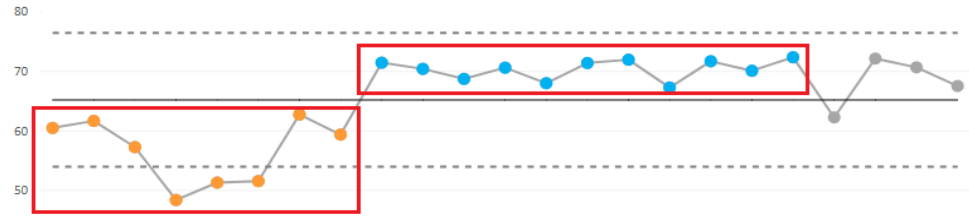
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

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.

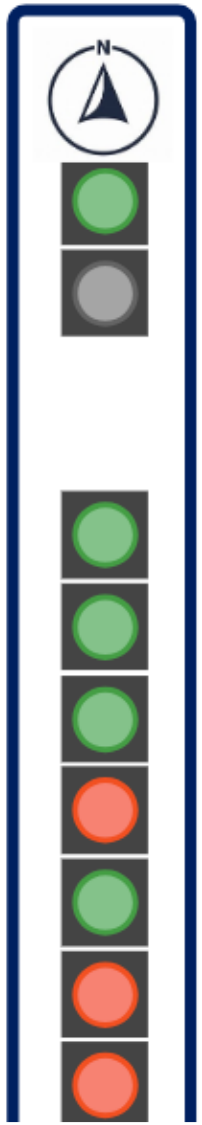


Trend: Counts the number of occasions there is a run of 7 consecutive points going in the same direction.

True North Report

Performance Improvement Overview

There are 11 True North objectives set for 26/27 to move us closer to our ambition of achieving excellent patient experience every time. These 11 True North objectives are supported by True North Projects, for which monthly update reports are included in this report.



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

Urgent Emergency Care: Reduce the proportion of Type 1 attendances

Achieve below 28% by March 2027

Urgent Emergency Care: Reduce the number of patients treated in non-designated areas

Ensuring patients accessing urgent and emergency care receive timely assessment. treatment and escalation in the right clinical environment.

Inpatients: Reduce the number of patients treated in non-designated areas

Ensuring all patients receive care in the right place, at the right time, in the right clinical environment- with no corridor care spaces in use

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

Elective: RTT: Increase proportion of patients waiting for first attendance who are waiting under 18 weeks

Achieve 67.1% by March 2027

Community: Increase 2-hour Urgent Community Response Compliance

Achieve over 70%

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

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

Q&S: Increase overall response rate for complaints and concerns

Workforce: Reduce the Monthly Sickness Absence rate

Drive down sickness absences to achieve an annual rate <5% by the end of 2026-27

Finance: Achieve Sustainable Finance

Meet our obligation to deliver the financial plan for 2026/27
NOF OF0081 Variance to plan year-to-date
Measured as YTD financial variance as a % of turnover

True North Report

Objective Status Down Is Good

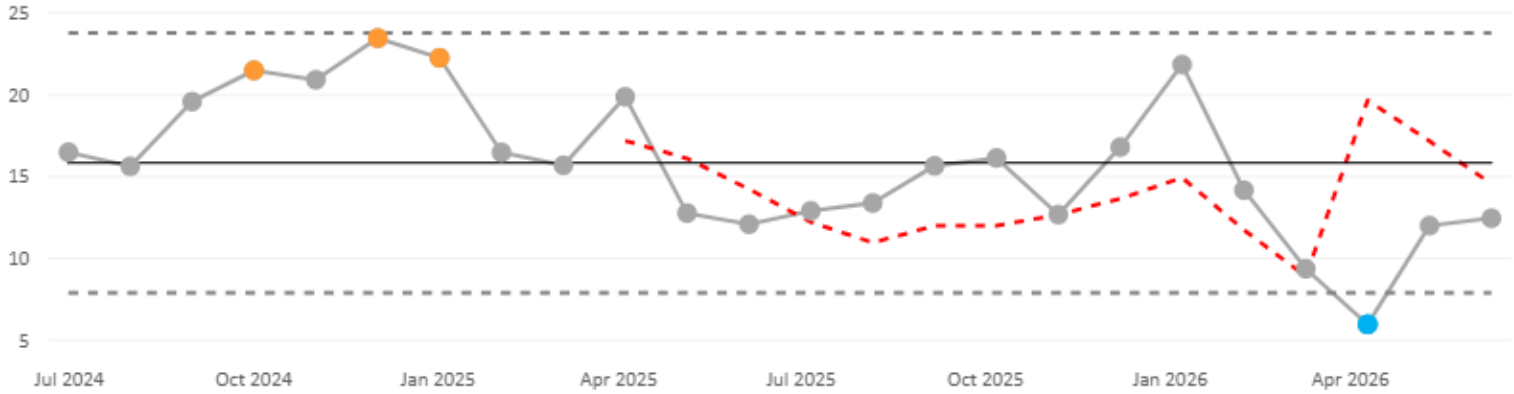
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target Mar 2027
Value	12%	12.9%	13.3%	15.6%	16.1%	12.6%	16.7%	21.8%	14.1%	9.3%	5.9%	12%	12.4%	5%
Trajectory	14.2%	12.2%	10.9%	11.9%	11.9%	12.6%	13.6%	14.9%	11.7%	8.9%	19.6%	17.1%	14.5%	

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 senior presence.
- Monitoring through fortnightly performance meetings and the monthly UEC Board.
- EAU supported a significant reduction in 12 hours delays in ED in April 2026. Ensuring EAU is operating well at both sites is a priority.

What are the current challenges?

- Transition to Nervecentre has caused disruption to processes both in ED and the wider hospital
- Some days with very high attendance levels at each site during June.
- Workforce: capacity, skill mix, absence rates.
- Financial constraints mean limited options for testing new ways of working.

What are we doing about them?

- Workshop in July to prioritise proposed changes to Nervecentre which could increase efficiency.
- Analysis of attendance 'spikes' carried out by NHS England regional team. No particular themes and actions identified, but possible link between attendances and lack of community primary care capacity. Regional team have been made aware.

True North Report

Objective Status — No Trajectory

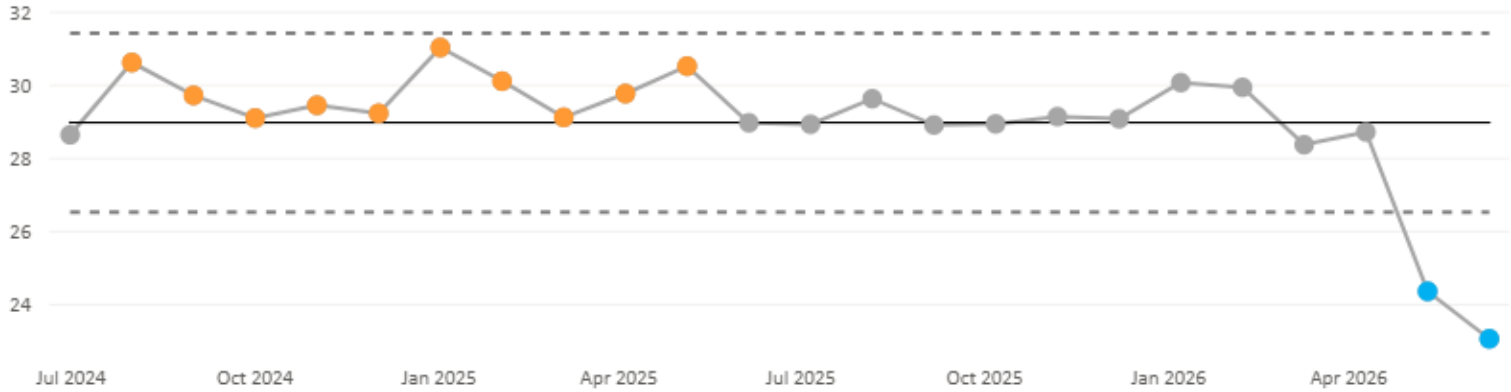
Urgent Emergency Care: Reduce the proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero

Achieve below 28% 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)?

2 found

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

Occurs

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

Does Not Occur

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target Mar 2027
Value	29%	28.9%	29.6%	28.9%	28.9%	29.1%	29.1%	30.1%	29.9%	28.4%	28.7%	24.3%	23%	28%
Trajectory														

What are the organisational risks?

- Extended length of stays contribute to high bed occupancy rates.
- This in turn causes poor flow out of Emergency Departments and Emergency Assessment Units.
- This leads to overcrowded departments and long waits, which are linked to patient harm.
- Corridor care is then necessitated due to lack of appropriate clinical space elsewhere.

How are we managing them?

Note: At the launch of Nervecentre, "inpatient admissions" no longer includes admission to SDEC areas. This explains the significant drop in May 2026.

Close working between frontline clinical teams and site / bed management office to reduce instances of 'blockages' in ED.

Daily UEC huddles taking place with Deputy COO to ensure available workforce is being utilised effectively and that gaps are escalated.

What are the current challenges?

- To ensure the 'new' conversion rate measure remains low, there is a requirement to ensure we have sufficient senior medical staff to cover all areas (ED, EEMAC, EAU) every day with ED, Acute and Geriatricians all essential. This is a challenge with current staffing levels, and the pathways do not run as effectively as they could.

What are we doing about them?

- A business case for additional senior medics is being prepared.
- Seeking mutual aid from other areas, particularly when nursing levels at the front door are insufficient.
- Coming off Corridors project seeks to reduce length of stay across wards, with a focus and additional clinical resource planned in September 2026.

True North Report

Objective Status — No Trajectory

Urgent Emergency Care: Reduce the number of patients treated in non-designated areas

Ensuring patients accessing urgent and emergency care receive timely assessment, treatment and escalation in the right clinical environment, with minimal use of corridor or temporary care spaces.

Lead Director: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy & Emma George

Committee: Resources & Quality

Is there special cause variation?

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

Insufficent data points

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

Insufficent data points

Shift: 7 points in a row, either Ascending or Descending

Insufficent data points

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target Mar 2027
Value													61*	0
Trajectory														

* Average of available daily June 2026 data. The monthly trajectory will populate from September 2026. The trajectory is subject to change as it has been calculated using June 2026 data only

What are the organisational risks?

- Increased risk of patient harm due to delayed assessment, treatment and clinical review in overcrowded urgent and emergency care settings.
- Reduced patient privacy, dignity and experience associated with care in non-designated areas.
- Increased risk for vulnerable patients, including older people, those with frailty, dementia, learning disabilities and mental health needs.
- Staff wellbeing, morale and retention risks associated with delivering care in sustained periods of operational pressure.
- Reputational, regulatory and compliance risks associated with corridor care and emergency department overcrowding.

How are we managing them?

- Executive-led **Coming Off Corridors** programme with daily operational oversight and escalation.
- Enhanced clinical risk assessment, senior decision-making and safety huddles during periods of crowding.
- Dynamic demand and capacity management across urgent, emergency and acute pathways.
- Strengthened escalation processes and system-wide working to improve flow and reduce delays.
- Continuous monitoring of patient safety incidents, complaints, harms and patient experience associated with corridor care.

What are the current challenges?

- Sustained growth in urgent and emergency care attendances and admissions.
- Delays in patient flow through the emergency pathway resulting from constraints across the wider health and care system.
- High ambulance arrivals and periods of significant emergency department crowding.
- Workforce pressures during peak demand and escalation periods.
- Balancing patient safety, quality of care and flow during sustained operational pressure.

What are we doing about them?

- Delivering the Trust-wide Coming Off Corridors improvement programme to eliminate corridor care across urgent and emergency care services.
- Improving same-day emergency care, rapid assessment and streaming processes to reduce crowding.
- Strengthening discharge pathways and collaboration with community, primary care and social care partners to improve flow.
- Expanding use of data and escalation triggers to support proactive capacity management.
- Embedding learning from patient feedback, incidents and staff experience to drive continuous improvement and assurance through Trust governance structures.

True North Report

Objective Status — No Trajectory

Inpatients: Reduce the number of patients treated in non-designated areas

Ensuring all patients receive care in the right place, at the right time, in the right clinical environment- with no corridor care spaces in use

Lead Director: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy & Emma George

Committee: Resources & Quality

Is there special cause variation?

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

Insufficent data points

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

Insufficent data points

Shift: 7 points in a row, either Ascending or Descending

Insufficent data points

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target Mar 2027
Value													22*	0
Trajectory														

* Average of available daily June 2026 data. The monthly trajectory will populate from September 2026. The trajectory is subject to change as it has been calculated using June 2026 data only

What are the organisational risks?

- Increased risk of patient harm due to delayed assessment, treatment, observation and escalation in non-designated care areas.
- Reduced patient privacy, dignity and overall experience.
- Increased clinical risk for vulnerable patients, including those with frailty, dementia, learning disabilities and complex needs.
- Staff wellbeing, moral distress and retention risks associated with delivering care in unsuitable environments.
- Reputational, regulatory and compliance risks associated with sustained use of non-designated care areas.

How are we managing them?

- Executive-led "Coming Off Corridors" programme with daily operational oversight and escalation processes.
- Risk-assessed use of escalation areas supported by enhanced clinical oversight, safety huddles and regular review of patient placement.
- Dynamic bed management, discharge optimisation and system-wide escalation arrangements to improve patient flow.
- Monitoring of patient safety incidents, complaints, harms and experience feedback associated with corridor care.

What are the current challenges?

- Sustained demand for urgent and emergency care alongside high inpatient occupancy and prolonged length of stays
- Delays in patient flow caused by discharge challenges and limited availability of community and social care capacity.
- Workforce pressures during periods of peak demand.
- Limited physical estate capacity and lack of flexibility within existing inpatient areas.
- Balancing patient safety, quality and flow during periods of operational escalation.

What are we doing about them?

- Delivering the Trust-wide "Coming Off Corridors" improvement programme to eliminate corridor care and reduce the use of non-designated care areas.
- Strengthening discharge pathways and collaboration with community, primary care and social care partners to improve flow.
- Expanding use of data and escalation triggers to enable earlier intervention and proactive management of capacity.
- Reviewing estate utilisation and exploring opportunities to increase safe clinical capacity.
- Embedding learning from incidents, patient feedback and staff experience to drive continuous improvement and assure progress through Trust governance structures.

True North Report

Objective Status Up Is Good

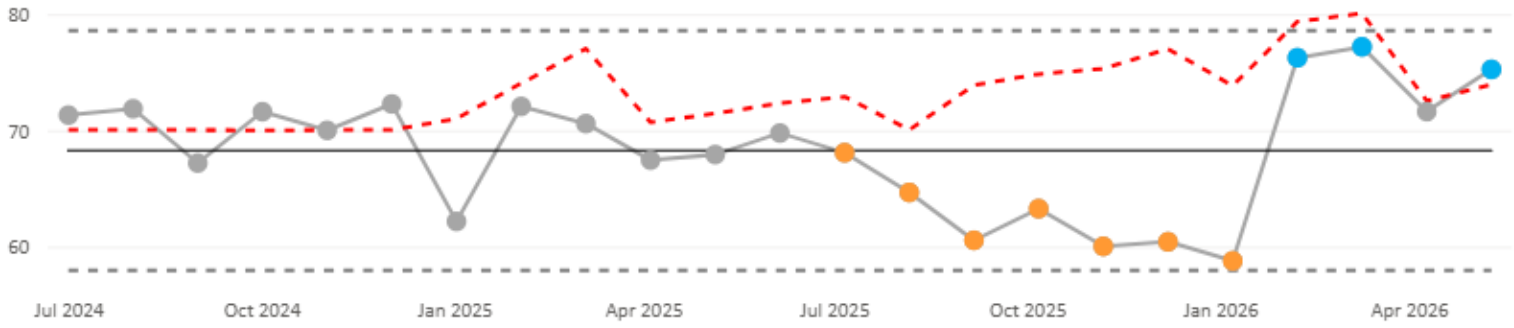
Elective: Cancer: Improve the Faster Diagnosis Standard

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?

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	67.9%	69.8%	68.1%	64.7%	60.6%	63.3%	60%	60.4%	58.8%	76.2%	77.2%	71.6%	75.2%	84.3%
Trajectory	71.4%	72.3%	72.9%	70%	73.9%	74.8%	75.3%	77%	73.8%	79.3%	80.1%	72.5%	73.9%	

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?

- Bi-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
- Fortnightly diagnostic improvement meeting with modalities
- Delivery of the cancer actions

What are the current challenges?

- Skin, 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 endoscopy and imaging
- Increase in suspected cancer referrals in 26/27 above planned levels.
- Histopathology delays in reporting

What are we doing about them?

- Continued prioritisation of cancer activity in Q1 26/27.
- 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 commenced June 2026
- Ongoing support around PTL management with additional weekly meeting to review thematic issues by tumour site.
- Review of impact of histopathology action plan on improved turnaround time

True North Report

Objective Status Up Is Good

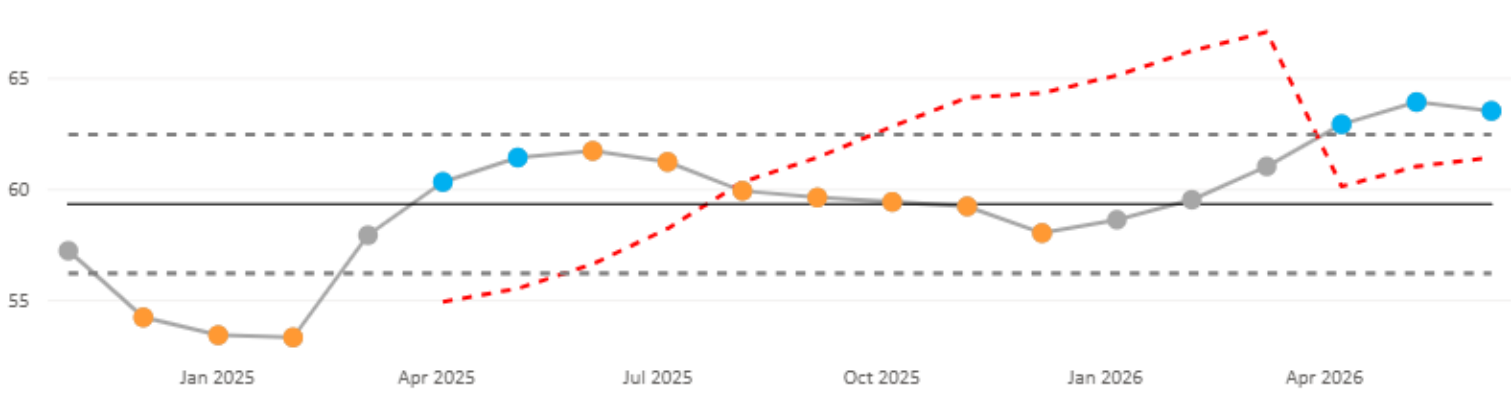
Elective: RTT: Increase proportion of patients waiting for first attendance who are waiting under 18 weeks

Achieve 67.1% 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)?

6 found

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

Occurs

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

Occurs

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target Mar 2027
Value	61.7%	61.2%	59.9%	59.6%	59.4%	59.2%	58%	58.6%	59.5%	61%	62.9%	63.9%	63.5%	67.1%
Trajectory	56.6%	58.2%	60.3%	61.4%	62.8%	64.1%	64.3%	65.1%	66.2%	67.1%	60.1%	61%	61.4%	

What are the organisational risks?

- Growth in RTT TWL and deterioration in RTT 18-week performance
- Increased likelihood of growth in 52week cohort
- Clinical deterioration prior to assessment
- Increased risk of emergency presentation
- Reduced productivity due to increased validation and PTL management requirement
- Increase in complaints and deterioration in the patient's experienced
- Regulatory risk of non delivery of 26/27 planned RTT improvement trajectories

How are we managing them?

- Non recurrent increase in outpatient capacity
- Recurrent capacity increase through template standardisation and manage N:FU rato's
- Monitoring of RTT success measures through weekly elective recovery meeting, fortnightly activity and performance meeting and monthly RTT delivery board
- Clinical triage of referrals so prioritisation us based on clinical risk
- PTL validation processes and maintain DQ monitoring using the LUNA methodology

What are the current challenges?

- Continued growth of GP referrals (5% 26/27 YTD increase from same period in 25/26)
- Delivery of 1st OP planned activity
- Workforce vulnerabilities to deliver planned capacity
- Large overdue follow up backlog
- Booking and scheduling processes, late notice capacity reduce effectiveness of chronological booking
- Delays in capital schemes to deliver additional capacity

What are we doing about them?

- Implementation and roll out of Single Point of Access
- Delivery of outpatient productivity schemes (reduce DNA, standardise templates, OP utilisation, PIFU and reduction in N:FU ratio) to increase first OP capacity
- Implement additional targeted non recurrent capacity
- Work with ICB to reduce GP demand back to 26/27 planned levels.
- Targeted waiting list validation

True North Report

Objective Status Up Is Good

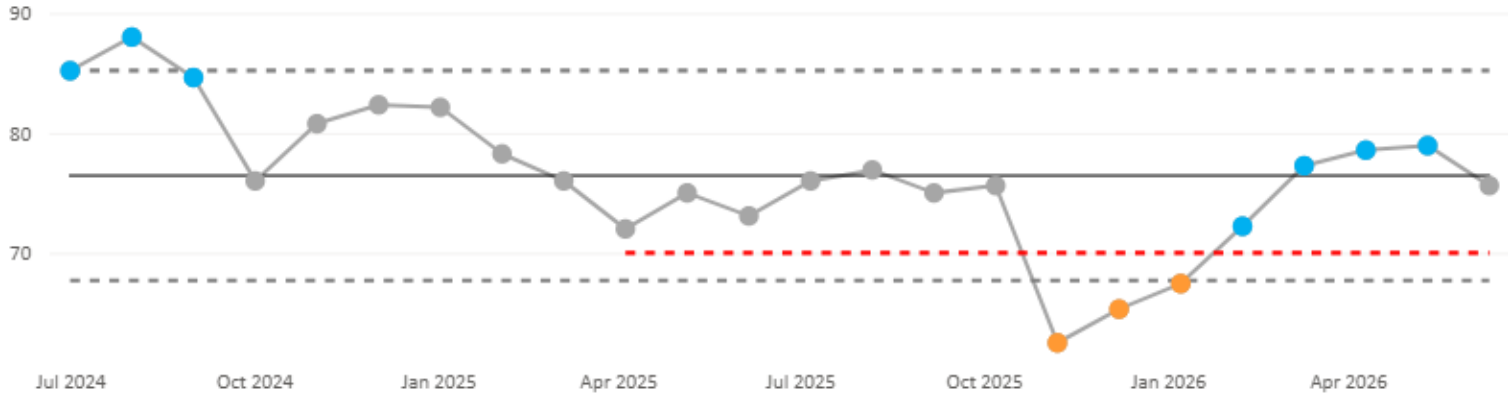
Community: Increase 2-hour Urgent Community Response Compliance

Achieve over 70%

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?

Does Not Occur

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

Occurs

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Target Mar 2027
Value	73.1%	76%	76.9%	75%	75.6%	62.5%	65.3%	67.4%	72.2%	77.3%	78.6%	79%	75.6%	70%
Trajectory	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	

What are the organisational risks?

- Demand out strips the available capacity
- Reduced confidence in service
- Attendance to the ED department
- Failure to achieve the minimum 70% target

How are we managing them?

- Work in partnership with key community providers to maximise capacity available
- Co location with other key providers to maximise speed in communication and decision making
- Validation start clocks are correct
- Staff training on start and stop clocks

What are the current challenges?

- When referrals come in as a cluster difficult managing the demands
- Geographical spread can make the allocation of visits more difficult

What are we doing about them?

- We are creating a case for change for a new community model this will see a shift in resource to home based teams and address the geographical challenges

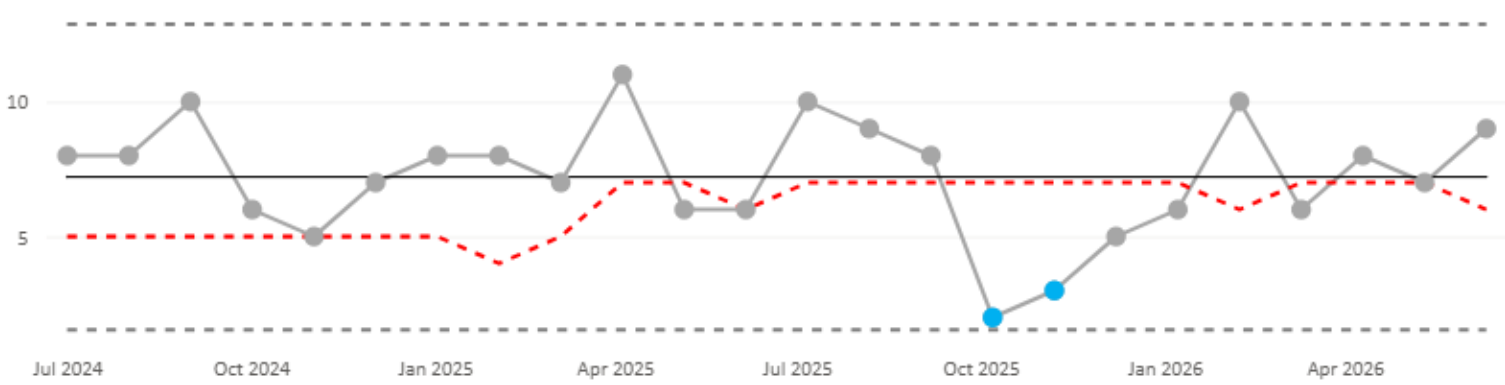
True North Report

Objective Status — Down Is Good

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

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

Lead Director: Joe Hague
Operational Lead: Sue 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

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

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 priority.
- 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 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.
- Progress against improvement plan reported via IPSAG, PSCE and quality committee

True North Report

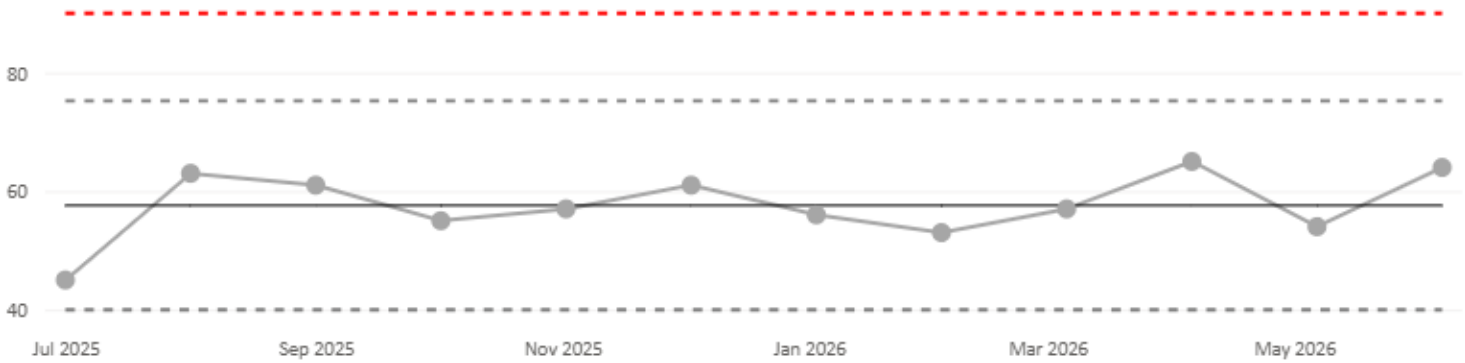
Objective Status Down Is Good

Q&S: Increase overall response rate for complaints and concerns

Lead Director: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy

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

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26		Target Mar 2027
Value	45%	63%	61%	55%	57%	61%	56%	53%	57%	65%	54%	64%		90%
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		

What are the organisational Risks ?

- Growth in numbers of complaints and concerns received and challenge of providing responses in a timely way
- Delayed organisational learning from patient feedback, impacting the pace of quality improvement
- Reduced public confidence and patient trust if concerns are not responded to in a timely manner
- Reputational and regulatory risk should response timeliness continue to remain below expected standards (currently 64%)

How are we managing them?

- Executive enhanced monitoring and escalation of overdue complaints through monthly Care Group Performance Reviews
- Clear accountability through Care Group leadership teams for delivery of response standards
- Reviewing complaint handling capacity within services experiencing highest demand
- Targeted review of services with persistent underperformance

What are the current challenges?

- Growth of complaint and concerns received of 81.77% (for the period April – June 2025 vs 2026).
- Demand continues to exceed available investigation and response capacity in some services.
- Variability in performance across Care Groups, resulting in inconsistent delivery of the Trust standard.
- Delays in obtaining clinical information and multi-disciplinary contributions to support high-quality responses.
- Balancing timeliness of responses with the requirement to undertake comprehensive investigations and provide meaningful learning.

What are we doing about them?

- Enhanced monitoring and escalation of overdue complaints.
- Implementing focused recovery plans with underperforming areas
- Strengthened Care Group accountability through monthly performance review
- Capacity and process review to improve response timeliness
- Streamlining investigation and responses processes to reduce unwarranted delays
- Using complaint themes and learning to reduce repeat concerns.
- Monitoring improvement trajectory monthly to assess whether current interventions are delivering output

True North Report

Objective Status — Down Is Good

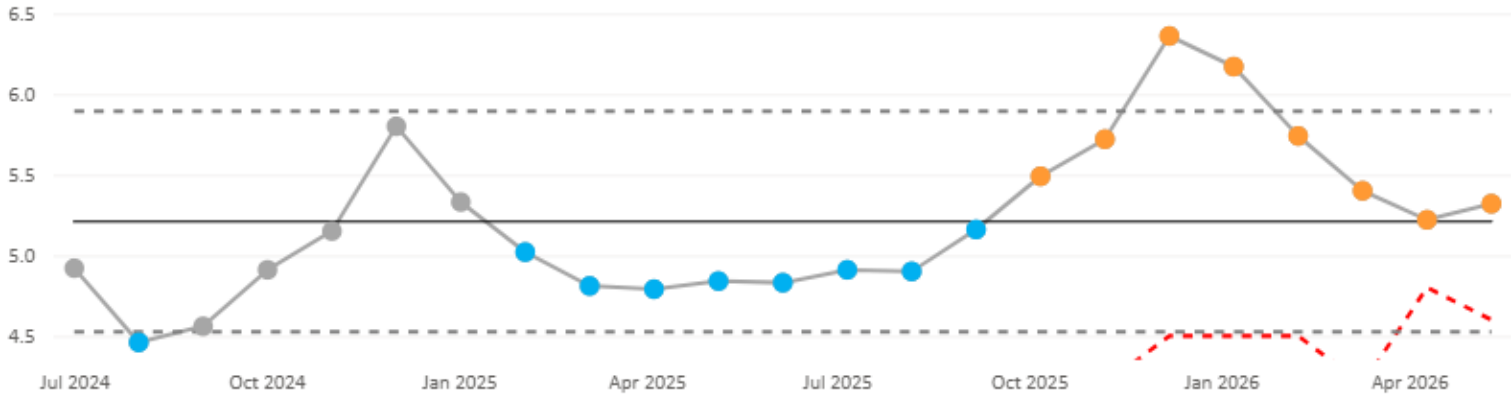
Workforce: Reduce the Monthly Sickness Absence rate

Drive down sickness absences to achieve an annual rate <5% by the end of 2026-27.

Lead Director: Lydia Larcum

Operational Lead: Nic English

Committee: Resources



Is there special cause variation?

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

3 found

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

Occurs

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

Does Not Occur

	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	4.8%	4.8%	4.9%	4.9%	5.2%	5.5%	5.7%	6.4%	6.2%	5.7%	5.4%	5.2%	5.3%	4.7%
Trajectory	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%	4.5%	4.5%	4.5%	4.2%	4.8%	4.6%	

What are the organisational risks?

- Increased workload pressures on remaining colleagues.
- Delays to diagnostics, treatment, and patient pathways.
- Increased temporary staffing costs and reduced financial flexibility.
- Reduced productivity and operational performance.
- Higher risk to quality, safety, and patient experience.
- Increased turnover, burnout, and workforce instability.

How are we managing them?

- Daily safe staffing reviews and workforce redeployment.
- Increased leadership visibility and colleague support.
- Enhanced wellbeing support and early intervention.
- Robust performance and workforce governance.
- Controlled temporary staffing expenditure and utilisation.

What are the current challenges?

- High levels of mental health-related absence.
- Persistent long-term sickness absence.
- Disproportionately high absence in Support Worker and Estates & Ancillary groups.
- Workload pressures and wellbeing impacts on remaining colleagues.

What are we doing about them?

- Consistent application of absence management procedures.
- Targeted plans for high-absence services.
- Manager training on attendance management.
- Partnership working with Trade Unions to strengthen attendance policies.
- Quality Improvement to address absence drivers.
- Refreshed Colleague Experience Improvement Plan.
- Culture change through values and behaviours work.

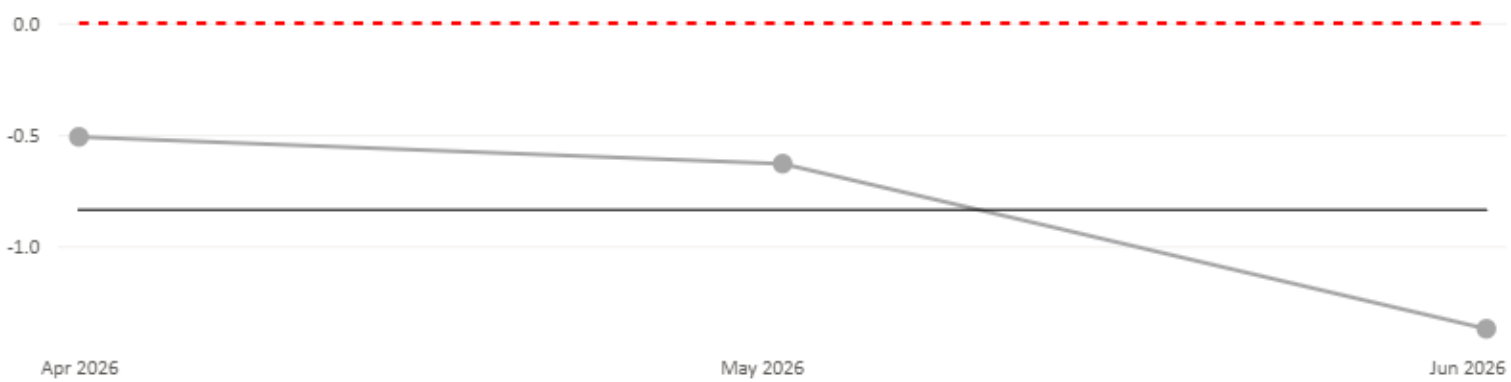
True North Report

Objective Status | Up Is Good

Finance: Achieve Sustainable Finance

Meet our obligation to deliver the financial plan for 2026/27
NOF OF0081 Variance to plan year-to-date
Measured as YTD financial variance as a % of turnover

Lead Director: Andrew Bertram
Operational Lead: Sarah Barrow
Committee: Resources



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

	Apr-26	May-26	Jun-26
Value	-0.5%	-0.6%	-1.4%
Trajectory	0%	0%	0%

Target Mar 2027
0%

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.
- **Cash Position** - deterioration in the Trust's cash position may require cash support from October 2027.

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 opportunities to be built into overall WRAP programme.

What are the current challenges?

- In May WRAP delivery falls £3.5m short of the YTD target.
- There is currently a planning gap of £2.3m (3.7% of overall target)
- £5m WRAP plans are High-Risk and £18m 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 phase of our EPR programme, which includes observations, clinical documentation for inpatients, urgent & emergency care, electronic prescribing & medicine administration, bed management and read-only diagnostic results, was successfully implemented in May 2026.
- Planning for the second phase (Tranche 2), which will implement Nervecentre Investigations for use by UEC and inpatient staff, is progressing at pace and is expected to go live in late August 2026.
- Tranche 2 will introduce the ability to order pathology and radiology investigations within Nervecentre for urgent and emergency care and inpatient services. This means that staff already using Nervecentre in their day-to-day role will no longer need to go to CPD to order tests and acknowledge test results, improving workflows.
- Tranche 2 user acceptance testing is underway, and staff training will commence during week commencing 13 July.
- Planning for Tranche 3, which is expected to go live in June 2027, is being progressed in parallel. The team are working towards a key design milestone which is due in September 2026.

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 to appoint a strategic partner to support us in developing our Quality Management System and our method of continuous quality improvement.
- The tender process has now concluded with the contract being awarded to a partnership between Catalysis, Royal Berkshire NHS Foundation Trust and KPMG. Catalysis and KPMG have worked in partnership with over 20 trusts in the UK and a further 9 in North America, to embed a successful quality management system and continuous quality improvement approach.
- Planning for an onsite start in August 2026 has commenced.
- 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. 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	£ 14,424,895
Delivered	£ 23,979,717	£ 10,889,898
Variance	**-£ 37,660,282**	**-£ 3,534,997**
Addititional Plans to be delivered		
Planned Low Risk	£ 12,063,088	£ 620,911
Planned Medium Risk	£ 18,184,793	£ 1,016,060
Planned High Risk	£ 5,096,989	£ 65,679
Total Additional Plans	**£ 35,344,870**	**£ 1,702,650**
(Planning Gap)/Over delivery	**-£ 2,315,411**	**-£ 1,832,347**

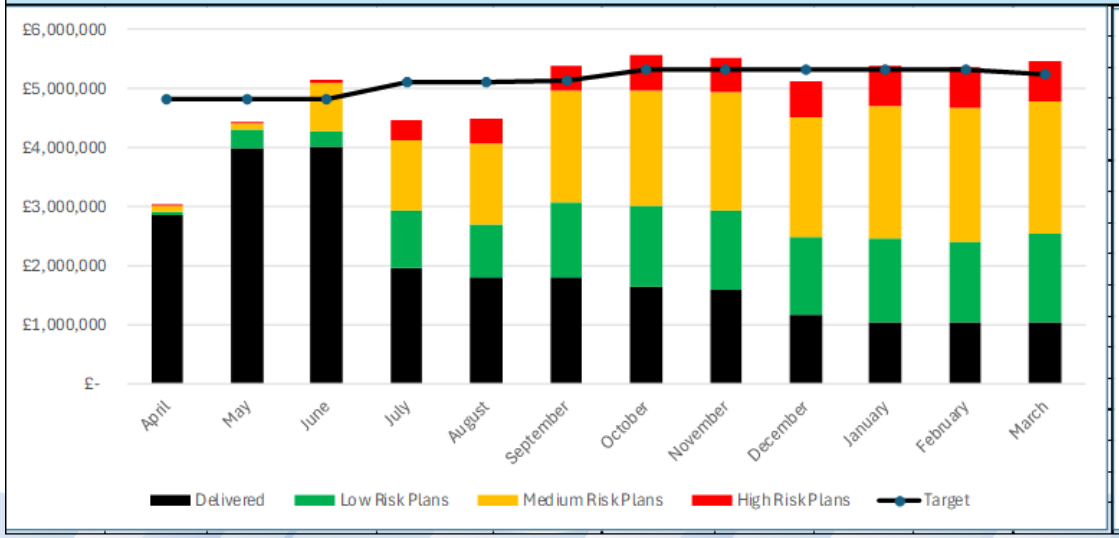
WTE Plan	194.20	**WTE Delivered**	59.39

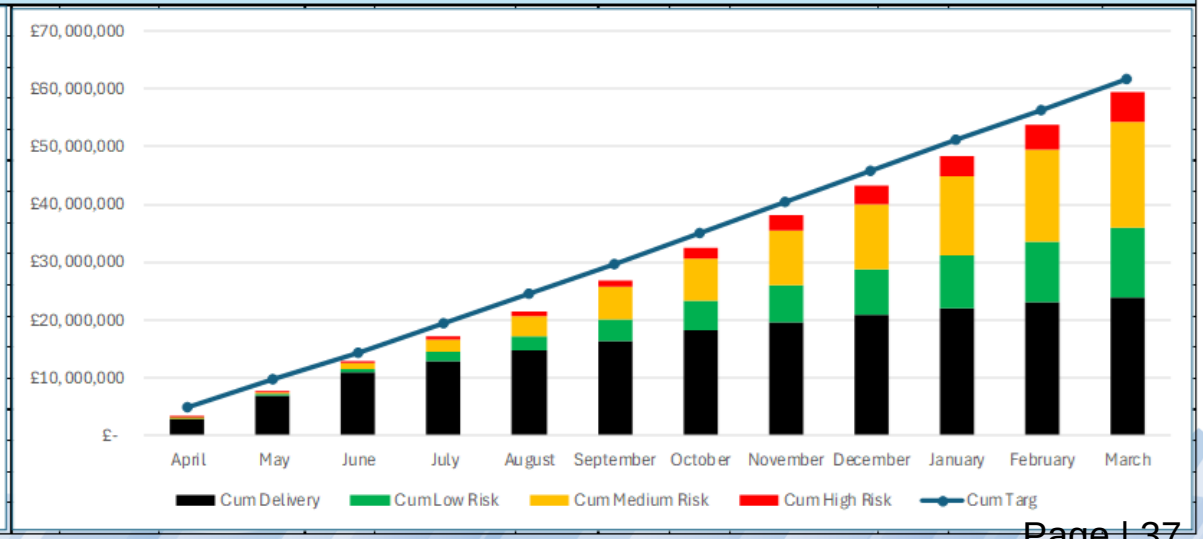
Scheme Governance

Total Number of Live Schemes						**146**			
EQIA Outstanding						42	29%		
Pre-Pipeline						32	22%		
Opportunity						14	10%		
Plan in Progress						11	8%		
Fully Developed						89	61%		
	Plans	**%**	**Delivered**	**%**		**Plans**	**%**	**Delivered**	**%**
Recurrent	£ 39,361,501	64%	£ 17,215,485	28%	**Pay**	£ 26,296,164	43%	£ 8,260,699	13%
Non Recurrent	£ 19,963,087	32%	£ 6,764,232	11%	**Non Pay**	£ 32,713,061	53%	£ 15,499,655	25%
Total	**£ 59,324,587**	96%	**£ 23,979,717**	39%	**Income**	£ 315,363	1%	£ 219,363	0%
					Total	**£ 59,324,587**		**£ 23,979,717**	

YTD Period Name	June 2026

In Year Plan Profile





Report to:	Board of Directors
Date of Meeting:	29 July 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 – July 2026

1. I have continued to visit various wards and services at Scarborough and York Hospitals including a 90-minute visit to the York Maternity ward, delivery suite and triage facility. Through conversations with colleagues during these visits and 121s, I pick up valuable insight and issues which I share with the Chief Executive as appropriate.

2. Since the previous Board meeting, I have had a detailed briefing about the position of the Trust's Waste Reduction & Productivity Programme.

3. I have undertaken my appraisal with the Chief Executive regarding her work and impact for the period November to March and confirmed her objectives for 2026/27. I will report further at the next meeting of the Trust's Remuneration Committee next month.

4. I was a panel member which carried out the interviews of the three shortlisted candidates for the position of Chief Culture & People Officer. A job offer has been made.

5. An excellent Member/Governor Constituency meeting for the York Constituency took place on 16th July. 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 Ros Shaw, an elected locality Governor for attending the meeting with me, along with Jim Cannon who is a York based voluntary sector stakeholder Governor. This was the second of this year's Constituency meetings. The next one is Selby on 13th August.

6. With Clare Smith, Chief Executive, I attended the North East & Yorkshire Leadership Event organised by NHS England. The key message I came away with was the need to develop new ways of doing things to lead to sustainable improvements and to ensure that at least 66% of colleagues have a flu vaccination.

Martin Barkley
Trust Chair

Report to:	Board of Directors
Date of Meeting:	29 July 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

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☒ 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:

- Malton Hospital fire and restoration of services.
- Financial position and 2026/27 planning.
- Resident doctors' pay agreement and consultant industrial action ballot.
- Nervecentre Electronic Patient Record Programme (Tranche 2).
- The publication of Baroness Amos' Independent National Maternity and Neonatal Investigation.
- Protecting patient confidentiality.

- NHS England's minimum standards for the elective patient experience.
- New NHS Staff Standards.
- Engagement on the future of health and care services in Bridlington.
- Chief Culture and People Officer appointed.
- June 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. Malton Hospital fire and restoration of services

Earlier this month, we experienced a significant incident following a fire in the Springwood Unit on the Malton Hospital site. The Springwood Unit is operated by Tees, Esk and Wear Valleys NHS Foundation Trust. Although the fire was not within Malton Hospital itself, its proximity required the full evacuation of our services as a precaution.

I am pleased to report that all patients, visitors and colleagues were safely evacuated, with no injuries. Following comprehensive safety checks and a phased restoration, all services at Malton Hospital have now returned to normal operation.

The incident demonstrated the professionalism, commitment and compassion of colleagues across our Trust. They responded quickly and calmly in challenging circumstances, ensuring patients remained safe and well cared for throughout. However, it should be recognised that this incident was a frightening experience for many of our colleagues and has impacted them.

I would also like to thank North Yorkshire Fire and Rescue Service, our partner organisations and the local community for their outstanding support. In particular, Malton School provided immediate assistance by accommodating patients during the evacuation, reflecting the strength of partnership working across our communities.

As with any significant incident, we will review our response and identify learning that will further strengthen our emergency preparedness. I would like to record my sincere thanks to everyone who contributed to the response and subsequent restoration of services. The way colleagues and partners worked together under pressure was a powerful demonstration of our values in action.

2. Planning update

We continue to engage with national and regional NHS England colleagues regarding our financial plan. The expectation remains that we deliver the plan approved by the Board of Directors while these discussions continue, and we await formal confirmation of the final planning position.

The plan as agreed by the Board for 2026/27 states that we will spend approximately £900 million this year while also delivering £62 million of savings but will finish the year with a £22m deficit. Achieving this will require significant improvements in productivity, careful management of expenditure and delivery of our agreed workforce plans.

The Trust has signed its contract with Humber and North Yorkshire ICB, however the overall plan has not been agreed. This is the first time the Trust has been unable to agree its annual plan with NHS England this far into the financial year which reflects the level of complexity and challenge the organisation is working through. We also await confirmation of whether any further action will be required this year, recognising the need to deliver a balanced financial position by 2028/29.

Colleagues across the organisation are already making a significant contribution through our Waste Reduction and Productivity (WRAP) programme, and I remain grateful for their

continued efforts. We must now build on this work and maintain a strong focus on making the best possible use of the resources available to us.

To support delivery of the plan and prevent the Trust falling further behind its financial trajectory, we have further strengthened our financial controls, including a more rigorous approach to vacancy management. It should be stressed that Recruitment decisions will continue to balance the need to maintain safe, high-quality services with the requirement to live within the resources available to the Trust. Additionally we are receiving support from NHSE through the Challenged Provider Programme who have assisted us in identifying two colleagues to join us for a period of time to support us in achieving our financial commitments.

3. Resident doctors' agreement and consultant ballot outcome

The national industrial relations landscape has continued to evolve over the past month.

Resident doctors have voted to accept the Government's pay offer, ending the period of industrial action by the British Medical Association's Resident Doctors Committee. The agreement includes a pay settlement and reforms to the resident doctor pay structure, alongside the Government's commitment to increase the number of training places in future years.

At the same time, consultant members of the BMA in England have voted in favour of industrial action over pay and pensions, providing the Association with a mandate for industrial action over the next 12 months. No dates have been announced. We will continue to monitor the national position and work with partners to ensure we are well prepared should any industrial action be called.

4. Nervecentre Tranche 2

Following the successful implementation of Tranche 1 of our Nervecentre Electronic Patient Record programme, we have confirmed the planned go-live date for Tranche 2 as the week commencing 24 August 2026.

This next phase will introduce pathology and radiology requesting through Nervecentre for urgent and emergency care and inpatient services, representing another important step in our digital transformation programme.

The experience of implementing Tranche 1 has provided valuable learning, which has informed our planning and approach to this next phase. Comprehensive training and support are now in place to ensure colleagues are well prepared and to support a safe and successful implementation.

5. Independent Maternity and Neonatal Investigations published

Earlier this month, the Independent National Maternity and Neonatal Investigation, led by Baroness Amos, was published. This followed the publication of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust at the end of June.

Both reports make for difficult reading and provide a powerful reminder of the importance of continually improving the care we provide for women, babies and their families. There are recommendations detailed in both reports aimed at driving long-term improvements across maternity and neonatal services nationally, with NHS England describing this as a potential turning point for maternity and neonatal care.

We will carefully consider each of the recommendations, assess our services honestly against them and take action wherever improvements are needed. Our response will be considered through the Executive Committee and Board to ensure appropriate oversight and accountability.

We will also continue to listen to the experiences of women and families and use those insights to inform our ongoing improvement work, alongside our existing maternity and neonatal quality and safety programmes.

At the same time, it is important to recognise the professionalism, compassion and commitment shown every day by our maternity and neonatal colleagues. They are dedicated to providing safe, high-quality care for every family they support, and I would like to thank them for their continued commitment to our patients and communities.

6. Protecting patient confidentiality

Earlier this month, we received a letter from Sir Jim Mackey, Chief Executive of NHS England, reinforcing the importance of protecting patient confidentiality following recent national concerns about the unlawful access of patient records.

The letter reminds all NHS colleagues that they have a professional and legal responsibility to access patient information only where there is a legitimate work-related reason to do so. Maintaining the trust our patients place in us to protect their personal and sensitive information is fundamental to the care we provide.

The overwhelming majority of colleagues handle patient information with professionalism and integrity every day, and I would like to thank them for their continued commitment to maintaining the highest standards of confidentiality.

We will continue to ensure that colleagues understand their responsibilities and the serious consequences of inappropriate access. Accessing patient records without a legitimate reason is a breach of confidentiality, Trust policy and the law. It can cause significant distress to patients, undermine public confidence in the NHS and may result in disciplinary action, referral to a professional regulator or criminal prosecution.

7. Minimum standards of patient experience

NHS England has published new minimum standards for the experience of patients waiting for elective care.

The standards set out the minimum level of communication and information that every patient should expect, from the point at which their referral is accepted through to the

completion of their care. They reinforce the commitment within the Elective Reform Plan to improve the experience of patients while they wait for treatment.

The guidance places clear responsibility on trust boards to assess current performance against the standards, identify any gaps and demonstrate how improvements will be delivered. NHS England has also asked boards to publish a statement setting out their approach to meeting the standards and to report annually on progress.

We will undertake a gap analysis against both the new minimum standards and the wider Elective Reform Plan to understand where further improvements may be required. We will also review how best to incorporate these expectations into our performance framework, so that patient experience, alongside operational performance, can be monitored consistently by specialty and site. This will provide the Board with appropriate assurance as improvements are implemented.

8. New NHS Staff Standards

The 10 Year Health Plan set out a commitment to developing a new set of staff standards, outlining minimum standards for employment across a range of areas in order to improve colleague experience. These new have now been launched, setting out a national framework to help ensure colleagues across the NHS have a fair, consistent and positive experience at work.

The standards cover a number of important areas, including health and wellbeing, flexible working, line management, tackling racism, violence prevention and championing sexual safety.

Improving colleague experience is incredibly important and is one of the priorities I identified through my First 100 Days conversations. We are considering what these new standards mean for us and how they align with the work we are already doing, particularly our Big Conversation and how we re-engage colleagues with our values.

The new standards will be an important component in making our Trust a place where everyone feels valued, supported and able to thrive.

9. Bridlington community engagement

As outlined in my report last month, East Riding of Yorkshire Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee considered proposals relating to the planned closure of the Bridlington Care Unit and made a number of recommendations.

A programme of public engagement has been launched to support our response to the recommendations, including community events taking place later this month at Bridlington Spa. These events will provide opportunities for local people, colleagues, patients and partner organisations to hear more about the proposals, ask questions and share their views. A public survey will ensure that those unable to attend in person can also contribute.

The feedback received will help shape the future development of health and care services in Bridlington and inform the next stages of this work. Our priority remains to provide safe,

sustainable and high-quality services that meet the needs of local people, both now and in the future.

10. Chief Culture and People Officer appointed

I am delighted to share that we have successfully recruited our new Chief Culture and People Officer.

At the time of writing we are not quite in a position to be able to share further details, but what I can say is that they will be an excellent addition to our team, bringing significant experience and offering strong leadership in strengthening how we listen, how we support colleagues to speak up safely, and how we build a workplace where everyone feels able to contribute and succeed.

I will share details as soon as I can. In the meantime, I would like to thank Lydia Larcum, Deputy Director of Workforce, who has done a fantastic job covering the Executive role on an interim basis, and who will continue to do so until our new appointee is in post.

11. Star Award nominations

Our monthly Star Awards provide an opportunity for patients and colleagues to recognise individuals and teams who have made a difference by demonstrating our values of kindness, openness and excellence. It is encouraging to see the consistently high number of nominations received each month, and I know how much colleagues appreciate it when someone takes the time to recognise their contribution. June's nominations are included at **Appendix 1**.

Date: 29 July 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

June 2026

Sophie Cundall, Sister **Scarborough** **Nominated by colleague**

Sophie has been instrumental in the effective rollout of Nervecentre within Maple Ward. Supporting both nursing and medical colleagues. I have had many people come to me and say how amazing she has been during this change, including a 'Great-ix' highlighting Sophie's engagement with the rollout of Nervecentre. Sophie actively engaged in the early stages by using the play environment to better understand how the rollout would affect her team. Sophie ensured nursing staff completed their training and consolidation modules prior to roll-out.

During rollout, Sophie actively engaged with the floor workers to refine the 'Live Flow' options to give better visibility for patients awaiting admission to Maple Ward. This was vital to ensure that patients were visible to the team on Maple and could be prioritised. Sophie's positive, can-do attitude and constructive challenge have ensured that staff have embraced the opportunities that Nervecentre will ultimately bring.

Sophie is a real champion of innovation and brings the best out of the people she works alongside. This ensures that patients are at the centre of everything Maple Ward does.

Stuart Wilkinson, Production Team Leader, Lyn Hugh, Retail Catering Supervisor, Sonny Pasco, Patient Catering Supervisor, and Claire Sturdy, Patient Catering Supervisor **York** **Nominated by colleague**

We would like to nominate and submit a Star Award for Stuart, Lyn, Sonny, and Claire for your exceptional support to Jenny and me over the weekend in relation to food and beverage provision for colleagues supporting the Electronic Patient Records rollout.

With a significant number of colleagues requiring support, your responsiveness, flexibility and commitment made a real difference. You were instrumental in adapting the service model at pace to ensure hot food was available wherever feasible, both during the day and throughout the night shifts. This was achieved despite the added challenge of a gas failure, which could easily have disrupted provision; instead, by drawing on your collective expertise across retail, patient catering, and production, and being creative with what was available in stores, you developed a thoughtful and effective alternative offer. Importantly, this ensured that night colleagues were not disadvantaged and continued to receive a high-quality service.

Your collaborative approach and willingness to go above and beyond ensured an improved and consistent offer for all staff at a critical time. This level of teamwork and problem-solving is greatly appreciated and reflects the very best of our service.

Raegan Humphrey-Smith, Maternity Support Worker and Charlotte Birley, Maternity Support Worker | **Scarborough** | **Nominated by colleague**

I would like to nominate Charlotte and Raegan, for a Star Award in recognition of the incredible support, dedication, and professionalism they consistently show to both patients and staff.

From the moment I joined the team as a student midwife, they went out of their way to help and support me. They immediately made me feel welcome, approachable, and included, taking me under their wing and helping me build my confidence within the department. They have been invaluable in helping me practice, learn, and settle into my role, always making time to answer questions and offer guidance no matter how busy the unit is.

They are an absolutely vital part of the ADAU team and play a huge role in keeping everything running smoothly and efficiently every single day. Their organisation, teamwork, and ability to stay calm under pressure are exceptional, and the department simply would not function as effectively without them. They are also incredibly caring and compassionate with the pregnant women attending the unit. They treat every patient with kindness, dignity, and reassurance, helping women feel safe, comfortable, and supported during what can often be a stressful or worrying time. Their friendly and approachable nature has a hugely positive impact on both staff morale and patient experience.

They consistently go above and beyond, always willing to help others and support the wider team wherever needed. They truly embody the values of the NHS and are extremely deserving of recognition for the outstanding contribution they make to ADAU every day.

Helen Williams, Lead Nurse, Jason Wilshire, Head of Medical Engineering, Darren Carmichael, Equipment Library Lead, Andy Mayes, Equipment Library Technical Operative, and Andrew McCauley, Equipment Library Supervisor	**Scarborough**	**Nominated by colleague**

I would like to nominate these individuals for a Star Award in recognition of their exceptional dedication and commitment to improving patient care.

Working tirelessly behind the scenes, they have driven a significant improvement initiative that has had a direct impact on clinical environments. Most notably, they successfully coordinated and delivered a large-scale project at the Scarborough site, where over 300 mattresses were removed, upgraded, and safely returned to use within the clinical setting. This achievement required meticulous planning, strong collaboration, and effective teamwork across multiple departments. Despite challenges, including working with difficult providers, they remained focused, professional throughout. Their ability to organise, lead, and deliver such a complex piece of work demonstrates not only their expertise but also their unwavering commitment.

They consistently embody the Trust's values, maintaining a positive attitude and supporting those around them to ensure successful outcomes. Their efforts have made a significant impact on patient care, underpinned by effective collaboration across numerous teams, and they are highly deserving of this recognition.

Gemma Stewart, Antenatal Unit Receptionist/Clerical Officer | **Scarborough** | **Nominated by colleague**

Gemma is an invaluable member of the team. Her knowledge and skills supporting, in particular, the joint Diabetes/Antenatal service are second to none, and she consistently works above and beyond her role to ensure women are reviewed in a timely fashion. Gemma will also challenge appropriately when necessary if this is not being achieved.

The reason for this nomination is an example of Gemma's dedication to providing excellent patient-facing care. A new referral was received into the department for a young woman new to the service. On reading the referral, Gemma escalated concerns, without delay, as she identified the patient had a new diagnosis of diabetes and required an immediate review. Gemma's actions in doing this enabled the diabetes team to contact the patient on the same day the referral was received. The team were able to initiate the appropriate treatment for the patient and offer much-needed support and guidance without delay.

Gemma's role as an administrator does not require this level of intervention; however, Gemma utilised her diabetes knowledge to take steps in actioning an urgent review. This is just one example of Gemma's dedication to the service and how she uses her knowledge and skills to ensure patient care is optimised. The Diabetes Team is very grateful to have Gemma as part of the extended team.

Rachael Cole, Clinical Digital Change Lead – Theatres | **York** | **Nominated by colleague**

During the Nervecentre go-live, I was a bed manager. Rachael was so supportive and helpful, going above and beyond, and coming back to support when she should have been off duty.

Communications Team | **York** | **Nominated by colleague**

I would like to nominate the Communications Team for a Star Award in recognition of the incredible support they have provided throughout the EPR programme, particularly during my time as EPR Communications Manager.

The team consistently went above and beyond to ensure communications were delivered quickly, accurately and effectively across the Trust. Their responsiveness and flexibility meant that urgent updates were shared with staff at pace, especially during key stages of the programme and go-live periods.

In particular, Emma Clement, Charlotte Swan, and Olivia Griffiths have been exceptional. Whether it was making rapid updates to the Staff Room, helping coordinate bulletins and messaging, or ensuring important information reached staff promptly, they were always supportive, proactive and dependable. Nothing was ever too much trouble, even when requests were last-minute or workloads were high. Their calm and collaborative approach made a huge difference and provided invaluable support throughout a demanding programme of work. Their dedication, teamwork and commitment to keeping colleagues informed has had a significant positive impact and truly demonstrate the values recognised through the Star Awards.

Helen Hope, Women's Unit Manager **York** **Nominated by colleague**

Helen is an excellent unit manager (Sister) of the Women's Unit in York. She works tirelessly to ensure the women's unit runs smoothly, and she is always supporting her staff and patients to the highest professional standards. She always embodies the Trust values.

This week, we have had a shortage of essential equipment for clinics. This meant patients had to be cancelled. Helen spent hours sourcing the equipment, working with management and suppliers to get this equipment to the unit as quickly as possible. She came up against many issues within the procurement processes, and she overcame them all to ensure the equipment was delivered as soon as possible, so the smallest number of patients were affected. When the equipment had not arrived by the allotted time, she went and searched through stores until they were found and quickly delivered to clinics. All this extra work added time to her already long days just to make sure our patients receive the best care possible.

Helen is appreciated by every member of the women's unit team. The unit would not run without her steady hands.

Shan Salim, Nurse **Site** **Nominated by colleague**

I worked with Shan on my night shift in May in EAU in Scarborough. Due to staffing problems, he had a higher patient load than usual. Throughout the shift, he looked after all nine patients with such a positive, calm attitude. Even though the department was busy, he kept smiling and prioritising patient care; he went out of his way to make sure the other healthcare assistants and I were okay and still offered to help us with our tasks even though he had a lot on his hands. We had a particular patient who was a 1:1 and couldn't settle. Again, he remained calm, made the patient laugh, and went out of his way to make sure she was safe and happy.

Although the shift was stressful, working with Shan was an absolute pleasure. He took everything in his stride, and his overall nature with patients and colleagues certainly changed the environment for the better. I've worked with Shan a few times in the last few months, and he is consistently working hard and looking after patients with a high standard of care, as well as making all colleagues feel welcome and appreciated whenever they work with him. I truly think he deserves some recognition for what a wonderful nurse and person he is.

Nicky Holliday, Medical Secretary **Community** **Nominated by colleague**

Nicky always shows care for the patients she interacts with. For one patient, she made all the difference. She was routinely booking the patient in for an outpatient appointment; however, on calling the patient, she was aware that the lady was feeling very unwell. She asked the patient questions about their symptoms, medications, and the circumstances prior to feeling so unwell. She then liaised with the stroke doctors on Ward 23, the patient's husband (who was with her at home), and other members of the stroke team. After confirming with Dr Ward and getting the patient's consent, Nicky called 999 on behalf of the patient and got her blue-lighted to York Emergency Department with a suspected stroke.

The patient was in hospital within an hour of Nicky contacting her. I feel Nicky deserves recognition for her kindness and concern for the patient and for getting her help so quickly.

Sarah York, Lead Nurse - Hysteroscopy and Colposcopy **York** **Nominated by colleague**

I am nominating Sarah in recognition of the constant care, support and dedication she pours into everyone here at the Women's Unit in York - patients and staff members alike.

She has set such high standards for herself that I feel her hard work can go unappreciated by even herself and us! She is the beating heart (or cervix) of Colposcopy. She always has time for my seemingly endless queries about our service and our patients - there is no question she wouldn't know the answer to. Sarah not only helps me but also countless other colleagues daily and is the medical point of contact for all outpatients that come through our unit. She manages to do all this while putting on extra clinics, seeing extra patients wherever she can fit them, and going truly above and beyond every single day. Colposcopy would be at such a loss without her (and we are only half her job!).

Through recent difficult life events, Sarah's work ethic has remained unwavering - and I just want her to know that everything she does is appreciated and we are lucky to have her.

Eve Forster, FY1 Emergency Medicine **York** **Nominated by colleague**

Eve is an inspiration for me. She is full of positive energy and excellent leadership skills. Eve's style of care for the patients has always given so much motivation that I have changed my practice as a doctor.

Olivia Swain, Deputy Sister/Charge Nurse and Hayley Clipperton, Healthcare Assistant **York** **Nominated by colleague**

When a patient was admitted to Obstetrics and Gynaecology acutely while on holiday in York and required emergency surgery, Hayley and Olivia went out of their way to help us care for not only the patient but also their family, making what would have been a potentially overwhelming situation much less daunting. Their kindness is very much appreciated.

Rebecca Greaves, Nurse **York** **Nominated by colleague**

I am nominating Becky on behalf of my sister-in-law and me. My sister-in-law, Kerry, was admitted to Ward 14 and was looked after by Becky until she was transferred to Ward 26 later that week. Kerry observed Becky running around after people and making sure that the patients all go their information and needs were seen to. My sister-in-law said she needed a medal for everything that she was doing, and so I mentioned the Star Awards - and hence this nomination.

Marie Hallam, Administration Manager	**York**	**Nominated by Peter Redfern, colleague**

Marie has been so supportive of me when I had an eye operation. She and I devised a plan to help me safely return to work. Marie was concerned about me and that I would make a full recovery. This was complicated by the fact that we had to use sensible judgement, so Marie trusted me to let her know what breaks I needed when my eyes hurt. More recently, my wife has had a minor stroke and needs extra care from me. Marie has not only asked after my wife, but she has also been concerned about me.

Marie has not only supported me professionally, but she has also gone above and beyond in being supportive of my mental health and wellbeing by checking in to see how my wife and I are.

Beth Fisk, Children's Speech and Language Therapist	**Community**	**Nominated by colleague**

Beth worked creatively and went above and beyond the call of duty to ensure that the needs of two vulnerable children were met. These children were not brought to community appointments, and Beth worked flexibly and collaboratively with the local school and the families to ensure that the children's speech and language assessment could take place in school, thus reducing health inequalities for these children and enabling their needs to be met.

The school were delighted with how Beth had worked with them and told our service: "Beth has been fantastic…brilliant with flexing the approach around non-engaging families and initial visit. We'll be forever grateful for what she's done for these two families, and I can't thank Beth enough"

Julie Morgan-Cox, Administration Team Leader	**York**	**Nominated by colleague**

Julie has been so helpful in assisting me in getting a gynaecology patient a fast-track appointment with ENT when I was struggling to get hold of anyone to help. Julie answered the phone, was extremely polite and professional, and worked really hard to help me sort out appointments for a cancer patient. She contacted the consultant for me, held appointment slots and uploaded all the information for me. She answered all my emails quickly and efficiently. She has made sure that a cancer patient did not get delayed. Julie embodies how teams should work together to provide the best outcome for the patient.

Victoria Birkett, Consultant in Radiology	**York**	**Nominated by colleague**

I would like to nominate Dr Birkett for a Star Award because she is, quite honestly, a breath of fresh air! As we all know, life in the Trust can be quite challenging at times, but by being kind to one another, we can all make a difference, and this is where Victoria shines. Every time you speak to Victoria on the phone or in person, she is smiley and polite and listens and offers valuable advice in a way that is not intimidating or condescending, putting the patient first.

I believe that to make a difference in the world, you don't have to do big things - it's the little things that make the difference, the things we perhaps overlook in times of business and stress, hence this nomination. If there were an award for an unsung hero, Victoria would get it!

Ruwani Rupesinghe, Specialty Doctor Respiratory Medicine, Locally Employed Doctor (LED) Tutor & IMG Lead | **Scarborough** | **Nominated by colleague**

Ru's kindness makes the workplace a much brighter place; she is genuinely one of the most helpful people I've worked with. She is always so supportive of all her colleagues. She makes highly challenging tasks look completely effortless and is always really positive.

Mark Fox, Business Intelligence Lead | **York** | **Nominated by colleague**

I would like to nominate Mark Fox for a Trust Star Award in recognition of his exceptional support, perseverance, and unwavering commitment demonstrated during a recent period requiring rapid performance modelling at very short notice.

During this time, Mark provided invaluable leadership and support to the team, responding quickly and effectively to urgent requests. Despite the reactive nature of the work and the significant time pressures involved, he consistently demonstrated focus, clarity, and resilience. His ability to quickly assimilate complex information, support robust modelling, and maintain momentum was critical in enabling us to meet tight deadlines and deliver a credible and defensible position.

Mark's approach went far beyond simply responding to a request. He was highly engaged, giving his time and energy generously to ensure the work was accurate, meaningful, and aligned with wider organisational priorities. He remained accessible and responsive throughout, offering both practical support and constructive challenge to strengthen the outputs. This created confidence across the team and ensured that the work progressed at pace without compromising quality.

His perseverance during this period was particularly notable. The work required rapid iteration, flexibility, and sustained effort, often under pressure and with evolving requirements. Mark remained committed throughout, maintaining focus and ensuring that progress was sustained despite these challenges.

Importantly, Mark demonstrated our Trust Values in a very real and visible way:

- Kindness – through his supportive and collaborative approach, taking time to listen and provide reassurance during a high-pressure situation
- Respect – in how he valued input from colleagues and worked in partnership to shape the modelling and outputs
- Openness – through clear, honest and transparent communication, ensuring shared understanding of challenges, assumptions, and decisions

Mark's leadership during this period had a tangible impact, not only on the successful delivery of the work but also on the confidence and cohesion of the team. His willingness to step in, support at pace, and stay the course exemplifies the very best of our organisational culture.

For his dedication, responsiveness, and the significant positive impact he made during this critical piece of work, I strongly recommend Mark for a Star Award.

Domestics and Facilities teams **York** **Nominated by colleagues**

We would like to nominate the Domestics and Facilities teams in recognition of all their hard work during the recent flood on the 5th floor of the Admin Block. The entire team worked incredibly hard to clean up the area and restore the space. Despite how busy they were, everyone remained friendly, helpful, and professional throughout, and nothing was too much trouble. Thank you from all of us in the Library Team.

Ellie Carter, Midwife **York** **Nominated by colleague**

Ellie consistently goes beyond her job role to provide kind, open and excellent care to the women and families under her care. I worked alongside Ellie for a week as a student midwife, and her mentorship was invaluable in creating a supportive and safe environment for me to learn in. It was a pleasure to witness the kindness Ellie gave to everyone under her care. Her advocacy for a patient in negotiation with EMBRACE to reunite mum with baby, who had been transferred to a neighbouring Trust's SCBU, was inspiring and a wonderful role model, on which I will base my future practice. I believe Ellie should be recognised for her outstanding care and the value she brings to the Trust.

Outpatient Radiology Booking Team **York** **Nominated by colleague**

This team are always upbeat, very helpful, and hard working. They have a difficult task booking all those appointments for a wide range of people, some with diminished capabilities. They reliably respond to queries in a timely manner. They always let me know if something is not possible, so I can immediately work on alternative solutions. I always get a cheerful response from them, and it's refreshing to see how well this team works as a unit. Keep up the good work.

Rebecca Rhodes, Team Leader-Practice Education **York** **Nominated by colleague**

I would like to nominate Rebecca for a Star Award in recognition of her exceptional contribution to the Practice Development and Education Team, particularly her work supporting the relaunch of the HCSW Buddy training programme.

Rebecca consistently demonstrates kindness, enthusiasm, and an unwavering willingness to support others. She approaches every task with warmth and positivity, creating a welcoming and encouraging environment for colleagues and learners alike. Her proactive approach has been especially evident in her support of the HCSW Buddy training relaunch.

Rebecca has embraced this challenge with energy and dedication, playing a key role in ensuring its successful implementation. She has shown great initiative in organising, supporting, and promoting the programme, always striving to improve the experience for both new and existing staff.

Rebecca takes on tasks and challenges with a truly positive attitude, never hesitating to step forward and help. Her enthusiasm is infectious, boosting team morale and inspiring those around her. She is always willing to go the extra mile, offering support and guidance to colleagues whenever needed. Her commitment to developing others, alongside her compassionate and professional approach, makes a real difference to both staff and patient care. Rebecca truly embodies the NHS values and is a highly deserving nominee for this award.

Hannah Doxey, Research Practitioner and Edoardo Brandani, Clinical Trials Assistant | **Site** | **Nominated by colleague**

Hannah and Edoardo are nominated for setting up and running the MISTY clinical trial to help develop new functions for the DAISY triage robot. They've consistently shown excellence in checking trial documents to make sure they are as clear as possible for patients to understand, and they have put so much time into their work, screening hundreds of patients each day. They have the kindness to persevere in delivering this study despite many setbacks and delays in the set-up of the trial, putting their own time and effort into making sure the trial went ahead.

Aysha Rowe, Staff Nurse | **Scarborough** | **Nominated by colleague**

Aysha is a wonderful nurse. She advocates for her patients and supports everyone she works with. She strongly advocates for nurses and healthcare when there are pressures within the department and ensures she can help as much as she can in areas that are struggling. She lives the Trust values every day on shift by always being kind, open, and striving for excellence. She is a true role model.

Julie Allan, Matron | **York** | **Nominated by colleague**

Julie demonstrated outstanding compassion, initiative, and patient-centred care when responding to a concern raised by a patient's daughter. The family believed the patient had been incorrectly marked as not attending her appointment - an especially distressing situation given the possibility of a cancer diagnosis. Their anxiety was heightened further when they felt their concerns were not being acknowledged when they called for help. When Julie read the concern, she instinctively understood how frightened and worried the family must have been.

Without hesitation, she arranged for the patient to be seen in clinic the very same day. Julie went down to meet the family in person. They expressed deep gratitude, telling her she was the only one who truly listened to them. This situation is just one example of how Julie consistently goes above and beyond for both patients and staff. Julie's dedication ensures that patients and families feel heard, supported, and cared for - especially during some of the most vulnerable moments of their lives.

Richard Grimes, Supervisor and Matt Bradshaw, Painter/Decorator | **York** | **Nominated by colleague**

I would like to nominate Richard and Matt for a Star Award in recognition of their outstanding help and support. As the chemotherapy sister, I recently needed assistance with moving cupboards and repainting a wall within the department. Richard and Matt were extremely helpful and completed all this work within just two days. They went above and beyond, taking on tasks that were not strictly part of their usual role, and did so willingly, efficiently, and with a positive attitude.

Their support made a real difference to the department and helped improve the environment for both staff and patients. I am very grateful for their hard work, teamwork, and willingness to help, and I feel they truly deserve recognition for this.

Emma Heelbeck, Patient Services Assistant and Ann Harland, Patient Services Assistant | **Scarborough** | **Nominated by colleague**

Emma and Ann went above and beyond to provide outstanding support to the Admiral Nurse team during Dementia Action Week 2026.

This year, the team set out to organise fundraising initiatives aimed at reintroducing music and movement onto the wards, recognising the vital role meaningful activity plays in reducing distress and improving wellbeing for patients living with dementia. In the current healthcare climate, wards are often under considerable pressure. Although staff remain committed to delivering high-quality, person-centred care, time constraints can limit opportunities for meaningful engagement. Nevertheless, there is strong evidence that music and arts-based interventions can significantly enhance patient experience, reduce anxiety and distress, and support holistic, non-pharmacological care.

Emma took the initiative to independently arrange for a professional musician to visit Chestnut Ward during Dementia Action Week at no cost. The musician moved between bays, singing to patients and creating a warm, uplifting atmosphere. The response was overwhelmingly positive. Notably, patients who were non-verbal were seen clapping, tapping their feet, and smiling. One patient commented, “Isn’t this marvellous? Wouldn’t it be lovely if this happened every week? It would give me something to look forward to.” This beautifully demonstrates the powerful and lasting impact music can have, even for those in later stages of cognitive impairment.

Our patient group frequently experiences prolonged hospital stays due to complex care needs and delays in discharge planning. During these extended admissions, access to meaningful and stimulating activity becomes increasingly important. Initiatives such as this not only enhance patient wellbeing but also contribute to a more positive and therapeutic ward environment. In addition to organising the music sessions, Emma and Ann played a pivotal role in supporting fundraising efforts. They worked hard supporting the team's raffle, securing prizes, and actively visiting wards to sell tickets. Their dedication and enthusiasm helped us raise over £1,600, which will be used to introduce regular music and movement sessions, improving the experience and journey of our patients.

Beyond these achievements, Emma and Ann are shining examples of person-centred care. They consistently go out of their way to get to know patients as individuals, treating them with compassion, patience, and respect. Their ability to build genuine relationships has enabled them to support patients in meaningful ways, often succeeding where others have struggled. This rapport extends to families as well - several relatives have shared that they actively seek out Emma and Ann when they are on shift, as they feel reassured by their kindness, approachability, and willingness to help.

Emma and Ann’s dedication, compassion, and commitment to improving patient care make them truly deserving of recognition.

Cathy Emmanuel, Senior Sister **Bridlington** **Nominated by colleague**

Cathy is great at supporting our care group with clinics, making sure there are rooms and staffing availability for the East Coast is tricky, especially for vascular, as we require multiple rooms for our clinics. She always makes our requests work and seems so organised. We all really appreciate her hard work, and it helps us to get our East Coast patients seen sooner. She deserves a Star Award!

Stroke Rehabilitation Team **Community** **Nominated by colleague**

May has been Stroke Awareness Month, and the team of nurses, healthcare assistants, PSAs, and therapists have put so much effort into decorating the ward, with purple for stroke, organising bake sales, and raising funds through raffles, they made over £700!

They have contacted companies for prizes and got patients and relatives involved, all on their own, in their own time. They entered a competition at Dobbies Garden Centre to brighten up the courtyard where patients sit out as they are here a long time on their rehab journey. Having access to the outdoors is an important part of the patients' therapy, and they won! First prize was £1000 to spend at the garden centre. A representative from Dobbies has come and done a plan. We will be having a planting area for patients to grow vegetables, plants, etc., to enhance the outdoor space, with fruit trees, as well as a water feature!

Colleagues have done all this themselves and are recruiting volunteers for a de-weed/tidy up before the planting begins. A special mention to Katy Hogg and Fran Hughes for going above and beyond to raise funds for the Stroke Association and enhance our outside space for our patients. The team at White Cross Court are passionate and dedicated to improving the lives of patients with stroke. It is such a privilege to be part of their team. I would very much like you to consider the whole team for this award.

Richard Taylor, Consultant Maxillofacial Surgeon **York** **Nominated by colleague**

I would like to nominate Richard Taylor, Consultant Maxillofacial Surgeon, for a Star Award. I have worked with him for about seven years, and his commitment to his patients is extraordinary. These patients are complex, having undergone or being about to undergo life-changing surgery and quite frankly, he is their rock, their support, and their advocate, and he is always there for them. Most of his working time is dedicated to them, fighting their cause and ensuring their needs are met.

I have seen him leave a clinic mentally and physically exhausted, yet he never shirks a job, phone call, or letter. I appreciate that many others will be like him, but I consider him unique, and I feel he deserves a little local recognition for being who he is and doing what he does. This is not meant to sound too gushing, but I feel privileged to work with him. After 50 years at York, it is nice that I can still say that about an individual, and I want it to be recognised.

Gary Adamson, Senior Digital Project Engagement Manager **Scarborough** **Nominated by colleague**

I was investigating a critical patient safety incident and didn't know how to use Nervecentre to investigate it.

I called Gary, and he answered my call immediately and then took over 30 minutes to take me through how to use Nervecentre to investigate a clinical incident. I identified all the information I needed thanks to his guidance, and he has since then agreed to record a 'live' session with other incident investigators to ensure that those who review DATIX can use Nervecentre to investigate incidents, identify areas for improvement, and improve the care for our patients.

Beyond this single event, Gary has been incredibly supportive to all of us in the UECC and has always been there to provide calm and professional advice and guidance to everyone in our Emergency Department.

Leah Swann, Ward Sister **Scarborough** **Nominated by colleague**

Leah is an asset to the Trust. After I became ill with my mental health and was away from my post for seven months, she went above and beyond in ensuring I was okay. Leah would contact me by phone or message weekly and even contacted me during her own family time and annual leave. If it wasn't for her, I would probably not have got as far as I have today. She has been my rock within the Trust, attending training with me to gain my confidence back. She has always told me, even though I am now back to work, she is always there for me, and I just need to reach out to her.

Heather Griffiths, Operating Department Practitioner **Scarborough** **Nominated by colleague**

Heather was so welcoming and went above and beyond to teach me during the spoke day I had as a student nurse with the trauma theatre team. Heather showed enthusiasm in her teaching and even showed me the process of what will be done on false bones, to enable me to fully understand the procedure the patient was having. Additionally, she showed great care and consideration towards her patients.

I thoroughly enjoyed learning from Heather.

Olivia Lomax, IT Service Desk Analyst | **Scarborough** | **Nominated by colleague**

The PACS Team and I are reliant on the Carestream administration tools to perform our everyday duties and maintain the PACS database.

We must have access to this software, and without it, we would not be able to make patients' imaging imported from other hospitals available or correct any mistakes that may have been made. The software is reliant on a certain version of Java, which, on countless occasions, auto-updates, stopping the Carestream admin tools from functioning. Olivia has helped other members of the team and me countless times.

I have lost count of how many times I have contacted Olivia. She will always go out of her way to help and resolve the issue. Even when she is busy, she will always get back to me as soon as she is available to sort the issue. She even went as far as writing a knowledge article so that other members of the service desk would also know how to resolve the issue. Olivia's responsiveness to sorting the issue promptly also has a direct effect on patient care, as without the software, we wouldn't be able to perform our daily tasks.

Thanks for all your help, Olivia, it is really appreciated.

Rebecca Lightfoot, Consultant in Emergency Medicine | **York** | **Nominated by colleague**

I would like to thank Beccy for the way that she consistently supports and teaches junior colleagues in the Emergency Department.

Despite the regular chaos, competing demands and constant time pressures of the department, she always remains friendly, calm and approachable. What stands out is the way that Beccy teaches, and rather than simply giving us the answer, she takes the time to ask questions, guide our thinking and draw all the information from us. This makes the learning more meaningful and ensures we understand the reasoning behind decisions rather than just the outcome.

Her approach helps us build confidence and enables us to independently apply that learning next time we encounter a similar situation. This is not just my own view but a common theme amongst the doctors who work with Beccy. She is widely recognised as someone who creates a positive learning environment, and her support makes a real difference to all junior staff. Thank you!

Hayley Clayton, Continence Specialist Nurse | **Community** | **Nominated by colleague**

Hayley is a real asset to our team and service. She is on a 10-hour-a-week contract but often works extra hours and is so flexible with her working week to fit in with service demands. She was appointed to be an in-reach service to the acute sites, concentrating on the inpatient units initially.

Due to poor continence practice and standards across the organisation generally, it has been a real challenge to attempt to improve standards and practice in continence care for patients, whilst also attempting to make cost efficiencies and consider the importance of sustainability. She has made great relationships with other staff whilst networking and in attempting to improve education and practice throughout. This has taken a great deal of resilience and demonstrates her commitment to her role and to the patients that we serve.

She demonstrates Trust values continuously, and I am proud to have her in our team. She is the voice for so many patients out there with bladder and bowel issues, and I know standards will continue to improve with Hayley's continuing commitment and passion.

Martin Kobo and Eugene Kayembe, Operating Department Practitioners | **Scarborough** | **Nominated by colleague**

I would like to nominate Martin and Eugene for a Star Award in recognition of the exceptional compassion, professionalism and dedication they have shown to a vulnerable patient, truly going above and beyond their roles as agency ODPs.

Martin and Eugene supported a patient who had been airlifted from a cruise ship off the East Coast and admitted to our hospital with no belongings and no ability to speak English. During an incredibly frightening and vulnerable time for this patient, they both showed extraordinary kindness and humanity to ensure she felt safe, supported and cared for.

Martin provided translation support whilst the patient was in theatre, helping her understand what was happening and reducing the fear and uncertainty of being unable to communicate in English. He continued this support throughout her admission by attending consultant ward rounds to translate and ensure she remained informed and involved in her care.

Together, Martin and Eugene visited the patient daily on the ward, providing practical and emotional support during what must have been an isolating experience away from home. They brought her food, comfort items and clothing out of their own money to make sure she had essentials and felt cared for during her stay.

Following the patient’s discharge, Eugene continued to show exceptional compassion by using his own lunch break to ensure she was safely settled into her taxi and supported as she left the hospital, giving reassurance at what could otherwise have been another stressful and vulnerable moment.

Martin and Eugene have demonstrated outstanding kindness, compassion and patient-centred care throughout this patient’s journey. Their actions reflect the core values of our Trust and show a level of dedication that extends far beyond what is expected of their roles. They have made a profound difference to this patient’s experience at an incredibly difficult time and are both truly deserving of recognition.

Sarah Wilson. Outpatients Services Administrator | **York** | **Nominated by colleague**

From the start of my employment, Sarah has been incredibly helpful. Unfortunately, soon after starting, I was diagnosed with cancer. However, throughout my treatment and recovery, Sarah's kindness was invaluable to me. As a new team member, she made me feel welcomed and valued. On return, she helped overcome any issues I had with re-learning systems, with patience and understanding, she actively encouraged me to overcome any obstacles I came across. I am now back working at a job I totally love. I would like to thank Sarah in an official way. To me, she is a superstar.

Heidi Young, Healthcare Assistant | **Scarborough** | **Nominated by colleague**

I have worked with Heidi on numerous occasions. I would like her to be recognised for her care and compassion towards all her patients and their relatives. She is always happy and goes the extra mile. Cherry Ward is an extremely busy ward, and everyone works exceptionally hard, but I would like to single out Heidi, as I have worked alongside her a few times and thought she was wonderful.

Mairead Atkin, Cleaning & Catering Operative | **York** | **Nominated by colleague (1) and patient (2)**

Nomination 1

Madge (Mairead) will help anyone within her capacity. She always goes that extra mile, whether it involves helping a patient, relative or a colleague - nothing is a problem, always cheerful, laughing and joking and is the most reliable person on the ward. I am nominating her especially for helping me on an incredibly stressful day to prepare Bay 1 for an HPV. Without her, it would have taken a lot longer. I want to show my appreciation, not just for this time, but for every time she has helped me and everyone else on the ward.

Nomination 2

I would like to nominate Madge for recently going above and beyond during my recent inpatient stay. I have difficulty trying new things (and I am autistic, which makes it harder), I have several dietary requirements, and other complicating factors. Madge went to various parts of the hospital to ensure I was fed, provided me with multiple options (without me asking her to), and never made me feel like too much trouble, even though it wasn't easy to do.

She didn't just focus on finding the bare minimum, but also found some nice treats to brighten my day. She was so reassuring, really took time for me and made a difficult time that bit easier for me. She brightened my day every day she was in during my stay, and I wanted her to be recognised for this.

Operating Department Practitioners Team **York** **Nominated by colleague**

I would like to nominate the Operating Department Practitioner Team for a Star Award due to their outstanding professionalism, support, and dedication that they demonstrate every day.

They consistently go above and beyond to provide high-quality patient care, working collaboratively and offering support to both patients and colleagues. The team truly embodies the Trust's values of kindness, openness, and excellence. Their kindness is evident in the compassionate, caring, and respectful way they treat everyone they encounter, often providing reassurance to patients during some of their most vulnerable moments. They foster a culture of openness through honest communication, approachability, active listening, and a willingness to share knowledge and support colleagues across all disciplines.

Their commitment to excellence is reflected in the high standards they uphold, their professionalism, attention to detail, clinical expertise, and continuous focus on delivering safe, effective, and patient-centred care. In addition to their clinical skills, the team consistently demonstrates the personal qualities that are so important in healthcare: empathy, integrity, reliability, patience, adaptability, and teamwork. They show genuine compassion for patients and families, remain calm and reassuring under pressure, and are always willing to help others. Their positive attitude, resilience, and commitment to supporting both patients and colleagues create a welcoming and supportive environment that benefits everyone.

The Operating Department Practitioner Team's dedication, expertise, and unwavering commitment make a significant difference to the patient experience and the wider multidisciplinary team. Their contributions have a lasting positive impact, and they are a valued and respected team whose efforts do not go unnoticed. They are a true credit to the Trust and an excellent example of the values and behaviours that underpin outstanding healthcare.

Amy Foster, Theatre Support Worker **York** **Nominated by colleague**

Practice placements are where AHP students make their most meaningful contributions, delivering compassionate, person-centred care to individuals and their families, while providing vital support to patients, colleagues, and fellow learners across a wide range of clinical environments.

Amy has consistently demonstrated the qualities of an outstanding Student Operating Department Practitioner. She has received excellent feedback from both patients and colleagues, who frequently comment on her calm, compassionate manner and her ability to make patients feel safe and reassured during perioperative care. Colleagues describe Amy as reliable, proactive, and highly professional. She integrates seamlessly into the team, communicates clearly, and shows strong clinical awareness for her stage of training. Her positive attitude and willingness to learn make her a valued member of the department.

Amy’s performance reflects a genuine commitment to high-quality patient care and collaborative practice, and she continues to make a meaningful contribution to the theatre environment. Her dedication, professionalism, and impact deserve recognition.

Jess Collings, Medical Staffing Officer | **Scarborough** | **Nominated by colleague**

Jess joined our team in December, and she has settled in well. This week, she has demonstrated the Trust values. During a busy time, getting ready for the August changeover (resident doctors), she has offered help and completed some of the tasks beyond her role. This not only releases some of the pressure on the senior members of the team, but it also helps us meet deadlines, which helps the resident doctors who are joining our Trust. This in turn creates a good first impression of our organisation and helps relations with the doctors, ready for starting in August, which I am sure settles some of their nerves. Nothing has been too much trouble for her, and she has gone that extra mile.

Josh O'Loughlin, Catering Operative | **York** | **Nominated by colleague**

Josh is always friendly and acknowledges me at the tills by name. He always thanks me as I leave the department, again by name. When metal cutlery wasn't available, he went out of his way to find some - and then find me in the department to give me some. His customer service skills are an asset to your team. Thank you, Josh

Justyna Sadej, Midwife | **York** | **Nominated by colleague**

Justyna has gone above and beyond to support staff training in preparation for a patient with additional needs accessing our service. She has developed clear assessment criteria and has proactively ensured that as many staff members as possible have completed hoist training, helping them feel confident and competent in providing safe care. Justyna has provided additional sessions to allow increased availability. She delivers her training with enthusiasm and passion, and she is always approachable; no question is ever too much for her. She is an asset to our unit.

Sarah Cox, Clinic Coordinator | **York** | **Nominated by colleague**

Sarah goes above and beyond for everyone and shows up every day with a smile. She is always there when one of the team needs help or has a question, even if she’s busy with her own work. She deals with everything with kindness, whether it be having to speak to patients as a clinic has been cancelled or speaking to patients when they arrive at the department.

Ben Fletcher, Staff Nurse Nelson's Court Nominated by colleague

I am incredibly proud to nominate Ben Fletcher for a Star Award in recognition of his truly exceptional leadership, clinical excellence, and profound compassion during a highly stressful shift. Managing a busy ward, maintaining one's own patient workload, and coordinating overall patient care is demanding enough. However, Ben went above and beyond by seamlessly leading the team through two consecutive acute medical crises back-to-back, all while maintaining absolute composure.

The First Incident: Corridor Crisis:
During the shift, a crisis arose in the corridor involving Patient 1. Ben immediately took charge of the situation. While ensuring the patient's absolute safety, he demonstrated superb situational awareness. He effectively delegated tasks to the team, directing colleagues with clarity and confidence, which allowed us to transition the patient from the corridor back into bed safely and efficiently.

The Second Incident: Back-to-Back Crash Call:
A mere 10 minutes later, a second, incredibly high-stakes emergency occurred. A crash call sounded at approximately 9.30am for Patient 2, who had collapsed and become unresponsive on the toilet. Faced with a second critical event in minutes, Ben didn't falter. He responded promptly and professionally to what was assessed as a severe vasovagal episode. His actions during this second crisis were exemplary.

- Airway & Clinical Management - He successfully kept the patient's airway open, appropriately monitored her vital signs, and brought her back around to consciousness.
- Team Leadership & Safe Transfer - He gave the multidisciplinary team clear, calm instructions and coordinated a safe hoist transfer to get the patient from the toilet back into her bed.
- Dignity & Compassion - Throughout the terrifying ordeal, Ben was extremely caring and fiercely protected the patient's dignity.

Ben's management of these dual incidents perfectly reflects a patient-centred, professional approach. He sought MDT support exactly when required, escalated care appropriately to the Advanced Clinical Practitioner (ACP), and maintained excellent, reassuring communication with both the patients and the staff involved.

What truly sets Ben apart as a star is what he did after the medical emergencies were resolved. Once Ben was happy that the patient was stable and reviewed by the ACP, he took the time to seek out his colleagues on the ward to check on their wellbeing. Recognising that incidents like these can be stressful and distressing, his proactive emotional support for his team during a heavy shift shows a level of leadership and emotional intelligence that is rare and deeply valued.

Ben is an absolute credit to Nelson's Court Ward 2. He kept his patients safe, protected their dignity in their most vulnerable moments, and actively looked after the mental wellbeing of his team. He thoroughly deserves this recognition. As a newly qualified international nurse at the Trust, I learn so much from Ben, and I find him inspirational.

Beth Horsman, Specialist Nurse Practitioner **York** **Nominated by colleague**

Beth is an experienced cancer clinical nurse specialist who always ensures the patients she cares for get excellent care. Recently, she went above and beyond and came to work when she was feeling unwell herself and should have stayed home. This was to see a young patient who was approaching the end of her life, along with the patient's husband and offer them both support and empathy as they were facing such sadness. Both the patient and her husband appreciated this enormously, and the husband has emailed twice to thank Beth for this after the patient died.

If Beth hadn't come to work, one of our colleagues would have offered support, but this would not have been as good as Beth was well known to them, and this makes a huge difference. Thanks so much, Beth - absolutely excellent care.

Mike Minihan, Community Nurse **York** **Nominated by colleague**

Mike is an amazing member of the Children’s Community Nursing team. He is positive, enthusiastic, and always happy to help his colleagues and the families we work with. Moreover, Mike has continued to be an example of positivity and kindness, all while simultaneously completing his Master's degree at the University of Leeds.

Mike has achieved a distinction in his dissertation, which will have a direct impact on the work the CCN team does and drive forward the excellent work the team does. Mike's research and dedication to outpatient antibiotic therapies will directly impact the families and children we work with. He has done all his studies without once showing his stress or exhaustion! He is a shining example of a great team player. We are so proud of him.

Romina Bamber, Team Leader **York** **Nominated by colleague**

I am nominating Romina Bamber, Theatre Team Lead, for a Star Award in recognition of the outstanding compassionate care and person-centred support she provided to a patient ahead of their admission for surgery.

Romina was contacted by the Autism Liaison Practitioner after the patient requested the opportunity to visit theatres before their admission date, as a reasonable adjustment to reduce anxiety and help them prepare for what to expect. Romina immediately responded positively and was more than willing to facilitate this visit, recognising the importance of taking time to understand and meet the patient's individual needs.

During the visit, Romina took the time to personally show the patient around the theatre environment and carefully explained each stage of the journey they would experience on the day of surgery. This included arrival in the department, meeting the nursing and theatre team, what would happen before the procedure, and what recovery would look like afterwards. She also created space for the patient to ask questions and ensured that answers were given clearly, honestly and in a way that the patient could understand. This approach helped to reduce uncertainty and enabled the patient to feel more informed and prepared.

Throughout the interaction, Romina demonstrated the Trust values of openness, excellence, and kindness to an exceptional standard. She was sensitive and thoughtful in the way she described the theatre environment and procedures, balancing honesty about what the patient should realistically expect with reassurance and emotional support. She showed a clear understanding of the patient's sensory needs and considered how the theatre environment, noise, unfamiliar people, and clinical processes might affect them. At the same time, she maintained appropriate expectations and professional boundaries, ensuring the patient was both well supported and accurately prepared. This was a highly skilled and compassionate intervention that reflected both clinical professionalism and genuine person-centred care.

As a result of Romina's support, the patient left the visit feeling valued, heard, understood, and significantly more confident about attending hospital for their surgery. Her willingness to go above and beyond in facilitating this visit made a meaningful difference to the patient's experience and helped ensure they were better prepared for admission. Romina's actions are an excellent example of inclusive, compassionate, and proactive care in practice, and she is highly deserving of recognition through this award nomination. Thank you, Romina, for the outstanding care, kindness, and professionalism you showed in supporting this patient.

Martha Callaghan, Special School Nurse **Scarborough** **Nominated by colleague**

Martha shows amazing resilience and excellence in all her work. She has the capacity to look at the details of how her service is run and aim for high standards, while also caring deeply for the children in her care. Her knowledge of children with complex needs is exemplary, and she always puts them at the centre of everything she does, despite the service pressures, staffing issues, and demands on her time.

She is a fab colleague and someone you can depend on. I feel that the school nursing service in Scarborough is a great service, and in no small part because of Martha and how she encourages her team.

Ciaran Ferris, Associate Specialist **York** **Nominated by colleague**

Ciaran is always a positive and approachable member of the team. She goes above and beyond for her patients. Recently, she took time and was very understanding of a patient who was incredibly anxious and helped reassure and assess the situation so the operation could go ahead. The patient and their family could not speak highly enough of how thorough and empathetic she had been towards them and of the considerations she had implemented.

Ciaran also recently offered to take a colleague home when they were stuck after working cross-site, which was very much appreciated. It may have seemed insignificant, but it had a huge, positive impact on this member of staff. Thank you, Ciaran, for being such a wonderful, kind, approachable individual that everyone looks forward to working with. You always make the day a little bit brighter!

Clare Smith, Chief Executive **York** **Nominated by colleague**

Since Clare Smith has come into the Trust, she has transformed it. By coming out to meet teams and people, she has improved the environment and atmosphere around the hospitals. When I am at York Hospital in the ward areas, departments, and on the main corridor, you can see the buzz she has brought into the Trust since November last year, which has transformed the Trust from what it was like this time last year.

Clare has been the best Chief Executive the Trust has had in the last few years. You can tell what she has been doing each week in the email she sends out, which is outstanding, and she has brought in Chat and a Brew and Y&S Live, which has helped to lift colleagues at the Trust. She is an outstanding Chief Executive. Well done, Clare, you are outstanding.

Georgie Garry, Specialist Speech and Language Therapist **York** **Nominated by colleague**

Georgie has been working very closely with a school, providing speech and language therapy to many children, and they have provided some excellent feedback:

“The Speech and Language Therapy pilot has been an extremely positive and successful initiative for our school. Having a dedicated Speech and Language Therapist in school on a weekly basis has enabled strong relationships to develop between the therapist, children, families, and staff, resulting in more effective communication, collaboration, and intervention delivery. Parent engagement has improved significantly, with all families attending initial consultation appointments; previously, non-attendance at appointments often resulted in children being discharged before support could be accessed. The consistent presence of the therapist in school has also strengthened relationships with pupils, allowing for a deeper understanding of their individual needs and more responsive support.

Georgie has been an excellent fit for our school and has played a significant role in the success of the project. She has developed a strong understanding of the complexities within our school community and has worked hard to build positive, trusting relationships with both children and families. This has been particularly evident with some of our pupils with more complex needs, where her consistent and nurturing approach has enabled meaningful engagement.

Georgie is very much viewed as part of the team, and her professional knowledge, insights and ideas are highly valued by staff. Her collaborative approach has helped to create a genuinely integrated model of support that benefits both children and adults across the school.

Donna O'Neill, Team Leader **York** **Nominated by colleague**

Donna is always willing to help, often at very short notice. Her expertise, reliability, and positive attitude make a huge difference to patient care and the team she supports. She thoroughly deserves this recognition.

Donna Rogers, Healthcare Support Worker **Malton** **Nominated by colleagues**

We would like to nominate Donna for a Star Award in recognition of her exceptional dedication, compassion, and unwavering commitment to patient care and team support within both the Gynaecology Clinic and the Joint Pelvic Floor Clinics in Malton. Donna is an outstanding Healthcare Support Worker who consistently goes above and beyond in everything she does. She is exceptional with patients, treating everyone with kindness, empathy, dignity, and respect.

Nothing is ever too much trouble for her, and she always takes the time to ensure patients feel comfortable, supported, and reassured throughout their clinic journey. Her dedication to the service is truly remarkable. Donna regularly stays late when clinics overrun, ensuring that patients continue to receive the highest standard of care and that both clinics run as smoothly as possible. She does this willingly and without hesitation, always putting the needs of patients and the team first.

In addition to her invaluable support to Mr Freites, Donna has been an incredible source of support and guidance to colleagues across both services. She has played a significant role in supporting specialist nurse, Janette, always sharing her extensive knowledge and experience with generosity and patience. She is also a tremendous support to our Admin and Medical Secretary staff, in particular Vicky, and can always be relied upon whenever assistance is needed. She is also a tremendous support to our Admin and Medical Secretary colleagues, in particular Vicky, and can always be relied upon whenever assistance is needed.

Donna’s knowledge of the Gynaecology Clinic, the Joint Pelvic Floor Clinic, their processes and patient pathways is second to none. She is often the person colleagues turn to for advice and guidance, and she is always willing to help. Her expertise, combined with her positive attitude and approachable nature, makes her an invaluable member of the team. No matter how busy the clinics become, Donna remains cheerful, professional and welcoming. Her constant smile, strong work ethic and willingness to go the extra mile have a hugely positive impact on both patients and colleagues. She is highly respected, greatly appreciated, and truly deserving of recognition.

Donna embodies the very best of the Trust values. She is kind in the way she supports and reassures patients, open in the way she works collaboratively with colleagues and shares her knowledge, and she pursues excellence through her consistently high standards, dedication, and commitment to improving the clinic experience for everyone. We are incredibly fortunate to have Donna as part of our team, and the three of us are unanimous in our belief that she is exceptionally deserving of this award and the recognition it brings.

Neil Sinclair, Facilities Operative **Scarborough** **Nominated by colleague**

Neil is a lovely colleague to work alongside and chat to. He always has a smile on his face and takes every challenge in his stride. His warm and happy-go-lucky personality is contagious and really boosts morale, and he always makes time to check in on you whenever he sees you.

Jane Davies, Catering Clerical Assistant **Scarborough** **Nominated by colleague**

Over the past few months, Jane has been managing a significant volume of challenges associated with the implementation of the new PECOS system. From navigating the complexities of invoice matching and resolving system-related discrepancies to liaising with suppliers regarding outstanding payments, she has consistently demonstrated professionalism and dedication in the face of ongoing pressures.

Throughout this period, Jane's patience, kindness, and commitment to excellence have been evident in every interaction. She has worked tirelessly to ensure that suppliers are kept fully informed, providing regular updates and maintaining positive working relationships even during difficult situations. Her calm and approachable manner has helped to build confidence and trust with both internal colleagues and external partners.

What stands out most is Jane's proactive approach to problem-solving. She continually seeks practical solutions, often identifying and resolving issues quickly to minimise disruption to the service. Despite the additional workload and challenges involved, she carries out her role with humility and rarely seeks recognition for her efforts. Jane's dedication, resilience, and unwavering support have played a vital role in ensuring continuity during a particularly challenging transition period, and her contribution has been greatly valued and appreciated by colleagues and suppliers alike.

Emma Sorby, Assistant Practitioner **York** **Nominated by patient**

I was booked for a USS-guided biopsy of my neck due to an unknown swelling. Being a retired nurse, I was extremely anxious as I knew what was coming. Being a nurse for 40 years, I was worried that the service I provided would be there for me when I needed it; I had nothing to worry about. Emma was assisting the radiologist - she was absolutely brilliant, her reassurance helped me relax and made me feel safe. She allowed me to hold and squeeze her hand, which helped more than she could know. She kept reassuring me throughout the whole procedure. She turned my anxious experience into a very positive one. Thank you, Emma. You are a credit to your department.

Lottie Gilham, Staff Nurse **Scarborough** **Nominated by patient**

I was in hospital for four weeks, suffering from a broken disc in my back and severe bruising. During that time, Lottie was the number one nurse out of everyone who cared for me.

She comforted me when I was feeling depressed, took the time to sit with me, and explained my injury and recovery in a way I could understand. She was not only professional and highly skilled but also felt like a friend when I needed one most. You can see that she puts her whole heart into her job and truly cares about her patients.

Having lost my husband in September, I was struggling emotionally, and Lottie helped stop me from falling into a deep depression. Her kindness, support and compassion meant more to me than words can express. She deserves 1,000 stars. I cannot adequately express how dedicated she is or how much of a difference she made to my recovery. She has a heart of gold and is an absolute credit to the nursing profession.

Selby Community Response Team **Community** **Nominated by patient**

For almost six months, the team has been providing me care after I broke my neck. It's not been the easiest of journeys, and I'm still not there yet, but their care, compassion, support and motivation have been more needed and appreciated than I can ever express. You guys are amazing.

Carol Hanson, Midwife **Site** **Nominated by patient**

I would like to formally nominate my community midwife, Carol, for the exceptional care, compassion, professionalism, and dedication she has shown throughout my pregnancy journey so far.

From our very first interaction, she has consistently gone above and beyond to ensure I felt supported, informed, and listened to. Her calm and reassuring manner made an enormous difference during what can often be an overwhelming and emotional time. She always takes the time to answer questions thoroughly, provide guidance without judgement, and make me feel genuinely cared for as an individual rather than just another patient. What particularly stood out to me was how incredibly efficient and proactive she has been. On multiple occasions, she had gone above and beyond her responsibilities, including organising urgent doctor's appointments on days she was not even working to ensure I received timely care. She also arranged required medication and blood tests to be completed the very same day, demonstrating an exceptional level of commitment, organisation, and genuine care for her patients' wellbeing. Her kindness, empathy, and professionalism have had a hugely positive impact on both my confidence and wellbeing throughout my pregnancy.

Carol is an outstanding example of the difference compassionate and dedicated healthcare professionals make to families every day. I truly believe she deserves recognition for the exceptional standard of care she provides and the positive impact she has on the people she supports.

Ren Evens, Diabetes Midwife **York** **Nominated by patient**

Ren has provided the most wonderful support for my baby and me, as well as my husband, throughout my pregnancy. I truly feel we have been a team in managing my gestational diabetes, and I feel that Ren has listened to any concerns I've had relating to previous experiences and shown the highest level of compassion and care. I think Ren's experience is invaluable as she discovered I had developed pre-eclampsia very late in my pregnancy, she insisted I was checked even though two days previously my results were normal, her instinct was correct. I was induced the following day, and now we have a healthy baby, and I am home and well.

Six years ago, I experienced a very traumatic labour, and I went into this pregnancy feeling very anxious about labour. Ren went above and beyond and took the time to listen to me and reassure me, which meant I was able to relax and look forward to the birth, which ended up being incredibly calm and enjoyable. We can't thank Ren enough for the kindness she has shown and for treating us as individuals and working with our personal circumstances.

Ren is an asset to York Hospital and the NHS.

Kelvin Odimbu, Healthcare Support Worker **York** **Nominated by patient**

I was sent to the Emergency Department by my GP as I had the possibility of losing my foot. When I got onto Ward 11, I was told I needed surgery under GA. Never had it before, so I was very nervous. Kelvin was on duty for two nights while I was there - on entering our room, he took time to ask every person if they were ok, if they needed anything and if they were comfortable. He made it clear we must press our buzzer if we needed anything, and that really put my mind at rest.

Reina Gatus, Staff Nurse **York** **Nominated by patient**

Reina and her team were so kind and understanding when I first arrived at Ward 21 for a blood transfusion. I was very upset and apprehensive about coming to hospital. I am agoraphobic. Reina, Dr Paneta, and team put me at ease, found me a private waiting space, and talked me through every procedure, giving me as much information as possible. Reina was especially very aware of my needs and addressed them with concern and without fuss or causing me unnecessary attention or embarrassment.

I called her 'The Queen', not just because of her name but also for her serenity and compassion. All the staff in Ward 21 and (especially Sophie, the catering lady) are absolutely fantastic.

Ward 21 **York** **Nominated by patient**

I have had several procedures on Ward 21. Without exception, everyone has been so kind and helpful. They have been responsive to my needs, finding me a comfortable place to lie when I was in pain, hand-delivering blood specimens to speed along waiting times, and offering solace and conversation when I was upset.

All staff were so happy to help and tolerant of every patient's whims and foibles - even though at least two are heavily pregnant. A student nurse called Georgia was kind and chatty and helped me feel at ease despite my agoraphobia and anxiety. Georgia had to take my blood pressure at three-minute intervals, and I noticed that my result was significantly lower on the second reading after chatting to her for those three minutes.

I was very anaemic and extremely upset and apprehensive when I first arrived for my first appointment and transfusion, but after three visits to Ward 21, I feel so much better physically. and more importantly, mentally.

Keith Maddison-Neil, Healthcare Support Worker **Site** **Nominated by patient**

He has been extra encouraging and gone the extra mile for me with my disabilities, as it is very scary.

Peritoneal Dialysis nurses **York** **Nominated by patient**

I'm writing this both as a member of the York Hospital staff 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, Caroline, 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.

Mark Andrews, Consultant in Orthopaedics and the theatres team | **Bridlington** | **Nominated by patient**

Mr Andrews was brilliant, and my operation has completely ‘changed my life’ for the better. His whole team were amazing.

Kymberly Wilford, Midwife and Sasha Evans, Student midwife | **Scarborough** | **Nominated by patient**

Thank you to all the staff on the Hawthorn and Labour Ward who cared for and looked after us. A special thanks to Midwife Kym and student midwife Sasha, who helped to bring our baby girl into the world.

Our little girl arrived in a bit of a hurry via emergency C-section from a placental abruption and Kym was brilliant. She kept me calm and talked us through what was happening. I knew that whatever happened, I was in the right place. She looked after my partner and made sure to take photos of our baby girl, which we will treasure for the rest of our lives. She made sure I got skin-to-skin contact in those first few minutes and was just generally wonderful from taking over our care, to the emergency button press, to the theatre and aftercare.

Thank you to the first midwife, Kim, and student midwife, Martha, who started our labour journey, talked us through the induction process and kept us entertained before your shifts ended. Thank you to the consultant (Gemma, I think she was called) and a thank you to Peter the anaesthetist (who I vaguely remember calling my best friend) - you're a pretty cool guy. Thank you to everyone in the theatre room. I did not catch all your names, but you are all awesome. Thank you to Lynda, who has taken care of us from the beginning. Many thanks to the rest of the team, domestics, healthcare assistants, midwives, etc., at Scarborough Hospital who looked after us and kept us safe.

Pravin Sandanshiv, Consultant | **York** | **Nominated by patient**

Being a wheelchair user, I’m always a little apprehensive and feel slightly vulnerable in new surroundings. From the moment I entered day surgery for cataract removal, I felt valued and cared for and knew I was in very safe hands. Every single member of staff made me feel important, and their kindness was exceptional. My experience under their care was quite simply perfection. Thank you to every one of you.

Niamh Barker, Student Nurse | **York** | **Nominated by a patient**

Niamh was a student nurse looking after me on the orthopaedic ward recently. I would like to nominate her as she had such a positive attitude and was always smiling. After she left the bay, the other patients and I were always commenting on how pleasant she was and that her bedside manner was excellent. She was gently supportive, she acted appropriately, and she really did brighten the day of the patients on the ward. She will make an excellent nurse, and I wish her all the best.

Charlie Oldfield, Operating Department Practitioner **York** **Nominated by patient**

I first met Charlie when I was admitted for unplanned surgery during the first trimester of my pregnancy. It was an incredibly frightening and uncertain time, and although the admission itself was rather difficult, the care I received from Charlie and his colleagues in theatres was outstanding.

Following surgery, I was feeling unwell, vulnerable, and overwhelmed, yet Charlie went above and beyond to ensure I felt safe, comfortable, and cared for. This continued through to my transfer back to the ward, where, despite being late at night, Charlie treated my husband with the utmost care and respect, as well as ensuring he was fully informed of what medication I received and how it helped. His calm manner, kindness, and genuine compassion made a lasting impression on us both during one of the most difficult periods of my life.

To my surprise, seven months later, Charlie walked into my delivery room when I attended for the birth of my son by Caesarean section. Coincidentally, the hospital had just implemented a new PACU recovery procedure, and Charlie, alongside Liv, had been allocated to support my post-operative recovery. Seeing a familiar face immediately put me at ease. Despite the pressures of a new way of working, Charlie once again demonstrated the same calm professionalism, warmth and compassion that I remembered from my previous admission. What stood out most was that Charlie remembered me from seven months earlier. He made a light-hearted joke about providing continuity of care, which instantly lifted my spirits and helped ease my anxiety at such an important moment. It was a small gesture, but one that meant a great deal to my husband and me!

Charlie embodies everything that patients hope for in healthcare professionals. He consistently treats people as individuals, demonstrates genuine kindness, and provides reassurance during some challenging moments. The fact that I encountered the same outstanding care from him during two separate admissions speaks volumes about the person and professional he is.

Deborah Selkirk, Radiology Services Administrator **York** **Nominated by patient**

I attended York Hospital for an ultrasound on 16 June. Debbie was very welcoming and professional when I arrived. While in the waiting room, I became concerned about the possibility of being allocated to a member of staff from a previous experience that I had found distressing. I spoke to Debbie and asked if it would be possible to see someone else. She didn’t ask me to explain or question me; she just reassured me that she would sort it and immediately made sure I was seen by someone else. I went on to have a great ultrasound experience with Jasmine. I’m grateful for how professionally and promptly Debbie handled my concern. Thank you, Debbie.

Mohamed Yassin Ahmed, Specialty Registrar **York** **Nominated by patient**

Yassin is a true star and an asset to the NHS. He carried out the safe delivery of my daughter, born at York Hospital on 12/06/2026. I will never forget the impact that he had during my labour and delivery of our baby girl. He went above and beyond every step of the way - providing constant reassurance, informing me of the plan, always discussing decisions with me and ensuring I was fully informed before making a decision, and always asking for my consent. He treated my husband and me with care and kindness, which we will never forget. He is calm and kind, and never once did I feel worried or like I did not know what was going to happen next.

I cannot put into words how thankful I am for his safe delivery of our daughter, and I will be forever grateful for the care we received. He showed true care, compassion, professionalism, and leadership throughout. Thank you, Yassin, for being such an important part of the journey to safely deliver our baby girl.

Gordon Williams, Consultant in Cardiology, Mayleen Yew, Specialist Cardiac Physiologist, and Tracy Yeates, Healthcare Scientist Cardio, Vascular and Respiratory **York** **Nominated by patient**

I attended an outpatient appointment for a cardiology stress test. I had to have the IV contrast and drugs to increase my heart rate. Throughout the whole appointment, which lasted about an hour, all three staff were kind and courteous. They clearly explained what the appointment would entail at every stage. They even apologised when they had to press harder to get a clear picture.

To say it was a stress test, it was the least stressful appointment I have had! What a wonderful team. They clearly have great respect for each other as well as patients. Five stars all around.

Sophie Smith, Maternity Assistant **Scarborough** **Nominated by patient**

Sophie went above and beyond when I was in hospital having my baby girl. Outstanding care was provided postnatally. I will be forever grateful for the care we received. Sophie is a credit to the maternity team.

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

Michelle looked after my baby girl and me on Hawthorn Ward, and I couldn't fault the care that we received from her. Michelle was amazing and gave us outstanding care. We will be forever grateful.

Alexandra Jones, Midwife **York** **Nominated by patient**

I cannot put into words how grateful I am for my community Midwife, Alex Jones. She has been the biggest support to me while I was pregnant, and she continues to be my support system postpartum and while I navigate this new journey of motherhood. She has been there for me day and night, just a phone call or text message away, during pregnancy, during labour and birth, and continues to do so now that my daughter is here too.

She is sunshine in human form, answers all my questions, supports me with any worries, and always ensures that I am informed throughout. She is kind, compassionate, caring, and amazing at her job. Thank you, Alex, for the amazing care that my daughter and I have received from you.

Emily Greaves, Deputy Manager **York** **Nominated by relative**

I am writing to share my sincere thanks and appreciation for the exceptional support we received recently, and specifically to recognise for a Star Award for the help provided by Emily, who answered the emergency contact number.

My mother-in-law is currently undergoing palliative chemotherapy at York Hospital, and the treatment is taking a significant toll on her physically. Following her second dose in the current cycle, she developed very painful blisters on her lips. She was prescribed antibiotics and a mouthwash, but the mouthwash caused her severe discomfort. The chemotherapy nurses prescribed a soothing gel intended to ease her symptoms and pain; however, when we tried to collect this medication, the hospital pharmacy had no stock and was unable to supply it. By the time I discovered this, I was unsure how to secure the relief she urgently needed, so I reluctantly contacted the emergency number and spoke with Emily. She was incredibly helpful, acted quickly to arrange for the medication to be obtained, and took time to explain in detail how to use it and what effects to expect.

Without Emily's prompt intervention and support, my mother-in-law would have been left suffering in pain while we tried to locate the medication elsewhere. Her kindness, efficiency and clear guidance made a huge difference to us at a very difficult time, and we are extremely grateful for her care.

Dr Tunde Ashaolu, Emergency Medicine Consultant, and the Emergency Department | **Scarborough** | **Nominated by relative**

We would like to thank Dr Tunde and the ED team for their outstanding care when my husband and I came to the ED after he choked on a piece of hot food. He has a neurological condition, and the difficulties he has include choking. This happened the night before, but it only became evident this was a serious problem the morning after, when he couldn't speak. After arriving at reception, the sister on duty recognised the severity of the problem and whisked us through. He was seen by Dr Tunde, who arranged an ENT consultation after an endoscopy showed his airway was at risk. All this was done in a courteous and friendly, yet professional, manner.

I'm a retired nurse, and I must say that at that moment I was so proud of our wonderful NHS and the staff at Scarborough Hospital ED. The Trust and the district should also be aware of what a fantastic job all the staff are doing. Thank you, you are all stars.

Jason Angus, Healthcare Assistant | **York** | **Nominated by relative**

Jason was amazing at bringing some joy and entertainment to my little boy, who was in for hours. He also said Harley was so entertaining and made his day, but he also made ours, so thank you so much for bringing joy to all the little children and probably all your colleagues, too.

Elise Robson, Registered Nurse | **Scarborough** | **Nominated by relative**

Elise went above and beyond with her care and compassion when looking after my husband whilst he was in a coma. She was an amazing nurse but also helped me through my worst days. Elise was 100% open and honest with me, and if I was unsure about anything, she explained it in great depth. One day, she even offered to bring me food back from her break as she knew I hadn’t eaten, as juggling children at home and my husband up on the ward, I didn’t have time for myself. She is a true star and a credit to the ICU team.

Ward 39 | **York** | **Nominated by relative**

The whole team have been outstanding with their kindness, care and patience in looking after our dad/husband. So many outstanding individuals making a superb team – healthcare assistants, nurse associates, nurses, ward clerks, patient service operatives, housekeeping, therapists, doctors, and more. You have kept Dad laughing and smiling (just how he likes it) despite being so ill. You've also managed to look after us, his close family, too, despite the hard times for seven weeks. You have allowed him to live out his final weeks with fun along the way, the way he would have wished. Thank you from the bottom of our hearts.

Cherry Dunlop, Midwife **York** **Nominated by relative**

It is clear that Cherry has many years of experience in the midwifery profession. It's this kind of person that I find plod along in life, continuing to do their best for everyone but generally going unnoticed.

We were in the maternity department in York recently for the birth of our third child. My partner has major whitecoat syndrome and a huge needle phobia. At every turn, Cherry was there being supportive and caring, and in my mind, she went above and beyond. She really understood her patient and adjusted her care accordingly. Nothing is too much trouble for this woman, and she is clearly very experienced and thoughtful. Not only did she care for 0my partner professionally, but she also did it with a smile. She read our vibe and joined in with our jovial nature to make the whole experience even more enjoyable and something that will personally stick with me for life.

The birth of a baby is a very special moment, but Cherry went out of her way to ensure we would forever hold fond memories of it all. She remained professional throughout, but it was clear she knew her roles and responsibilities well enough that she didn't need to follow a textbook to bring our daughter safely into the world.

Cherry should be commended for her continued care and support of her patients; she does an amazing job.

Siwan Jones, Specialty Registrar **Scarborough** **Nominated by relative**

My daughter was acutely unwell this weekend and presented with non-classic appendicitis symptoms. Having had a less-than-desirable experience in the ED, our faith was restored in the system, and Siwan was pivotal to this.

She demonstrated real compassion and went above and beyond her role to ensure my daughter made an urgent USS, for which she had sourced a slot whilst discussions were still ongoing about the most appropriate course of action with the consultant. She then took it upon herself to wheel my daughter down to ultrasound to ensure the slot wasn't missed and waited there with her. The scans determined that an appendectomy would be required, and Siwan returned to run through the surgical consent with Mia.

She took her time and explained everything in great detail, and that continuity of care, together with the compassion she had already demonstrated, meant the world to us. Thank you, Siwan.

Simon East, Surgical Care Practitioner **Scarborough** **Nominated by relative**

My husband, for over nine weeks, has been very ill. Simon has had to explain so much about my husband's condition, more than anyone, and completely understands the recovery. The wellbeing and care he has shown is appreciated – thank you.

Geraldine McEnroe, Consultant in Anaesthetics **York** **Nominated by relative**

My son, who has complex needs, ASD, LD, and sensory processing, required an MRI under GA.

Geraldine called in advance to understand his needs and pre-plan how to make the whole process as smooth as possible. My son dislikes hospital environments and has extreme anxiety in these situations, and previous procedures have not gone well. However, this time, it went swimmingly from start to finish, and my son was not distressed with very limited anxieties due to Dr Geraldine allowing this to be a patient and parent-led process.

I believe that, as an organisation, we still require improvements in caring for patients with ASD, LD, and other neurodivergent conditions, and we must think outside the box. In my opinion, Geraldine could lead the way forward for this and practices exceptional role modelling. Her kindness, openness, and transparency from start to finish embodied outstanding character, high moral integrity, and exceptional competence.

Paediatric Psychology Epilepsy MD Team: Dr Gulati, the Epilepsy Nurses, and the Psychology Team **York** **Nominated by relative**

Dr Gulati, the wonderful epilepsy nurses, and the Psychology Team have made a huge difference to our daughter's life and to our family. Since her epilepsy diagnosis, they have provided exceptional care, support, and reassurance during what has often been a very difficult journey.

They have always treated our daughter with kindness and compassion, taking the time to listen, answer questions, and ensure that she feels understood and supported. The team consistently demonstrates values of kindness, openness, and excellence. Their communication is always clear and honest, and they work together to provide outstanding care tailored to our daughter's needs. Alannah's support is valuable in helping our daughter understand the emotional challenges that can come with living with epilepsy.

The Monday group is a fantastic idea to help our young people talk to others experiencing the same diagnosis and anxieties. It would be great in a group setting; however, I understand this is difficult to arrange. We are incredibly grateful for the dedication and commitment shown by Dr Gulati, the epilepsy nurses, and the Psychology Team.

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

My son was born prematurely in 2020, and hospital stays and procedures are all that he has known since birth. As a result of this, he has significant hospital trauma. He was referred to Charlotte at the beginning of 2025 following another surgery and multiple procedures back-to-back that left him unable to even enter the hospital doors without having an anxiety attack.

The difference that attending play therapy sessions with Charlotte has made has been life-changing for my son and our family. She is the kindest person and always goes above and beyond to make sure that my son is supported and that attending the hospital is a positive experience for him. She remembers all the little details my son shares with her and makes an effort at every appointment to connect with my son through his interests.

My son has gone from being unable to enter the hospital due to anxiety to being excited to attend. She communicates with him in a way that he understands and makes sure he has a full understanding of what is going on. My son's anxiety is sometimes hard for medical professionals to identify due to the way he presents, but she has taken the time to understand my son fully. She has been an amazing advocate for my son during any procedures he has had and has not only hugely helped in removing his anxiety but also mine as his mother, too. She is kind, caring, considerate, and always goes the extra mile to do what she can to improve things for some of the most vulnerable patients. She demonstrates the Trust values in all that she does in her role with a constant smile on her face, and she is a real credit to York Hospital.

We feel very lucky to have been referred to Charlotte and are extremely grateful for all that she has done for our son and many other children. We would like to thank her for her excellent child-focused treatment and for being the best advocate we could have asked for to support our medically complex son.

Jenifer Simpson, Healthcare Assistant **Scarborough** **Nominated by relative**

My husband has been very ill and was eventually diagnosed with Legionella's disease. He was moved to Oak Ward, Scarborough Hospital, in early June. I would like to nominate Jenny for a Star Award as she is very caring, respectful, and professional - nothing was too much for her. Jenny has such a great positive attitude, and I would like to nominate her for this award for her hard work and her dedication to her patients and their relatives, which needs to be acknowledged.

Rosie Seal, Deputy Sister **York** **Nominated by relative**

My sister, Heather Cawte, died on Ward 24 after being on the ward for several weeks. The care and compassion that Rosie demonstrated to my nephew and me made an enormous difference to us as we came to terms with the death of a beloved mother/sister at the age of 64. Rosie acknowledged that she was dealing with a patient who had a huge intellect and phenomenal memory for details and who could be engaged in conversation as an equal. This made a great difference to my sister's final days.

Ward 16 **York** **Nominated by student**

The Ward 16 team have helped advance my student nursing skills. They have helped me progress and push me in my future nursing career. As a team, they are compassionate and caring and have the courage to provide high-quality care. They helped me learn what different teams do on the ward, which has allowed me to see multidisciplinary teamwork within the team. They show high levels of communication within the team and with others. My six-week placement was short; however, it was long enough to see the person-centred care they strive for. When I qualify, I hope to be on a ward that shows so much compassion, communication, care, and courage as Ward 16 does. They have helped support me to grow not only as a professional but personally as well.

Item 10

Committee Report

Report from:	Quality Committee Assurance Report
Date of meeting:	21st July 2026
Chair:	Lorraine Boyd

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

ALERT
* **Sepsis Q4 Update** provided evidence indicating awareness and timely identification of sepsis in ED is consistent and in line with expectations across both sites. However delays across the treatment pathway remain a significant concern. Inconsistency persists and performance is significantly above the national 1 hour standard. There is limited assurance of progress with evidence of a deterioration in time to antibiotic administration in Scarborough ED. This represents a risk to our ability to deliver safe and timely care and continues to be a focus of QI work with high levels of scrutiny and oversight through PRIM and PSCE. Data extraction from Nervecentre is currently limited with reliance on manual audits as an interim measure. Dashboard development is an active workstream but progress is limited by competing priorities for the IT development teams. This will not change before full Nervecentre implementation and development of sepsis functionality. A gap in assurance remains in relation to sepsis identification and management in In Patient areas. * **National Hip Fracture Database (NHFD) Q3 update** was shared with the Committee by Surgery Care Group, in response to previously raised concerns. A mixed picture across the sites was presented. Overall there is poor performance against Best Practice Tariff. 35% of 115 York hip fracture patients and 17% of 58 Scarborough patients met all national care standards indicating significant pathway and capacity constraints. Timely surgery is the principal operational risk (and consequently quality and safety risk) with theatre capacity identified as the main cause of delays. Nonetheless assurance data provided evidence that clinical outcomes and surgical performance remain strong. Areas for further improvement include access to ring fenced specialist beds and consistent access to physiotherapy support. * **Chaplaincy Annual Report** - data presented confirmed that 2025/26 key objectives of increasing referrals, improving inclusion and support of patients at the end of life were largely met. Patient and carer feedback demonstrated positive outcomes across all CQC domains. Increasing demand and staffing levels below the national recommendations are mitigated by the contributions from honorary chaplains and volunteers. Recording data on patient faith/ belief is an area for

improvement and currently limits assurance on equitable access for minority groups.

* **Reasonable Adjustments Regulatory Requirement** is not expected to be met by the September deadline, pending the necessary Nervecentre functionality scheduled for Tranche 3. Other systems, including System1 and Badgernet, are being updated to support compliance.

* **Board Assurance Framework** improvements in line with the Well Led Review recommendations were discussed and the strengthened oversight and reporting should be in place by the September Board meeting.

ASSURE

* **Cancer Harm Review completion** is improving in Surgery Care Group, however a significant number remain outstanding so assurance, whilst improving, is still limited.

* **Surgical Invasive Procedure Group** was reported to have poor attendance and clinical engagement, representing a safety risk and assurance gap. Future attendance will be monitored closely via PRIM.

* **Maternity and Neonatal Voices Partnership (MNVP) feedback survey** outcomes were shared indicating a high level of satisfaction with maternity services, particularly valuing continuity of care. Areas requiring further improvement were identified, which included consistency of communication, variation in post natal care and issues with delivery of community post natal support. Quality Improvement work to address these areas is embedded in the Maternity and Neonatal Improvement Plan, with coproduction supported by MNVP in line with recent Ockendon recommendations.

* **Maternity Regional Heatmap** overall score has continued to fall and has now dropped from red rated to amber. Further improvement is anticipated in the coming months.
*
* **Post Partum Haemorrhage (PPH) rates** remain broadly stable and comparable with other Trusts nationally

* **Stillbirth and Neonatal Death Data (May)** raises no cause for concern. All instances are reviewed using the Perinatal Mortality Review Tool (PMRT) and presented at a monthly Perinatal Mortality Meeting with quarterly detailed PMRT report and action plan reported to private Board.

* **Biannual Maternity and Neonatal Workforce Report** highlighted that Neonatal Nurse Staffing levels in York and Scarborough are not British Association of Paediatric Medicine (BAPM) compliant. A business case is in train to address this gap in assurance. Additionally Tier 1 and Tier 2 medical staffing at York is not BAPM compliant, with plans to address the gap through changes to consultant on

call rota arrangements. Staffing constraints is also contributing to non compliance with Neonatal Resuscitation training in line with Resuscitation Council expectations and the supporting mitigations

* **Midwifery Staffing Levels** were noted to be over establishment at the end of Q3. However, when roster unavailability (sickness and supernumerary status) and the funding gap are accounted for there remains an adverse variance from Birthrate Plus standards

* **Prescribing Incidents Update** was presented, addressing progress and challenges relating to CRR54. Processes put in place to reduce the incident rate since the last report to Quality Committee in January 2026 were shared. During the reporting period the risk reduced from 16 to 12. Examples of improvements contributing to this included reduced number of reported incidents and of incidents causing harm over 6 consecutive months and specifically reduction in insulin related incidents following focused QI work. Anticoagulation incidents remain an opportunity for improvement and is an active QI workstream currently.

* **Yellow Card Reporting** increased by 97% from the previous year placing the Trust as 6th highest reporter in the Northern and Yorkshire regions, suggesting good assurance on engagement with medicines safety.

* **Nursing Workforce and Quality Paper** provided triangulated data demonstrating that quality and safety are being maintained despite workforce pressures. Triangulating workforce and quality to provide greater insights and assurance on patient safety and experience and the potential impacts of workforce challenges is an evolving assurance workstream. Nursing Risk assessment data is currently unavailable following Nervecentre implementation, with workarounds leading to inconsistencies. Organisational thresholds are yet to be agreed introducing further inconsistency. Assurance, therefore, is limited but improving.

* **Clinical Effectiveness Update** was presented, outlining the current position and responses to the mandated clinical audit programme. Visibility and assurance relating to clinical outcomes is becoming increasingly robust. The Trust responses to the Non Elective Laparotomy (NEL) outlier alert was set out, strengthening assurance. The current position with regard to NICE updates was also shared, indicating 17% of clinical policies and 21% of clinical documents are overdue. Responsibility for completion is delegated to Care Groups, reporting to Patient Safety and Clinical Effectiveness Sub committee of Quality Committee.

* **Concerns and Complaints Annual Report 2025/26** outlined the performance and improvement activity in the handling of concerns and complaints throughout a year of intense focus by the care groups, supported by the corporate nursing team. Evidence of robust governance and oversight, improving response times and resulting service improvements provides moderate assurance. External Ombudsman reviews of complaints align with Trust identified themes. Whilst response times are improving, they remain well below ambition. Volume of

complaints is rising, recurrent themes persist and evidence of measurable impact is scant providing limited assurance on consistent, sustained improvement and outcomes.

* **Quality and Safety Internal Audit Actions Update** outlined the governance process to monitor Internal Audit Actions and the progress to delivery of these. Current progress was discussed. Estates related ventilation governance remains a concern, with several overdue actions, and ongoing discussion to resolve and strengthen assurance.

ADVISE

* **AMOS and Ockendon Reports** were discussed and initial Trust response shared with actions mapped to the Maternity and Neonatal Single Improvement Plan as appropriate. 5 new high level actions have been added as a result. Board update session is scheduled for 22.07.2026

* **Maternity Community PROMPT Training** is recognised as an exemplar and is being showcased by NHS Resolution.

* **CQC update report** highlighted that the Trust is awaiting final reports following a number of recent CQC inspection visits to Easingwold Renal Unit, York and Scarborough Maternity Services and York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER): Breast Screening Programme

* **Paediatric Surgical List** took place for the first time at Bridlington Hospital in June and further lists are planned to take place every 8 weeks, supporting patient experience and care closer to home.

* **Prescribing in Nervecentre** and the important, labour intensive task of transcribing across was acknowledged. Risks that emerged had been largely anticipated ahead of go live. Unanticipated risks have been a rich source of learning and will guide future development of the Medicines Management and Prescribing modules.

* **TPR** was reviewed through a Quality and Safety lens.
* IPC was identified as an area of increased concern. An IPC time out is planned to support a focused review and strengthening of action plans.
* Service demand and increasing referral rates was highlighted as a growing safety as well as operational risk, particularly in dermatology, pain management and paediatric speech and language services. Demand is outstripping capacity to deliver but concerningly, in the face of high numbers of suspected cancer referrals (without commensurate increase in incidence), the ability to triage and safely prioritise those at highest risk is challenging.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
CRR Risks assigned to Quality Committee remain unchanged with mitigating actions continuing. Of those risks not under the direct remit of Quality Committee but with a potential to impact quality and safety, the cyber security risk was noted to have risen and assurance was requested on mitigations to minimise any potential impact on safe care. **MNVP funding** remains a risk as previously outlined, with ongoing endeavours to close the risk. **CRR54 Medicine Management** was reviewed through the Prescribing Incidents Update **Increasing referral numbers** in some specialities, compromising the ability to identify and prioritise those at highest risk of cancer or other adverse outcomes, is an emerging safety risk **Reasonable Adjustments Regulatory Compliance** **Risks contributing to PR1** discussed included Non-compliant BAPM Neonatal staffing levels Suboptimal compliance with Neonatal Resuscitation training (with mitigations to ensure safety maintained) Time to medical review and administration of antibiotics in sepsis Performance against national care standards in management of fractured neck of femur Surgical Invasive Procedure Group efficacy Surgery cancer harm reviews Clinical Effectiveness IPC
ASSURANCE GAINED
Concerns and Complaints Annual Report 2025/26 - limited but improving assurance Chaplaincy Annual Report - good assurance Nursing Workforce and Quality - limited but improving assurance Sepsis Pathways - limited assurance Medicines Management - good assurance

Fractured neck of femur pathways - limited assurance
Maternity outcomes - good assurance
Internal Audit Action oversight - moderate assurance
Clinical Effectiveness - moderate assurance

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	29 July 2026
Subject:	Q1 Well-Led Action Plan Progress Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

Reports of progress against the External Development Well-Led Action Plan are to be provided quarterly to Board. Updates at the end of Q1 are as follows:

- Total number of actions requiring completion by end of Q1 - 71
- Actions completed by end of Q1 – 49 (69%)
- Actions required to be completed remaining open by end of Q1 – 22 (31%)

Those actions remaining open are due to large programmes of work in development including the Big Conversation, Continuous Quality Improvement, Clinical Strategy Development and Board reporting of action outcomes scheduled for future meetings.

Overall, on the full External Development Well-Led Action Plan 54 of 99 actions have been completed - 55% by the end of Q1.
Recommendation: The Board of Directors is asked to note the Well-Led Progress Update Report.

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

Meeting/Engagement	Date	Outcome/Recommendation
Well-Led Action Owners	June/July 2026	Updated

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Well-Led Developmental Review

York and Scarborough Teaching Hospitals NHS Foundation Trust

December 2025

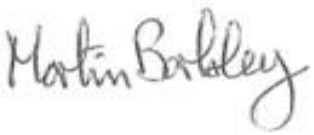
Version: Final Report

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

Executive Summary

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

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



Chair

Chief Executive

Introduction

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

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

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

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

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

Overview – summary of findings

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

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

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

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

Quality statement 1: Shared direction and culture

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By (2026/27 unless specified)	Progress Update Q1 2026
1	**The Trust should consider strengthening senior leadership capacity and ownership of strategy and planning to help raise socialisation of the Trust strategy and drive through formal front-line to Board objective delivery connectivity.**	1.1 Appointment of Executive Director of Strategy by Q2 of 26/27.	Chief Executive	End Q2	A new Clinical Strategy Implementation Lead in post following interim Director of Strategy input. Full recruitment will take part in 27/28.
		1.2 Executive development workshop to ensure clear Executive sponsorship of supporting strategies.	Chief Executive	End Q2	In development
		1.3 As part of the Trust's review of organisational engagement approach develop and implement plan to socialise the Trust strategy through leadership forums, communications, Board discussion and visible executive leadership.	Director of Communications	End Q1	See 3.1. Delivery continuing. Big Conversation provides further opportunity to reconnect colleagues with delivery of the strategy's ambition by re-engaging colleagues with the trust's values and behaviours.
		1.4 Develop and implement a Trust-wide Performance Management and Accountability Framework, aligned to a defined organisational development plan to support high quality objective setting, appraisal, and consistent and escalation and delivery monitoring.	Chief Executive	End Q1	CQI partner tender completed Q1 and now appointed and will commence with the co-creation of the IAF during Q2.
2.	**The Trust should ensure that it has a full suite of in-date and aligned enabling strategies which support delivery of the**	Develop and align strategies which in turn have measurable plans with scorecards, defined ownership and	Chief Executive	End Q3	

	Trust strategy and provide sufficient detail to enable clarity of understanding how they are to be delivered and are capable of measurement, monitoring and oversight over delivery.	assurance mechanisms. Supporting strategies will be: • Clinical Strategy – Medical Director • Quality Strategy – Chief Nurse • Estates Strategy – YTHFM Managing Director • Financial Sustainability Strategy – Finance Director • Organisational Development – YTHFM Managing Director • Sustainability – YTHFM Managing Director			
3.	**The Trust should consider ways in which it can further socialise the Trust's strategic objectives and values alongside reinforcement of the values and behaviour framework.**	As part of the Trust's review of organisational engagement strategy, it will develop and implement plan to socialise the Trust strategy through leadership forums, communications, Board discussion and visible executive leadership.	Director of Communications	End Q1	See 1.3. Delivery continuing. Big Conversation provides further opportunity to reconnect colleagues with delivery of the strategy's ambition by re-engaging colleagues with the trust's values and behaviours.
4.	**The Trust should consider ways in which it can ensure that appropriate focus is given over to strategy, oversight of delivery and ensuring that an appropriate culture is in place.**	4.1 (also 1.1) Appointment of Executive Director of Strategy by Q2 of 26/27.	Chief Executive	End Q2	
		4.2 (also 1.2) Executive development session in Strategy development to ensure clear executive sponsorship of supporting strategies.	Chief Executive	End Q2	

		4.3 The timetable of Board development sessions will be reviewed and sufficient time given to the review, development and discussion of strategies will be scheduled.	Associate Director Corp Governance	End Q1	Completed. The annual Board Development and Strategy Programme has been reviewed and redesigned to ensure dedicated time is scheduled throughout the year for the review, development and discussion of the Trust Strategy and associated enabling strategies. This is being considered.
		4.4 Executive development sessions will be held four times a year focused on strategic development.	Chief Executive	End Q1	Completed and reported – May 2026.
		4.5 Review and rebalance Board agendas and assurance processes to ensure appropriate focus on strategic delivery, outcomes, culture and performance against agreed scorecards.	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
		4.6 Strengthen organisation development and a programme of strategic leadership development for all sub Board leaders.	Director of Workforce & OD	End Q3	Strengthen organisation development - Appointment of Chief Culture and People Officer planned. Work being undertaken to clarify OD aims and priorities, with focus on releasing capacity for BAU work to support ownership and

					empowerment across teams. Big Conversation planned to underpin cultural development. Strategic leadership development for all sub Board leaders - first step of 360 feedback/appraisals in progress. Plan to use this as a LNA to then design and commission support for development.
5.	**The Trust should consider development of a renewed cultural and organisational development (OD) plan that targets considerations contained within this report, and in particular strengthens cultural oversight and focus along with staff feedback and engagement processes including improvements in connectivity of senior leaders with the Trust.**	5.1 Develop and implement a Chief Executive lead deep and meaningful approach to staff engagement across the Trust.	Chief Executive	End Q1	Big Conversation will commence Q2 following development in Q1, and Chief Culture and People Officer appointed and will commence in post Q3.
		5.2 Full review and revision of the Trust's approach to Organisational Development including leadership and management.	Director of Workforce & OD	End Q2	Informed by work referred to in 4.6. Internal leadership and management offer being reviewed in line with launch of national M&L Framework.
		5.3 Development and implementation of a revised senior leadership visibility programme to strengthen connectivity with staff across sites and services.	Director of Communications	End Q4 25/26	Completed and reported – May 2026.
		5.4 Full review of all corporate meetings with the aim of releasing 30% back to focus on engagement and transformation.	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.

6.	**The Trust should look to develop a medium term financial plan once the suite of enabling strategies are sufficiently developed and respond accordingly to its outcomes in terms of ensuring the necessary capacity and capability is in place to deliver its requirements (including transformation).**	6.1 Develop through co-production a comprehensive clinical strategy in order support the development of a financial sustainability plan.	Chief Executive Medical Director	End Q1 for framework End Q3 for detail	Clinical Strategy Implementation Lead in post. Draft Clinical Strategy under review and undergoing further engagement
		6.2 Commission and then embed a continuous improvement approach across the Trust to support transformation of services with clear expected outcomes and KPIs.	Chief Executive	End Q1 for commission	Appointment of a CQI partner has been completed and timescales for training and delivery are being finalised.
		6.3 Develop Trust Performance Management and Accountability Framework.	Chief Executive	End Q1	As per 1.4. CQI partner tender completed Q1 and now appointed and will commence with the co-creation of the IAF during Q2.

Quality statement 2: Capable, compassionate, and inclusive leaders

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q1 2026
7.	**The Board should consider formalisation of its capability assessment via a structured Board Development Programme that includes team building, development of a formal Board Skills Matrix to demonstrate suitability of skills/experience and identify gaps, and an associated Succession Plan which sets out the forward look regarding Board requirements and known churn.**	7.1 Commission a Board Development Programme agree requirements, scope and timescales.	Associate Director Corp Governance	End Q1	Completed. A revised Board Development Programme proposal has been received and is being considered.
		7.2 Strengthen Board assurance arrangements and Fit and Proper Persons Test annual report to be on CoG agenda	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
		7.3 Maintain and refresh Board and Executive succession plans, taking into informed by skills gaps, anticipated churn and diversity considerations.	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
8.	**The Trust should consider how it can strengthen Board connectivity into the Trust, paying particular attention to executive visibility across sites and all services.**	8.1 See actions 5.3 and extend executive and senior leader visibility arrangements consistently across Care Groups and services.	Director of Communications	End Q4 25/26	Completed and reported – May 2026.
		8.2 Executive Directors meeting to be held at each Hospital site with purposeful 'back to the floor' time prior to each meeting.	Chief Executive	Complete	Completed and reported – May 2026.
		8.3 Schedule a Board meeting in 2026 at Malton and Selby followed by Board visits to clinical areas.	Associate Director Corp Governance	End Q3	Underway. Dates and specific venues being considered for future meetings at Malton and Selby.
9.	**The Trust should consider how it might increase the voice of stakeholders (staff, patients and external partners) into Board and committee to provide**	9.1 Patient story at start of each Board meeting.	Chief Nurse	Complete	Completed and reported – May 2026.
		9.2 Patient survey results to be reported to Board.	Chief Nurse	Start Q1	There are 6 national patient experience surveys per year that focus on specific areas

	improved triangulation of assurances.				such as cancer, inpatient care and end of life care as well as other areas. The next main national inpatient survey is due to be released in August 2026 and will be reported to Patient Experience Subcommittee in September 2026 and onward to Quality Committee then Trust Board as required.
		9.3 Patient complaints and PALS reports to Board every three months.	Chief Nurse	End Q1	The first report that will be formally presented to Trust Board is scheduled for September 2026.
		9.4 Increase Freedom to Speak Up reporting to the Board every three months supported by triangulated themes with other workforce and quality intelligence	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		9.5 Develop and implement a structured stakeholder management plan for 26/27, including objectives, engagement cadence, escalation routes and feedback loops.	Director of Communications	Start Q1	Underway. Final draft plan ready for discussion and approval. Approval route tbc. See 29.1 and 30.1.
10.	**The Trust should consider introducing a more formalised NED induction process addressing the points raised within this report.**	Develop and implement new and strengthened Non-Executive Director induction plan. All NEDs who have commenced in the last 18 months to undertake in addition to new starting colleagues.	Associate Director Corp Governance	End Q2	Underway. A revised induction programme currently under development for future Board of Directors proposal.
11.	**The Trust should consider how it might further strengthen collegiate working within the**	Corporate Directors meeting to be restructured with scheduled areas of focus each week along with a clearly	Chief Executive	Complete	Completed and reported – May 2026.

	executive team and ensure that briefings/reports into Board and committee meetings have been socialised, discussed and owned across the executive team.	communicated requirement for papers to be socialised and agreed prior to submission to Board.			
12.	**The Trust should consider the relevance of the existing Leadership Framework and how it might re-energise it and monitor take up and impact.**	12.1 Undertake a full review of the leadership and development programme across the organisation (see 4.3)	Director of Workforce & OD	End Q2	Informed by work referred to in 4.6. Internal leadership and management offer being reviewed in line with launch of national M&L Framework.
		12.2 Provide digital literacy and AI training for managers and leaders where this is identified on their PDP	Chief Digital Officer	End Q4	Over the past year the Trust has delivered a comprehensive Microsoft skills and adoption programme covering Outlook, Teams, OneDrive, SharePoint, Microsoft 365 collaboration tools, Power BI and Microsoft Copilot. This has included formal Microsoft-led training, self-service learning through the NHSmail Academy and Viva Learning, SharePoint and Teams adoption support, dedicated Copilot training pathways, prompt engineering workshops, a Copilot Champions network, and access to national NHS AI learning programmes. Together these initiatives

					have helped staff develop digital confidence, adopt modern ways of working and realise productivity benefits from the Trust's investment in Microsoft technologies.
		12.3 (see 5.1 and 5.2) Undertake detailed scrutiny of staff wellbeing, absence trends and workforce processes, identifying root causes and targeted interventions.	Director of Workforce & OD	End Q1	Completed
		12.4 KPIs for completion of HR processes with points of escalation for additional support	Director of Workforce & OD	End Q1	Completed

Quality statement 3: Freedom to speak up

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

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

	areas of cultural concern and/or themes.	14.3 Reportable issues log to include themes of grievances along with triangulation of FTSU data.	Director of Workforce & OD	End Q4 25/26	Completed.
		14.4 To further embed the Managing Violence and Aggression policy launched in 2025 to manage patients who are racist or discriminatory to colleagues	Chief Nurse	End Q1	The Chief Nurse will be leading an update of the current policy in line with its expected review date, with a particular focus on the pathway management of challenging behaviour across both a clinical and non-clinical manifestation.
		14.5 Support staff networks to fulfil their potential through clarifying their role, support they can expect and executive sponsorship.	Director of Workforce & OD	End Q1	Completed.
15.	**The Trust should consider the appropriateness of hosting the FTSU process within the DWOD's portfolio and the effect on perceived independence.**	Host FTSU process via the CHIEF EXECUTIVE	Chief Executive	Complete	Completed and reported – May 2026.
16.	**The Trust should consider ways in which it can strengthen feedback from the FTSU process to demonstrate impact of speaking up to encourage take up of the service.**	16.1 FTSU report to Board every three months (as per 9.4).	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		16.2 Quarterly article in *Staff Matters* on positive changes resulting from FTSU.	Director of Communications	End Q1	Completed. First article featured June 2026. Quarterly meetings in place with communications team and FTSU Guardian to plan content.
		16.3 At quarterly Board meetings where FTSU report will be received substitute a	Director of Workforce & OD	End Q1	Completed and reported – May 2026.

		patient story for a colleague story in an anonymised way to evidence how learning from FTSU has been taken.			

Quality statement 4: Workforce equality, diversity and inclusion

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q1 2026
17.	**The Trust should consider strengthening alignment of EDI actions with feedback concerns and ensure systematic evaluation of the effectiveness of interventions.**	Full review of key themes arising from the staff survey for colleagues with protected characteristics leading to a targeted plan that is co-produced with the staff networks	Director of Workforce & OD	End Q1	Completed. Full analysis of results have been undertaken and shared with the Anti Racism Steering Group. Actions added to WRES and WDES action plans, EDI workstream actions and played into planning for the next Staff Survey.
18.	**The Trust should ensure that EDI issues form part of the overall Trust approach to improving culture including Board oversight and scrutiny of EDI matters.**	Progress against plan to be reported back to the Board every six months on progress to date via the Executive Sponsors.	Director of Workforce & OD with Exec Sponsors	End Q2	WRES and WDES action plans were shared with Resources and Board in April and updates will continue as per the schedule.
19.	**The Board should consider how it can further improve the diversity of inputs at Board and senior leadership levels of the Trust.**	Increase the diversity of Board members to be more reflective of the organisation.	Associate Director Corp Governance	Q1	Completed. Explicit considerations of diversity will be included in future Board role advertisements. The Trust is also works with underrepresented groups on Board experience as part of the Insights Programme.
20.	**The Trust should ensure that executive sponsorship of staff networks leads to meaningful**	20.1 CHIEF EXECUTIVE to set clear expectations of role of Executive Sponsors of the staff network groups (also see 18).	Chief Executive	End Q4 25/26	Completed and reported – May 2026.

	inputs, dialogue and effective outcomes.	20.2 Each executive Director to have a meaningful and measurable EDI objective set at annual appraisal	Chief Executive	End Q1	Completed.
21.	**The Trust should undertake deep dive scrutiny over staff absences and ensure that the Trust wellbeing offer helps address and mitigate the root causes.**	Undertake ongoing scrutiny of staff wellbeing, absence trends and workforce processes, identifying root causes and targeted interventions feeding through to the Resources committee.	Director of Workforce & OD	End Q1	Completed.
22.	**The Trust should seek ways in which it can improve medical staffing appraisal rates.**	N/a	Medical Director	Complete	Completed and reported – May 2026.

Quality statement 5: Governance, management and sustainability

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q1 2026
23.	**The Trust should seek to clarify the role and purpose of the unitary Board and its committees and ensure an appropriate focus is maintained at each level supported by strengthened governance processes as identified within our report.**	23.1 Review Terms of Reference and work plan of the Trust Board meeting and Committees including frequency, scope and attendees.	Associate Director Corp Governance	End Q2	Completed and reported – May 2026.
		23.2 Clarify inclusion or exclusion of the BAF at committees via review of the terms of reference.	Associate Director Corp Governance	End Q1	Completed. Oversight of the respective Board Assurance Framework (BAF) risks are included on Committee's Terms of Reference, to be reviewed quarterly and reported to the Board of Directors.
		23.3 Board development session to be scheduled on the role and optimal function of a unitary Board and highly functioning committees.	Associate Director Corp Governance	End Q2	Underway. To be included in a forthcoming Board Development Seminar provided by an external partner.
		23.4 Improve action plan/log hygiene through standard work e.g. specific dates not 'asap' and only complete when it can be evaluated (i.e. not an intention)	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		23.5 Board Committee escalation reports to include a heading "Assurance Gained".	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
		23.6 Capital expenditure report in the monthly financial report to include forecasts	Director of Finance	Complete	Completed and reported – May 2026.
		23.7 Strengthen Programme Management and reporting arrangements	Chief Executive	End Q1	This has been delayed and will be completed in Q2 linked to transformation and the roll out of the CQI.

		23.8 Consider annual joint working programme with Council of Governors	Associate Director Corp Governance	End Q1	Completed. A joint Board of Directors/Council of Governors meeting is scheduled for 9 September to discuss the Clinical Strategy where further joint working will be discussed.
		23.9 Governor questions to be on the public agenda of CoG and categorised by: governance, public, staff, stakeholder	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
24.	**The Trust should consider the appropriateness of oversight of the digital agenda including the existing arrangements for EPR implementation given the level of risk such a transaction presents to the Trust.**	24.1 EPR as standing item on Risk Committee Meeting.	Chief Executive	Complete	Completed and reported – May 2026.
		24.2 Increase Board visibility and assurance over EPR delivery via Monthly Board report, including risks, readiness, dependencies and post-implementation requirements.	Chief Digital & Information Officer	Start Q1	Completed and reported – May 2026.
25.	**The Trust should consider how it can assure itself over the adequacy of data capability and capacity both within the digital function and wider Trust to deliver the forward requirements of the digital transformation agenda.**	Undertake a comprehensive review of the current data and analytics capability across the Digital function and the wider Trust, including skills, capacity, operating model, and data quality maturity. Using the findings, develop and implement a Trust-wide Data Capability and Capacity Framework that sets out required competencies, resource levels, training pathways, role clarity (including information asset ownership), and an approach to improving data literacy across all levels of the organisation. This framework will also define the model for business intelligence service delivery	Chief Digital & Information Officer	End Q3	

		and ensure alignment with the Trust's digital and clinical strategies.			
26.	**The Trust should consider introducing a Performance Management and Accountability Framework supported by appropriate roll out training and support.**	26.1 (Also 6.3) The Trust will develop an Integrated Accountability Framework from ward to Board that has clearly defined roles and responsibilities.	Chief Executive	End Q1	Will be completed via the roll out of the IAF as part of the CQI tender.
		26.2 Each lead executive responsible for a pillar of delivery (Quality, finance, workforce, service delivery) will work to streamline and strengthen assurance processes from ward to Board through good governance.	Chief Executive	End Q1	Will be completed via the roll out of the IAF as part of the CQI tender.
		26.3 Launch of the IAF will be supported by organisational development so roles and responsibilities at all levels are understood.	Director of Workforce & OD	Start Q2	This will form part of the latter stages of the 'Big Conversation' programme of work, which will commence in July 26.
27.	**The Trust should consider strengthening its approach to risk management in line with our report observations including the operationalisation of risk appetite to support risk escalation / de-escalation within the Trust**	27.1 Risk Committee terms of reference to be reviewed to become a subcommittee of the Board	Associate Director Corp Governance	Start Q1	Completed and reported – May 2026.
		27.2 Ensure consistent format of reports from Care Groups and Directorates	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		27.3 Develop and deliver a comprehensive risk management training package	Associate Director Corp Governance	End Q2	CSCS Care Group Risk Management Training conducted by specialty. Q2 focus is on Family Heath.
		27.4 Resolve, explain difference between SHMI and HSMR	Medical Director	End Q1	Completed and reported – May 2026.
28.	**The Trust should consider implementing a more consistent and Trust-wide**	28.1 (Also 26) Review of PRIM and approach to accountability framework to be undertaken, including roles and responsibilities.	Chief Executive	End Q1	Will be undertaken as part of the IAF review in conjunction with the CQI.

	approach to PRIM and care group management level meetings which includes clear 'do minimum' expectations regarding inputs (agenda, coverage, paper format, and attendance) and outcomes (minutes, action logs, escalations) in line with our report observations.	28.2 Develop 'standard work' for agendas and minutes etc of PRIMs and Care Group Management Boards.	Chief Operating Officer	Start Q2	PRIM TOR reviewed, and a move to formal minutes commencing from Q2. Care Group meetings reviewed, and an improvement plan for reporting assurance to be developed with the Associate Director for Corporate Governance through Q2.

Quality statement 6: Partnerships and Communities

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q1 2026
29.	**The Trust should consider how it might raise the profile and voice of stakeholder feedback as part of triangulation of assurances. This should include the voice of staff, patients and system partners.**	29.1 See recommendation 9.	Director of Communications	Start Q1	See 9.5. and 30.
		29.2 Seek specific partner stakeholder feedback annually prior to appraisal.	Director of Communications	Start Q4	
30.	**To support the above, the Trust should consider the development of a more proactive and structured approach to stakeholder management.**	See 9.5	Director of Communications	Start Q1	See 9.5. and 29.1.
31.	**The Trust should ensure that its Communications Strategy refresh exercise takes into consideration the findings within this report, the work of the Trust change makers as well as wider engagement with internal and external stakeholders.**	31.1 Refresh the Communications Strategy to strengthen two-way communication and visible feedback loops.	Director of Communications	Start Q1	Underway. Draft strategy ready for discussion and approval. A number of changes already implemented to improve two-way communication to support the Chief Executive's First 100 Days engagement plan and in response to recommendations from the colleague survey carried out in partnership with the Change Makers.
		31.2 (See 1, 3 and 5) detailed and deep staff engagement exercise to be completed with the aim embedding a	Chief Executive	End Q1	Will be completed via the Big Conversation which is

		strong and supportive culture across the organisation.			being planned in Q1 and delivered in Q2.
32.	**As part of the shift to proactive and more strategic partnership relations, the Trust should consider its anchor institution role and what this means for the Trust alongside how it can best support improvements in health inequalities.**	32.1 Director of Strategy to take Executive responsibility in advancing the role of the Trust as an Anchor Institute with an annual report to Board on progress and plans.	Director of Strategy	End Q3	
		32.2 Clinical Strategy to contain focused work on helping to address health inequalities across the Trust's geography.	Medical Director	End Q2	Clinical Strategy development ongoing.
33.	**The Trust should ensure that deputies are well briefed and able to represent the Trust when deputising for Trust officers at system meetings beyond any immediate operational needs.**	Individual Executives are to ensure that deputies who attend understand meetings on their behalf are able to attend meetings in an informed way with a clear understanding and pre agreed level delegated authority.	Executives	End Q4 25/26	Completed and reported – May 2026.

Quality statement 7: Learning, improvement and innovation

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q1 2026
34.	**The Trust Board should ensure appropriate oversight and assurance of the rollout of QI methodology and building of QI capacity given that it is one of the Trust's breakthrough objectives for 2025/26.**	34.1 Initial rollout plan to be monitored Resources Committee and reported to Board.	Chief Executive	After commissioning and commencement	On track.
		34.2 Strengthened PMO oversight, clear benefit realisation and assurance framework to be developed as part of the programme and reported to Board via Resources and Quality committees.	Chief Executive	After commissioning and commencement	Is being undertaken as part of alignment of transformational leadership.
35.	**The Trust should consider ways in which it can strengthen the dissemination of learning within and across care groups. This should also include consideration of the formal mechanisms and processes for triangulating learning across multiple data points.**	35.1 Approach to shared learning across care groups will be agreed via Senior Leaders Forum and mapping conducted in how sharing is already conducted.	Director of Quality, Improvement and Patient Safety	End Q1	Mapping our learning opportunities and current learning approaches underway within Care Groups and we will triangulate this with corporate approaches. Currently we have the weekly Patient Safety Bulletin that is disseminated via email to all users. This is also presented to Patient Safety and Clinical Effectiveness Subcommittee on a monthly basis. We also have the Staff Matters Magazine in which there is a dedicated section on patient safety. In addition, we also have the Health and Safety Bulletin that goes out via email on a monthly basis.

		35.2 Executive Committee and Senior Leaders Forum will be used for triangulation purposes and a schedule of areas of focus will be devised (supported by data) in order to direct and focus on continuous quality improvement.	Director of Quality, Improvement and Patient Safety	End Q1	The update from May is still relevant. In addition, we have started the work of mapping key safety indicators across 6 specialties linked to national Quality Accounts and through engaging senior clinical staff in identifying key safety indicators to them. This will then support further work to develop key quality indicators for triangulation of multiple data points within specialties.
36.	**The Trust should consider its approach to assuring itself that it has sufficient transformational change capacity and capability to support its forward agenda. This should include clarity of leadership of transformation and Board/committee reporting for assurance purposes.**	36.1 Chief Executive to review programme management, project management and continuous improvement capacity and capability, including approvals, reporting and accountabilities arrangements as well as benefit realisation	Chief Executive	Start Q2	Is being undertaken as part of alignment of transformational leadership.
		36.2 Commission a follow-up internal audit of the Quality Assurance Framework	Associate Director Corp Governance	End Q3	To be concluded. Discussion required at the Audit Committee for a change to the Internal Audit annual plan to incorporate a review of the Quality Assurance Framework.
37.	**The Trust should consider whether the existing profile and membership of the Research & Innovation**	37.1 Review the profile, membership and reporting of the Research and Innovation Committee to align with strategic ambition and teaching status.	Associate Director Corp Governance	End Q1	Completed. A proposal has been drafted for review for revised Research and Innovation Committee arrangements.

	Committee is commensurate with the Trust's teaching status and stated desire to increase research activities as part of delivering the Trust's strategy.	37.2 Agreed and including role as MEDICAL DIRECTOR as Chair or Deputy Chair of R&I Committee	Associate Director Corp Governance	End Q1	Completed. A proposal has been drafted for review for revised Research and Innovation Committee arrangements.

Quality statement 8: Environmental sustainability

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q1 2026
38.	**The Trust should review its Green Plan against the latest NHSE guidance to ensure compliance with requirements.**	Review the Green Plan against the latest NHSE guidance.	Managing Director YTHFM	End Q2	The work to update the Trust's Green Plan is nearing completion. As part of this, the Sustainable Models of Care workstream has been reviewed and will move to a joint leadership approach across nursing, medical and allied health professional colleagues. This will provide clearer clinical leadership and oversight, with the joint leads working through the Medical Director and Chief Nurse and into the care groups to identify and take forward opportunities for embedding sustainability more consistently into the Trust's healthcare delivery. Once finalised, the updated Green Plan will be presented to the Trust Board for approval.
39.	**The Trust should consider how it might demonstrate increased whole Board interest and ownership of sustainability including the appointment of a Board level sustainability champion.**	Agree a Board level sustainability champion.	Associate Director Corp Governance	End Q1	Completed. YTHFM Managing Director is the Board level sustainability champion.

40.	**The Trust should consider the merits of appointing a clinical lead for sustainability to support wider engagement with services.**	Appoint a clinical lead for sustainability.	Medical Director	End Q1	Plan has been created for clinical models associated with sustainability. Potential sustainability champions and clinical leads across professions being engaged with.

OTHER CONSIDERATIONS - MISCELLANEOUS

Ref	Action	Responsible Officer	Completion By	Progress Update Q1 2026
M1	Board Assurance Framework - Resolve inconsistencies; cause/effect/controls/ assurances - Identify lead Executive Directors for each principal risk Board to review 1 principal risk each meeting led by lead Executive Director	Associate Director Corp Governance	Apr 26	Completed and reported – May 2026.
M2	Action logs to be completed in advance of meeting sent out with agenda papers (standard work 23.4)	Associate Director Corp Governance	Apr 26	Completed and reported – May 2026.
M3	Coaching to be provided to presenters of Board reports to bring insight into what the paper a paper is telling the reader and where discussion should be focussed.	Associate Director Corp Governance	Apr 26	Completed and reported – May 2026.
M4	Update Constitution, Standing Orders etc to ensure consistency and to represent the Group structure in relation to the LLP.	Associate Director Corp Governance	May 26	Completed and reported – May 2026.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13

TRUST PRIORITIES REPORT

July 2026

Table of Contents

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

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
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-06		F	12.4%	14.5%	5%
ED - Conversion rate (Proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero)	2026-06	L	?	23%		28%
Cancer - Faster Diagnosis Standard - Declared Position	2026-05	H	F	75.2%	73.9%	84.3%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-06	H	F	63.5%	61.4%	67.1%
2-hour Urgent Community Response (UCR) Compliancy %	2026-06		?	75.6%	70%	70%
Total Number of Trust Onset MSSA Bacteraemias	2026-06		?	9	6	7
Response rate overall for complaints and concerns	2026-06		P	64%	90%	90%
Monthly sickness absence	2026-05	H	?	5.3%	4.6%	4.7%
Variance year-to-date to financial plan	2026-06			-1.4%	0%	0%

National Operational Framework

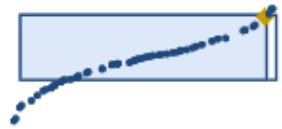
Rank Oversight

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

July 2026

Executive Owner: Claire Hansen

Summary Position

Performance across Operational Activity & Performance remains mixed, with acute flow and elective recovery under sustained pressure from high demand, workforce gaps, diagnostic constraints and community/social care capacity. June detail shows improvements in some core trajectories, but delivery remains dependent on system discharge capacity, diagnostic recovery and specialty-level grip.

UEC: June ECS was off trajectory; 68.8% against the 69.2% trajectory, with Trust-controlled sites performance at 65.2%. Average ambulance handover was behind trajectory at 22m 37s, but Type 1 12-hour waits were ahead of plan at 12.4% against 14.5%. Non-elective LoS, DRD performance and discharge delays remain behind trajectory, reflecting constrained community/social care capacity and EEMAC/EAU flow issues.

Cancer: The Trust achieved both the FDS and 62 Day Cancer targets; May FDS was 75.2% against the 73.9% trajectory and 62-day performance was 67.8% against 67.1%. Risks remain from diagnostic/pathology delays, endoscopy and imaging constraints, referral volumes and site-specific issues in colorectal, skin, gynaecology, urology and lung. Recovery is being managed through tumour-site trajectories, with highest-risk cohorts subject to additional weekly review and pathway-specific mitigations.

RTT: Total waiting list was off trajectory with 56,537 against a 54,210 trajectory; zero waits over 65 weeks was maintained. Under 18-week waiters was ahead of trajectory at 58.7% against 58.3%, but 52-week waits were off trajectory at 1,115 against 806. GP referrals are 5% higher YTD than 2025/26, with material growth in Pain, Orthopaedics, Paediatrics and Gastroenterology. RTT recovery is being managed through weekly/fortnightly specialty-level grip, with Pain Management identified as the most significant variance and subject to additional capacity, commissioning and external review actions.

Diagnostics: DM01 improved to 79.4%, ahead of the 77% trajectory, with reductions in the total waiting list and long waits. Delivery remains exposed to MRI staffing and breakdowns, NOUS capacity and provider transition, echo space/staffing, urodynamics vacancies and CT/MRI equipment delays. Diagnostics is the clearest recovery area this month, with DM01 ahead of trajectory and sustained reductions in long waits; the focus is now on protecting improvement from modality-specific workforce, equipment and provider risks.

Outpatients, CYP and Community: PIFU reached 5.0% but remains below the 5.6% trajectory; RACP improved to 89.1% but remains below the 99% target; DNA remains low at 4.5%. CYP RTT52 waits remain off the zero trajectory and CYP ECS is below plan. Community UCR achieved 76% against the 70% target, while SLT delivered the June trajectory but remains subject to workforce risk. Outpatient productivity provides positive assurance: DNA remains low compared with the national average, RACP is at its best level since pre-COVID, and PIFU has reached 5.0% for the first time, although further acceleration is required to meet trajectory.

Executive Owner: Claire Hansen

Key Risks (Cross-cutting)

- Acute flow remains constrained by community/social care capacity; LoS, discharge delays and Discharge Ready Date metrics are behind trajectory.
- UEC delivery is sensitive to Nervecentre optimisation, Type 3 performance, EEMAC/EAU utilisation and ambulance handover escalation.
- Continued GP referral growth (+5% YTD) is increasing RTT and outpatient demand, with pressure concentrated in Pain, Orthopaedics, Paediatrics and Gastroenterology.
- RTT52 waits remain above trajectory and diagnostic delays/cancer prioritisation may increase long waits.
- Diagnostic recovery is exposed to MRI/CT equipment delays and breakdowns, NOUS capacity and transition, echo constraints, urodynamics staffing and national workforce shortages.
- Cancer recovery depends on diagnostics/pathology, endoscopy turnaround, referral/FIT compliance and delivery of site-specific recovery plans.
- Community, SLT and virtual ward improvements depend on recruitment, medical cover and funding for expanded home-based/neighbourhood models.
- Capital and estate schemes (CDC, RAAC, CT/MRI replacement, hybrid theatre/procedure rooms) remain a capacity risk.

Strategic Priorities (Q2/Q3)

- Stabilise UEC and flow: optimise Nervecentre, improve Type 3 performance, maximise EEMAC/EAU use, complete missed-opportunities audit and handover breach reviews.
- Strengthen system discharge and community pathways: progress acute-to-community alternatives, Hospital at Home/UCR expansion tests and complex-discharge escalation processes.
- Recover and maintain Cancer and Diagnostics: maintain FDS/62-day gains, progress colorectal/gynae/skin/lung actions, expand endoscopy/imaging capacity and deliver CDC, insourcing and recruitment mitigations.
- Improve RTT and elective performance: maintain zero >65-week waits, reduce RTT52 waits and TWL through specialty delivery meetings, RTT Delivery Group, ARIP and pain management focus.
- Increase outpatient productivity and demand management: PIFU-as-standard, template redesign, utilisation and DNA work, C2C reduction and single point of access rollout.
- Address CYP and Community backlogs: progress the SLT business case/new community model.

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 68.8% vs monthly 69.2% trajectory. Average Ambulance Handover behind trajectory. Long stays below trajectory; 12 hr waits in department (T1) 12.4% (ahead of 14.5% trajectory). Flow constrained by community and social care capacity.	A new North Yorkshire and York task and finish group was established to develop and implement a plan to shift care from acute to community, however the group is on hold pending ICB staff changes. In the meantime, we continue to liaise with Yorkshire Ambulance Service about alternative pathways. A missed opportunities audit is being planned, to look at patients who are in our care with no criteria to reside and whether alternative pathways could have prevented their original conveyance, attendance and/or admission. ECS and handover recovery require tighter grip on Nervecentre optimisation, Type 3 performance, EEMAC/EAU use and system discharge capacity. A formal July prioritisation process is in place for Nervecentre optimisation, with urgent and safety-related changes already being actioned and operational metrics monitored through site-level daily review.	Full recovery dependent on wider system demand management and community discharge capacity.
Cancer FDS/62 day	May FDS 75.2% vs 73.9% monthly trajectory. May 62-day 67.8% vs 67.1% monthly trajectory. Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.	New colorectal cancer lead appointed and MDT streamlining commenced. Ongoing discussions with endoscopy around pilots to improve TAT through streamlining booking processes and provide additional capacity. Initial scoping discussions around COLOFiT, awaiting alliance lead on next steps. 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, MOPs continued to be prioritised on clinical urgency. Scoping for community models pre-LES expiry in December 2026 but no definitive system plan yet.	Gradual improvement through 2026/27. However national targets remain high risk due to referral volume and diagnostics.
RTT TWL / %<18w/52w	TWL 56,537 provisionally against the trajectory of 54,210. Provisional <18w: 58.7% vs 58.3% trajectory; Trust was ranked 93/118 in April. 52-week waiters 1,115 (Provisional position) v trajectory of 806. GP Referral growth +5% 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 79.4%, ahead of trajectory (77%). Impact from MRI workforce shortages, mobile breakdowns, NOUS outsourcing capacity levels, 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. Handover of CT at Scarborough CDC complete and now fully operational which should help maintain performance.	Improvement through quarter but recruitment and equipment risks remain.
Outpatients	PIFU 5% vs 5.6% trajectory. RACP 14-day performance 89.1%, below 99% target. Best Performance since pre-COVID. 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 waits9off trajectory of zero. CYP ECS 81.9% below trajectory of 93%.	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 July .	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 Hospital at Home in ED, SDEC and Selby.	Large strategic change required with confidence for 2026/27 if WTE mitigation can be recruited.

Headlines:

- It was hoped that the impact of the change to Nervecentre would settle during June and support recovery of key metrics, however this has not been possible.
- The June 2026 Emergency Care Standard (ECS) position was 68.8%, behind the monthly planned improvement trajectory of 69.2%. 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. In the latest available national data (May 2026) the Trust ranked 94th out of 118 providers and 10th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group (April performance saw the Trust at 54th and 6th respectively). ECS Performance for Trust controlled sites was 65.2% in June 2026.
- Average ambulance handover time in June 2026 was behind trajectory at 22 minutes 37 seconds against trajectory of 20 minutes 20 seconds.
- 12.4% of Type 1 patients spent over 12 hours in our Emergency Departments during June 2026, ahead of the monthly improvement trajectory of 14.5%. **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 8.1 days in June 2026, behind the trajectory of 6.3 days.
- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) during June 2026 was 84.8%, against the trajectory of 87.9% 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 5.8 days, behind the submitted trajectory (3.4 days).

Factors impacting performance:

- The use of Extended Emergency Medicine Ambulatory Care (EEMAC) and Emergency Assessment Unit (EAU) pathways has not been maximised.
- Type 3 performance was 91% in June (target 95%), negatively impacting the overall Trust performance. Investigation into this is underway.
- Staffing issues continue, with instances of high levels of late-notice absence and the need for internal aid.
- There are ongoing community health and social care constraints causing delays to discharges for patients requiring onward care.

Actions planned in July 2026:

- A workshop is taking place in July to work through the list of ~100 suggestions for changes to Nervecentre and agree a process for prioritisation. Requests considered urgent or impacting safety are being immediately actioned.
- Identify reasons for poor Type 3 performance and put a plan in place to rectify.
- Submit business case for investment in substantive frontline staff in both Emergency Departments / Emergency Assessment Units.

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	2026-06			76.4%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-06	L		6.4%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-06		F	12.4%	14.5%	5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-06		F	1595	1565	558
ED - 12 hour trolley waits - Declared Position	2026-06		F	288		0
ED - Emergency Care Attendances - Declared Position	2026-06			19124		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-06		F	68.8%	69.2%	82%
ED - Emergency Care Standard (Trust level) - Declared Position	2026-06			65.2%		
ED - A&E attendances - Type 1 - Declared Position	2026-06	H	?	12858		10999
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-06		F	52.8%	45%	70.1%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-06			6266		
ED - Median Time to Initial Assessment (Minutes)	2026-06	L		3		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-06	L		19.7%		

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		* Of those overnight general and acute beds open, proportion occupied	* Number of non-elective admissions
COMMON CAUSE / NATURAL VARIATION	* Overnight general and acute beds open	* Community bed occupancy/availability	* Patients receiving clinical Post Take within 14 hours of admission
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

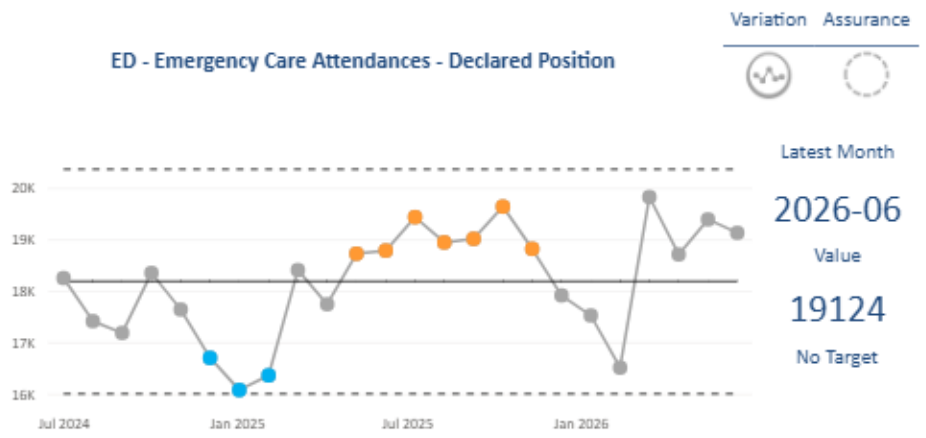
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

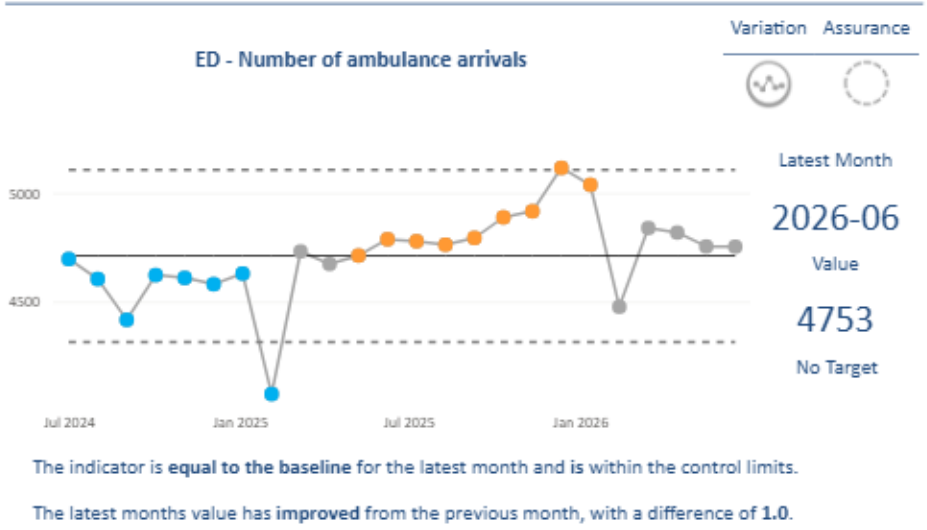
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of SDEC attendances	2026-06			6170		
Proportion of SDEC attendances transferred from ED	2026-06			44%		
Proportion of SDEC attendances transferred from GP	2026-06			18.8%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-06			95.7%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-06			22.1%		
Number of RAFA attendances (York Only)	2026-06			0		
Number of attendances at SAU (York & Scarborough)	2026-06			3		
ED - Proportion of Ambulance handovers within 15 mins	2026-06			30.4%		
ED - Proportion of Ambulance handovers over 15 mins	2026-06			69.6%	61%	49.6%
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-06			23.2%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-06			4.3%	2.3%	0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-06			0%		0%
ED - Number of ambulance arrivals	2026-06			4753		
ED - Ambulance average handover time (number of minutes)	2026-06			23	20	19

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

A new North Yorkshire and York task and finish group was established to develop and implement a plan to shift care from acute to community, however the group is on hold pending ICB staff changes. In the meantime, we continue to liaise with Yorkshire Ambulance Service about alternative pathways.

A missed opportunities audit is being planned, to look at patients who are in our care with no criteria to reside and whether alternative pathways could have prevented their original conveyance, attendance and/or admission.

What is the expected impact?

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

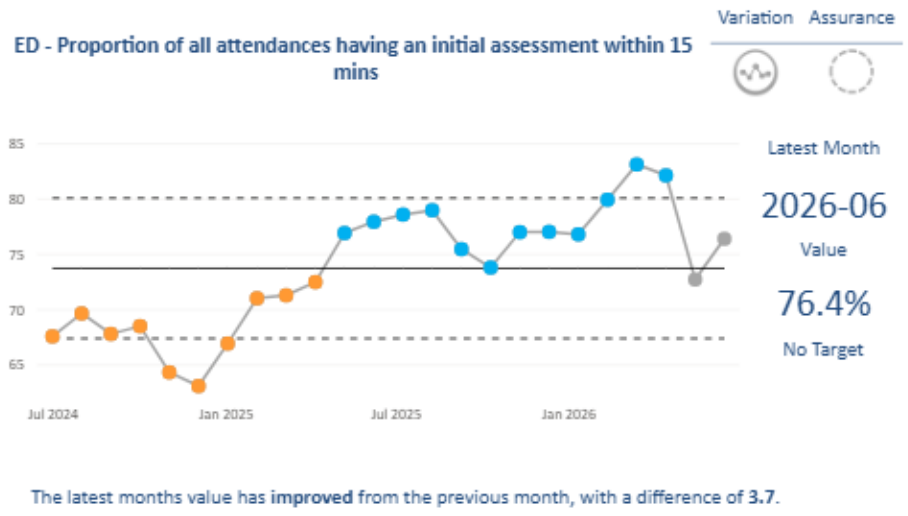
Increasing use of non-ED pathways may reduce or slow the increase of ambulance arrivals and attendances in the meantime. Currently we are tracking slightly below last year's arrival numbers.

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 declined as expected during the early implementation of Nervecentre, and is now showing signs of recovery.

The senior ED team has plans in place to more closely monitor time to streaming and time to initial assessment by site and by hour; there is a daily meeting in place for reviews.

What is the expected impact?

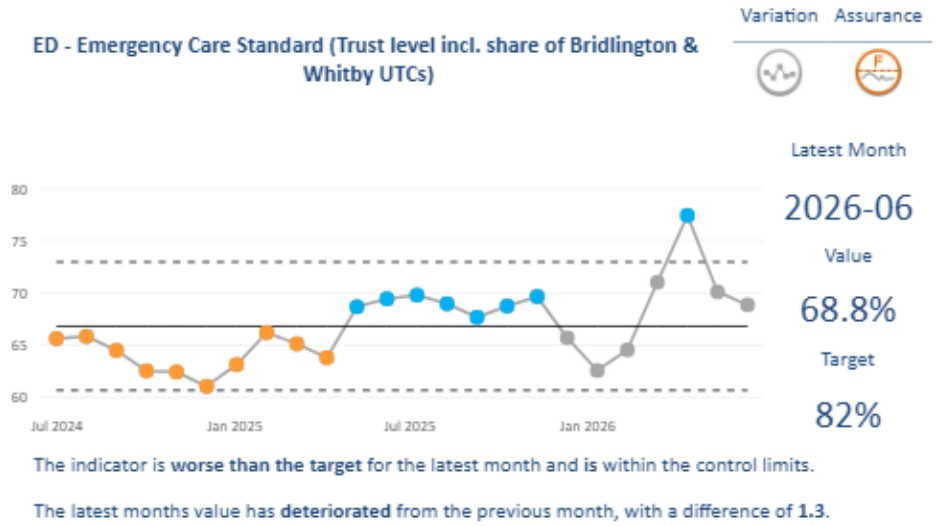
It is expected that multiple key metrics relating to our Emergency Departments continue to recover in June 2026 as the new system becomes more embedded.

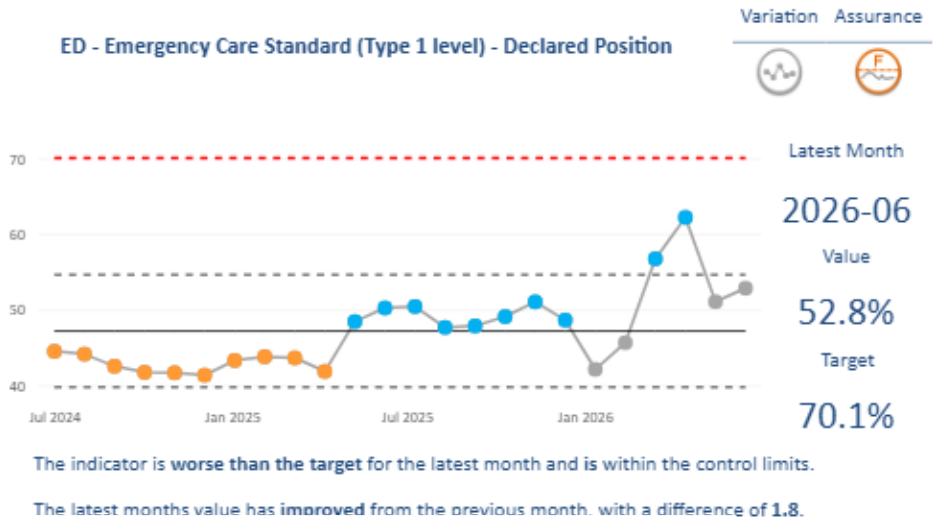
Potential risks to improvement?

- Staff absence rates
- Some days with extremely high attendance levels

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

As per national mandate from 2026/27 100% of Bridlington and 50% of Whitby UTCs are mapped to the Trust for performance purposes.

What actions are planned?

Both Emergency Departments continue to be impacted by Nervecentre, as staff adjust to new processes. Staff are requesting small changes to the system which could increase efficiency. A workshop is taking place in July to work through the list of ~100 suggestions and agree a process for prioritisation. Requests considered urgent or impacting safety are being immediately actioned.

Escalation process for issues with Type 3 performance are being reiterated and must be followed, with total performance in June 2026 at 91%, below the target of 95%.

Breach validation is a focus for the operational team, while clinical teams get used to real-time recording.

What is the expected impact?

Closely monitoring and managing Type 3 performance in July could lead to performance increases of ~2 percentage points overall. Identification and correction of 'false' breaches through validation could produce a further ~1 percentage point.

Potential risks to improvement?

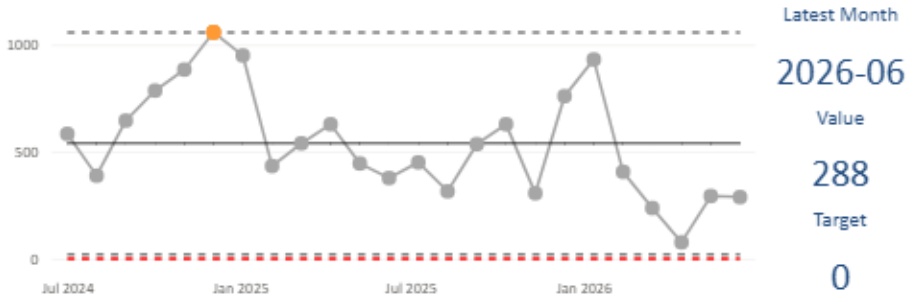
- Lack of operational capacity and multiple conflicting priorities.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

ED - 12 hour trolley waits - Declared Position



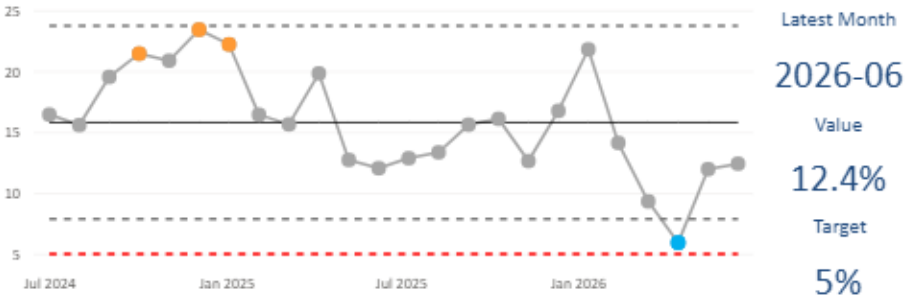
Latest Month
2026-06
Value
288
Target
0

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

The latest months value has **improved** from the previous month, with a difference of **5.0**.

Variation Assurance

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



Latest Month
2026-06
Value
12.4%
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 **0.4**.

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

What actions are planned?

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

In May and June there have been challenges with flow out of EAU, causing a 'bottleneck' which limits its effectiveness in taking patients out of ED. The senior ED team is planning to undertake reviews of EAU patients awaiting acute plan, diagnostics or onward transfer and to confirm the escalation route when EAU is unable to pull from ED or is being used as short-stay capacity. This will enable revision or reiteration of the process, and clear escalation for when it is not being used appropriately.

What is the expected impact?

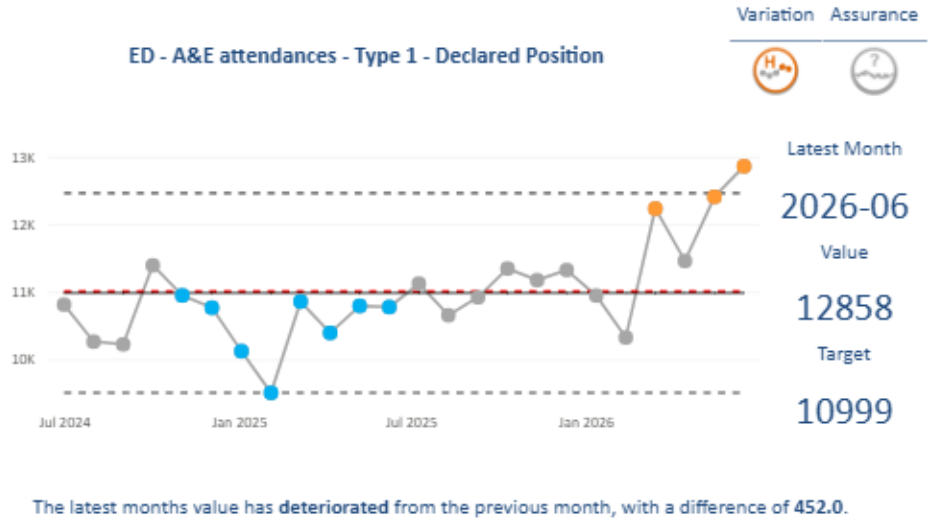
We expected the July position to be like May and June while escalation processes are agreed and become embedded.

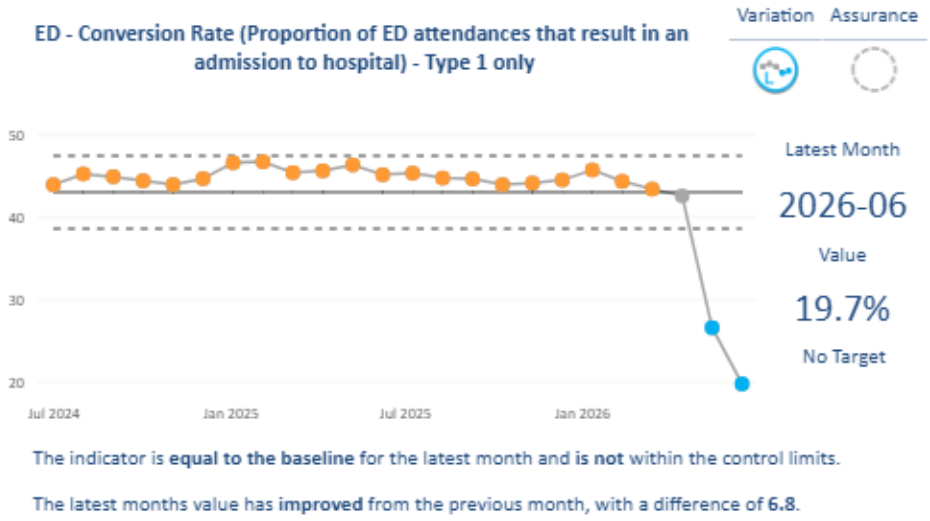
Potential risks to improvement?

- Community health and social care capacity remains challenged.
- Limited capacity in ED and acute teams to monitor, escalate, review, refine, and communicate changes. High volume of competing priorities for action.

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.

What actions are planned?

Following some spikes in attendance levels in June, with extremely high attendance levels at both main sites, analysis was carried out by our NHS England regional colleagues. This has been reviewed and no clear patterns, themes or causes were identified, meaning there is little action we can take to protect ourselves from a similar situation in future.

To ensure the 'new' conversion rate measure remains low, there is a requirement to ensure we have sufficient senior medical staff to cover all areas (ED, EEMAC, EAU) every day with ED, Acute and Geriatricians all essential. A business case for additional senior medics is being prepared.

What is the expected impact?

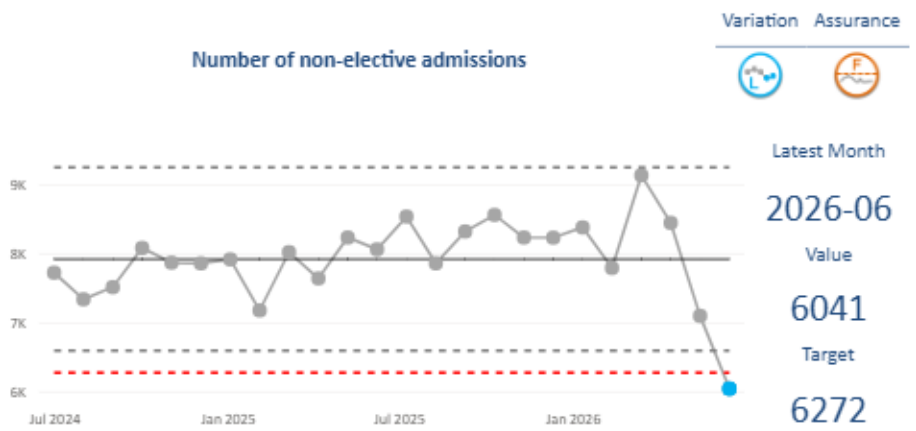
The reduction in admissions to the main bed base, ie general and acute beds, should hold.

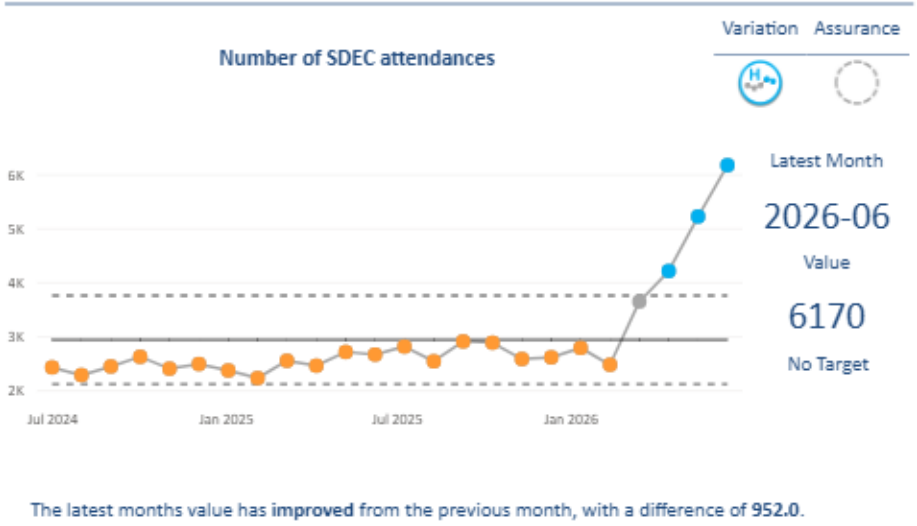
Potential risks to improvement?

There is a risk that the workforce required to maximise the impact of new front-door pathways will be unaffordable given our financial position.

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.

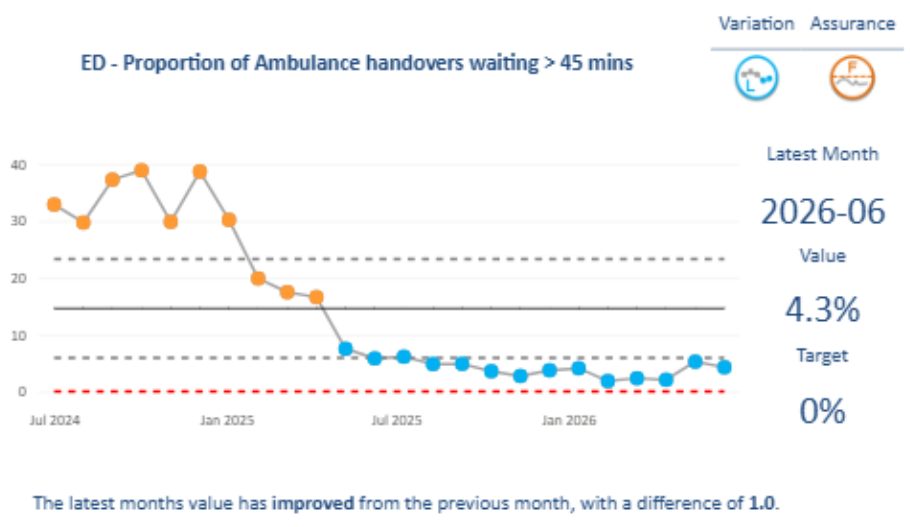
Note: At the launch of Nervecentre, admissions no longer includes admission to Type 5 SDEC areas. This explains the significant drop off in NEL admissions and the corresponding rise in SDEC attendances May 2026.

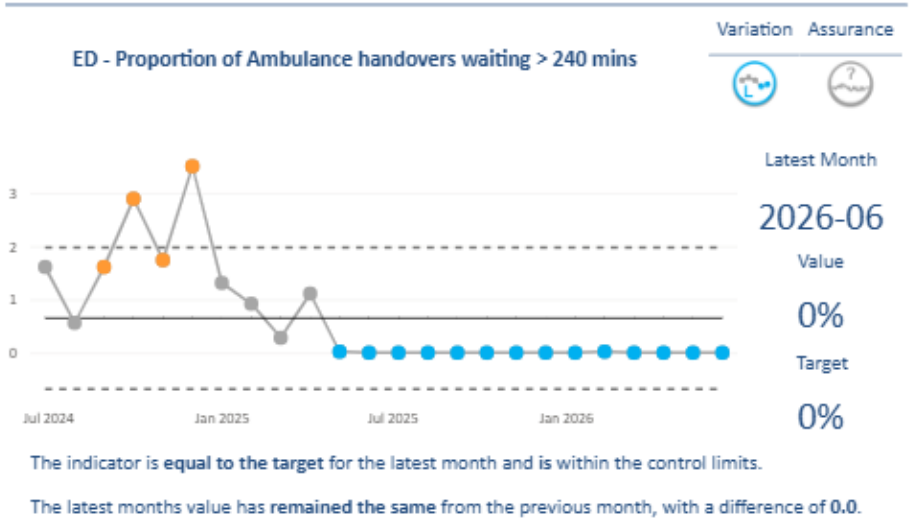
SDEC attendances includes all patients going to EEMAC and EAU, which accounts for the large increase in SDEC activity.

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?

Regular meetings with Yorkshire Ambulance Service (YAS) team leaders for both sites have started, to ensure cross-organisational team working on this priority.

Several actions are due to start in July to support this metric, including:

- Validate ambulance handover delays and breach reasons daily
- Reconfirm handover escalation triggers, including >30 and >45 minutes
- Review all handovers exceeding 45 minutes to identify avoidable delay
- Review receiving area capacity, oversight and escalation process
- Ensure fit-to-sit and cohorting processes are applied and clinically safe
- Link ambulance handover delays to flow actions, not just ED actions
- Review staffing levels for ambulance receiving and escalation areas

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?

High number of competing priorities for the senior ED and acute team, risking ability to complete agreed actions.

Acute Flow (3)
Scorecard

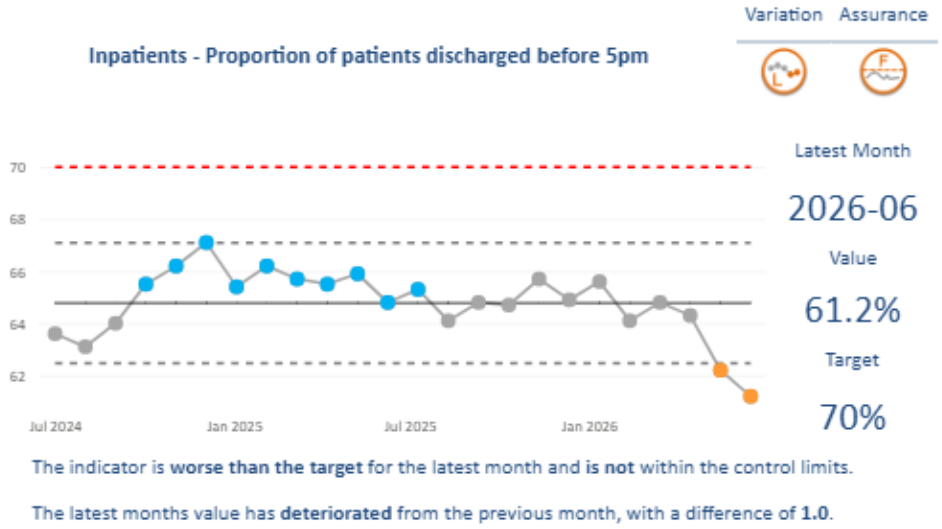
York and Scarborough Teaching Hospitals NHS Foundation Trust

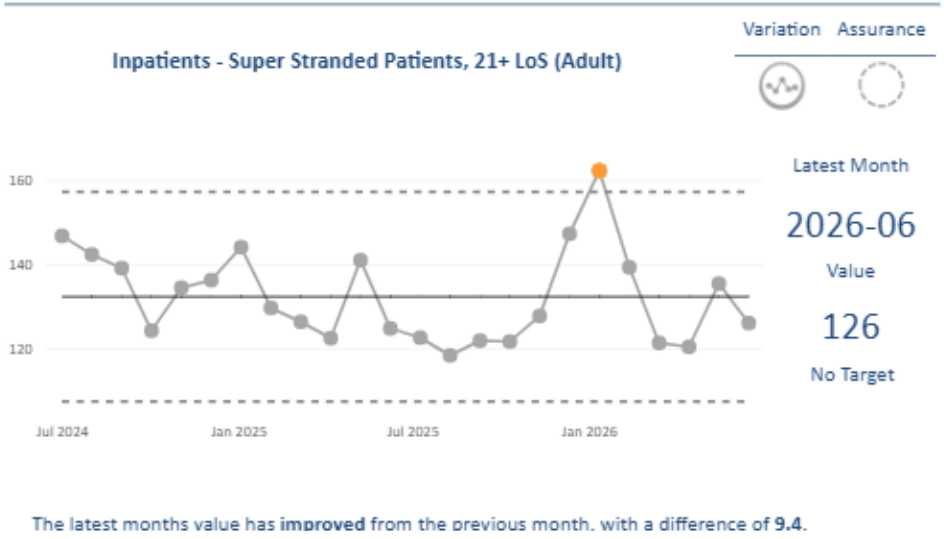
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2026-04		F	78.4%		90%
Patients with Senior Review completed at 23:59	2026-04	L		44.7%		
Inpatients - Proportion of patients discharged before 5pm	2026-06	L	F	61.2%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-06	H		1855		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-06			13.5%		
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-06	H	?	5.8	3.4	3.7
Number of non-elective admissions	2026-06	L	F	6041	7809	6272
Number of zero day length of stay non-elective admitted patients	2026-06	L		901		
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-06			126		
Overnight general and acute beds open	2026-06		P	878	843	843
Of those overnight general and acute beds open, proportion occupied	2026-06	L	?	90.2%	92.1%	93.2%
Community bed occupancy/availability	2026-06		?	89.1%		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

Note, the graph does not take into account that many patients move to the discharge lounge before 5pm, making beds available.

What actions are planned?

- The Coming off Corridors project is progressing and one element is 'long length of stay'. A QI workshop is planned with clinical leads in July, for them to consider options for safely reducing length of stay on their wards. These ideas will then be shared with the rest of the MDT for refinement and progression of actions.
- Coming off Corridors is planning for clinicians to have protected time throughout September to progress actions to support discharges.
- In the meantime there is enhanced operational support for reviewing medical patients with a long length of stay, and a targeted approach for intervention.

What is the expected impact?

- Expecting levels of super-stranded patients to hold position before an improvement in September.

Potential risks to improvement?

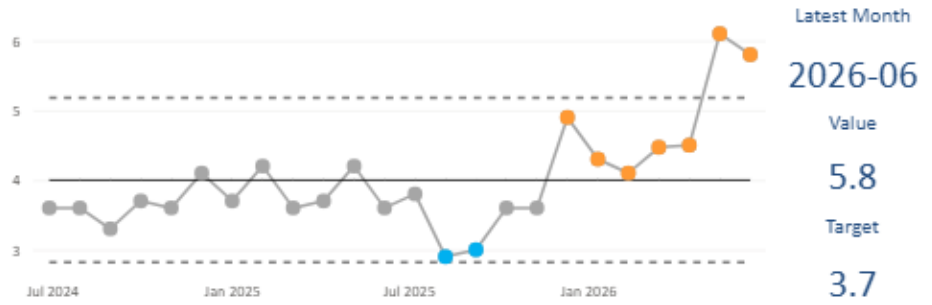
- Ongoing limitations in community health and social care capacity.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

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

Variation Assurance



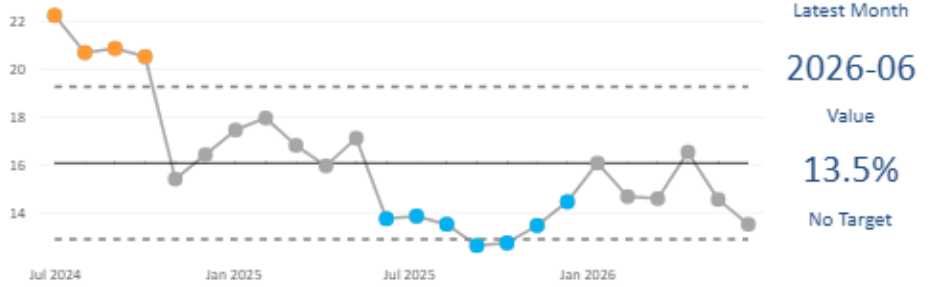
Latest Month
2026-06
Value
5.8
Target
3.7

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

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

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

Variation Assurance



Latest Month
2026-06
Value
13.5%
No Target

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

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

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 with Nervecentre, and supports a shift to 'describe, not prescribe' and patients moving out of acute care sooner. Further feedback from local authorities is being sought throughout July, now that there has been a settling in period.
- For delayed complex discharges we have held a process-mapping session with the QI team and system partners, to review the escalation process. Next steps are being developed and a follow-up session is planned.
- This review of escalation routes and processes will support discharges for patients with no criteria to reside, and particularly to reduce the delays between discharge ready date and departure date.

Potential risks to improvement?

- Ongoing 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			* Cancer - Faster Diagnosis Standard - Declared Position
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait from diagnosis to first treatment - 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	2026-05	H	F	75.2%	73.9%	84.3%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-05		F	67.8%	67.1%	80%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-06			146		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-06			5.9%		
Cancer 31 day wait from diagnosis to first treatment - Declared Position	2026-05		?	95.5%	96.2%	96.3%
Total Cancer PTL size	2026-06			2290		

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

- The Cancer performance figures for May 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 75.2% achieving the monthly improvement trajectory of 73.9%. In the latest available national data (April 2026) the Trust ranked 94th out of 119 NHS providers nationally and 7th out of 11 against our Model Hospital peer group (March: 90th and 7th respectively). **This is a True North Metric.**

- 62 Day waits for first treatment service standard in May 2026 was 67.8% , with the monthly trajectory of 67.1% achieved. In the latest available national data (April 2026) the Trust ranked 47th out of 119 providers nationally and 3rd out of 11 against our Model Hospital peer group (March: 70th and 3rd 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 May 2026: Breast & Non-Site Specific. Urology achieved above their internal trajectories.

- The following cancer sites exceeded 75% 62-day service standard in May 2026: Breast, Haematology, Skin . Gynaecology & 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 May, the proportion of patients waiting over 104+ days equates to 1.8% 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 54% of this patient cohort.

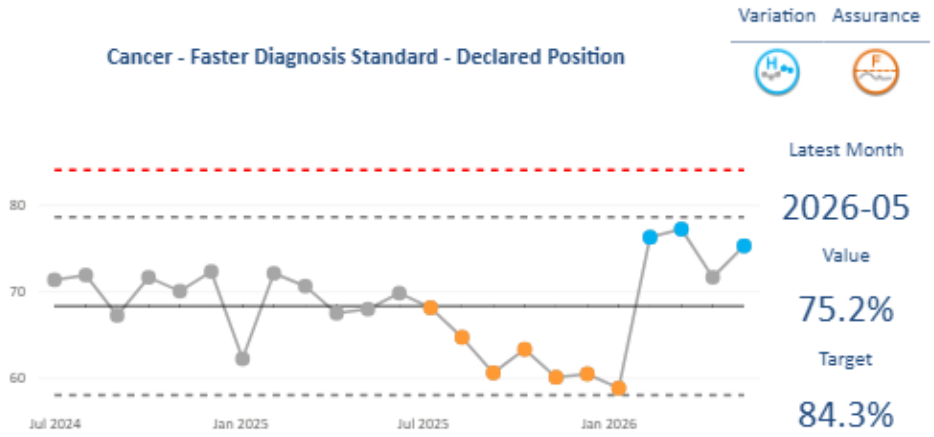
- Diagnostic performance, in particular pathology turnaround time, colonoscopy and fast track imaging acquisition is impacting faster diagnosis performance due to delays in diagnostic pathways.

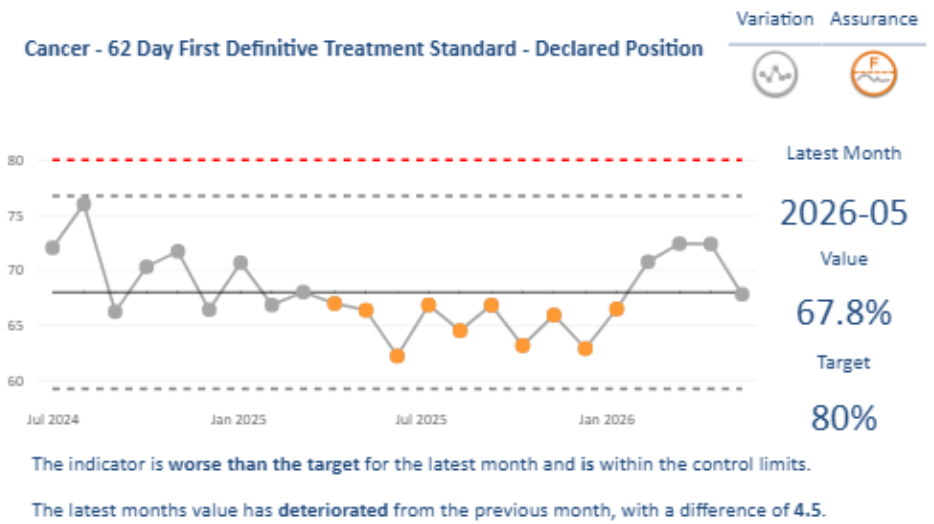
Actions:

- Please see following pages for details.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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

What actions are planned?

- 2nd weekly Trust wide meeting implemented to review specific FDS cohort and newly diagnosed patients
- Targeted investment and transformation schemes from alliance funding

Colorectal Plan - Provisional position of 60.0% against internal trajectory of 64.5%. New colorectal cancer lead appointed and MDT streamlining commenced. Ongoing discussions with endoscopy around pilots to improve TAT through streamlining booking processes and provide additional capacity. Initial scoping discussions around COLOFiT, awaiting alliance lead on next steps.
Gynaecology Plan - Provisional position of 52.8% against internal trajectory of 67%. 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 - Provisional position of 72.4% against internal trajectory of 77%. 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, MOPs continued to be prioritised on clinical urgency. Scoping for community models pre-LES expiry in December 2026 but no definitive system plan yet.
Lung- Provisional position of 61.1% against internal trajectory of 80%. Operational and service manager change, and flux escalated to ACOO for additional support.

What is the expected impact?

Focus on maintaining and sustaining improved performance, whilst transformational actions also run in parallel to return to trajectory, although remains high risk. Each cancer site has own trajectory for FDS and 62 day, to achieve month and year end position against national targets and expected impact is that

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 June 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 June 2026 behind the trajectory submitted to NHSE as part of the 2026/27 planning submission: 56,537 against the trajectory of 54,210 (+2,327).

- 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 June: 58.7% against 58.3%. In the latest available national data (April 2026) the Trust ranked 114th worst out of 118 NHS providers and 11th worst out of 11 in our Model Hospital peer group (March: 113th and 10th respectively).

- The Trust is provisionally behind the **RTT patients waiting over fifty-two weeks** trajectories submitted within the 2026/27 planning submission; 1,115 waiters and 2% of the total RTT Total Waiting list against the trajectories of 806 and 1.5%, respectively (+309 and 0.5%). Validation before submission is expected to improve but not deliver performance against the trajectories. In the latest available national data (April 2026) the Trust was ranked 93rd worst out of 118 NHS providers and 9th worst out of 11 in our Model Hospital peer group for the proportion of the TWL waiting over 52 weeks (March: 113th and 10th respectively). Nationally at the end of March 2026 there were 6,645,271 patients on the national TWL, of which 94,781 (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 63.5% against the end of June 2026 ambition to be above 61.4%. There is no nationally available comparative data for this metric. **This is a True North Metric.**

Factors impacting performance:

- 5% increase in GP referrals compared to 2025/26 (2,013 additional referrals YTD). April at 5% from previous April, 1.4% in May from May 2025 (3% YTD) and 9.7% in June from June 2025 (5% YTD). There have been significant increases in several specialties, namely; Pain Management (+39%), Orthopaedics (+14%), Paediatrics (+39%) and Gastroenterology (+60%). 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 - Waits over 52 weeks for Incomplete Pathways - Provisional Position * RTT - Proportion of incomplete pathways waiting less than 18 weeks - 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			
SPECIAL CAUSE CONCERN		* RTT - Total Waiting List - Provisional Position	

Referral to Treatment (RTT)
Scorecard

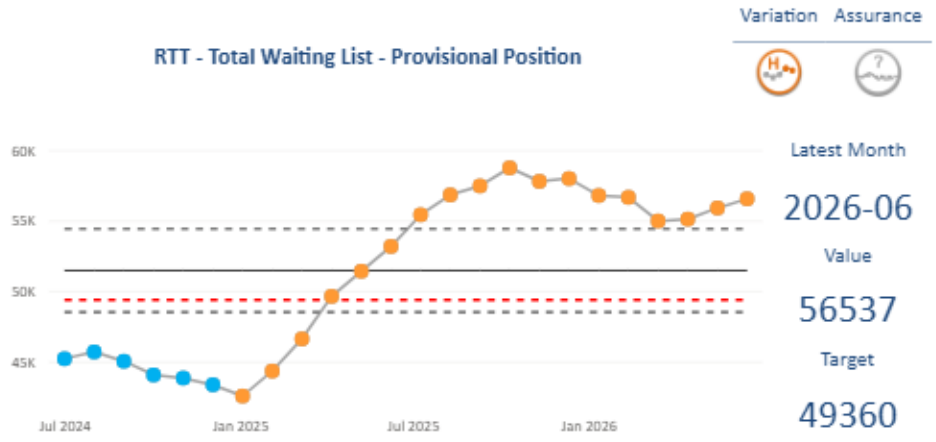
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-06	H	?	56537	54210	49360
RTT - Waits over 78 weeks for incomplete pathways - Provisional Position	2026-06	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Provisional Position	2026-06	L	?	0		0
RTT - Waits over 52 weeks for Incomplete Pathways - Provisional Position	2026-06	L	F	1115	806	0
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-06	H	F	58.7%	58.3%	67.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-06	L		17.3		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-06	L	F	2%	1.5%	0%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-06	H	F	63.5%	61.4%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-06	H		2.1%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-06	H		12.5%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-06	H		68.4%		

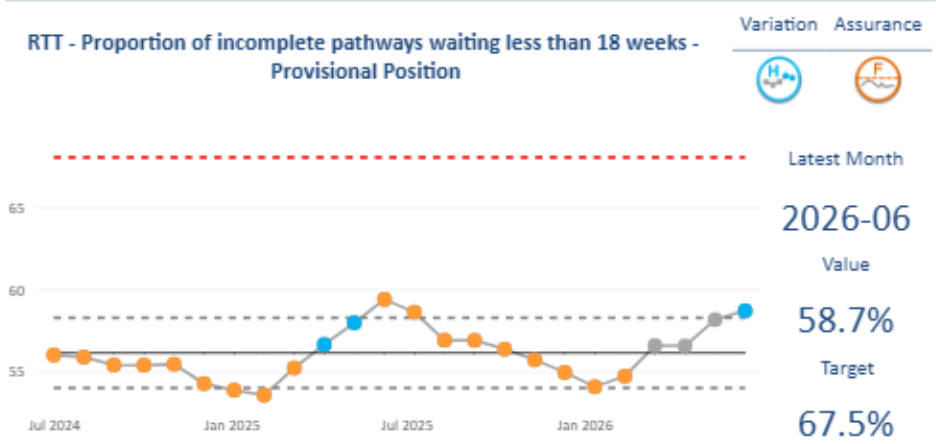
Executive Owner: Claire Hansen

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 **652.0**.



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 **0.5**.

Rationale: SPC1: To measure the size of the Referral to Treatment (RTT) incomplete pathways waiting list. **SPC2:** To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC1: Aim to have less than 49,360 patients waiting by March 2027. **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%.

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.
- Gynaecology intensive improvement week, supported with primary care physician being held early July 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.
- First quarterly workshop scheduled for July 2026.

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?

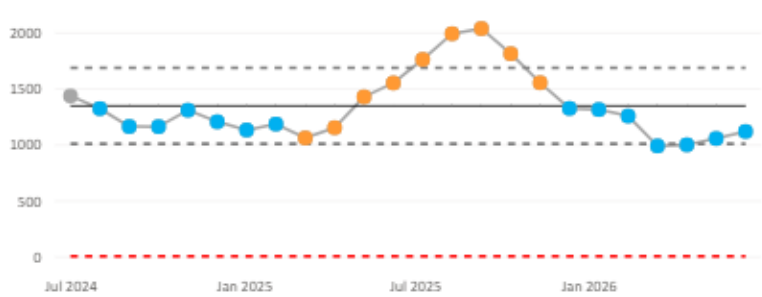
- Increase in GP referrals in YTD 2026/27 compared to 2025/26 (up 5%).
- Impact of delayed capital builds (CDC, Hybrid theatre, MRI, VIU, SGH Roof and RAAC), resulting in reduction in capacity and increasing waiting times.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

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

Variation Assurance



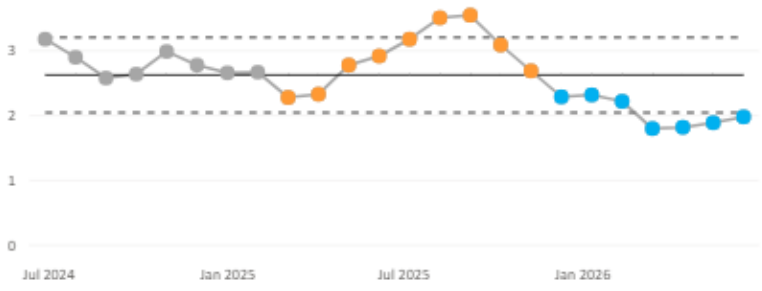
Latest Month
2026-06
Value
1115
Target
0

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 **63.0**.

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

Variation Assurance



Latest Month
2026-06
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 **0.1**.

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

What actions are planned?

- Weekly monitoring of RTT52 week waits throughout the month with weekly trajectory in place. Scope of weekly meeting expanded in April 2026 to monitor full pathway metrics rather than focus on longest waiters. Maintaining zero RTT65 week waits remains a priority.
- Fortnightly meetings with Care Groups to review in month performance against activity and performance targets.
- Focused on improvement actions for Pain Management who are 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 June 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 5.6% with performance of 5%. This is however the first time that the Trust has achieved 5%. Y&S has three specialties in the upper quartile of Trusts within the NE&Y region (Clinical Haematology, Physiotherapy and Rheumatology).

- Rapid Access Chest Pain (RACP) seen within 14 days was at 89.1% below the target of 99% (May: 83.7%). Best Performance since pre-COVID.

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 remained at 4.5% in June 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. Initially planned for end of June but roll out now scheduled in July 2026.

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

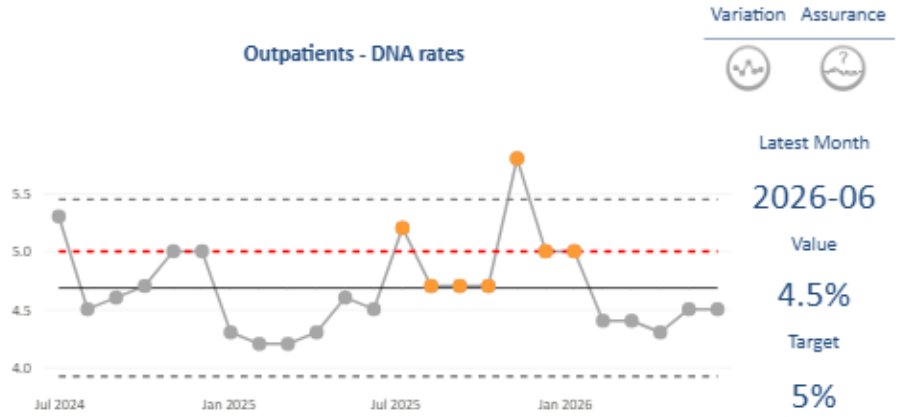
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

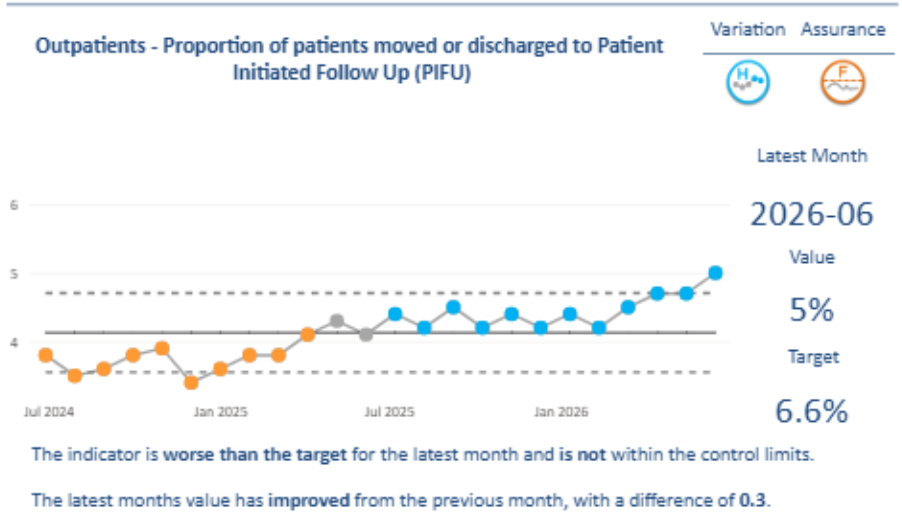
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2026-06	H	F	22.3%		25%
Outpatients - DNA rates	2026-06		?	4.5%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-06		?	21121	21597	23266
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-06		P	47232	52422	55935
Outpatient procedures	2026-06			14094		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-06		F	28355		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-06	H	F	5%	5.6%	6.6%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-06	H	F	89.1%		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*	2026-06		?	4		0
Day Cases (based on Activity v Plan)	2026-06		?	6770	6868	7781
Electives (based on Activity v Plan)	2026-06		?	629	671	660
Proportion of elective admissions which are day case	2026-06		P	91.5%		85%
Outpatients: All Referral Types	2026-06			26657		
Outpatients: Consultant to Consultant Referrals	2026-06			2715		
Outpatients: GP Referrals	2026-06			12140		

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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 Q2 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 1.3% improvement from March to June.

- DNA reduction project also commenced with targeted specialties 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?

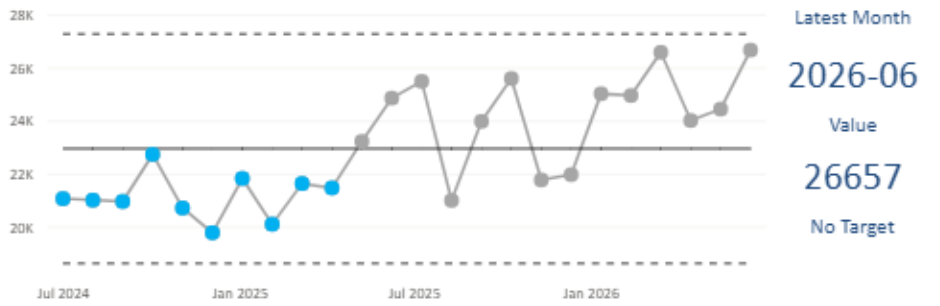
- Patient administration processes to ensure PIFU is appropriate actioned through worklist on CPD and patients are given unnecessary follow ups.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Outpatients: All Referral Types

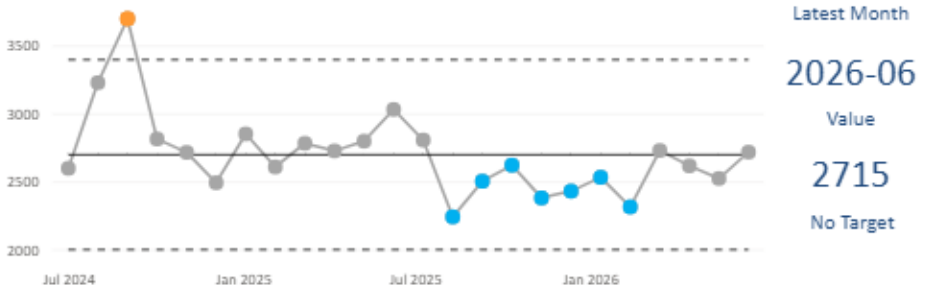


The indicator is **equal to the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **2228.0**.

Variation Assurance

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 **deteriorated** from the previous month, with a difference of **194.0**.

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 16% compared to the same period in 2025/26.
- ICB conducting review of GP referrals to identify outlying practices for further discussion and education.
- Single point of access proposal approved by 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. A project group has been established with colleagues from primary care involved.

What is the expected impact?

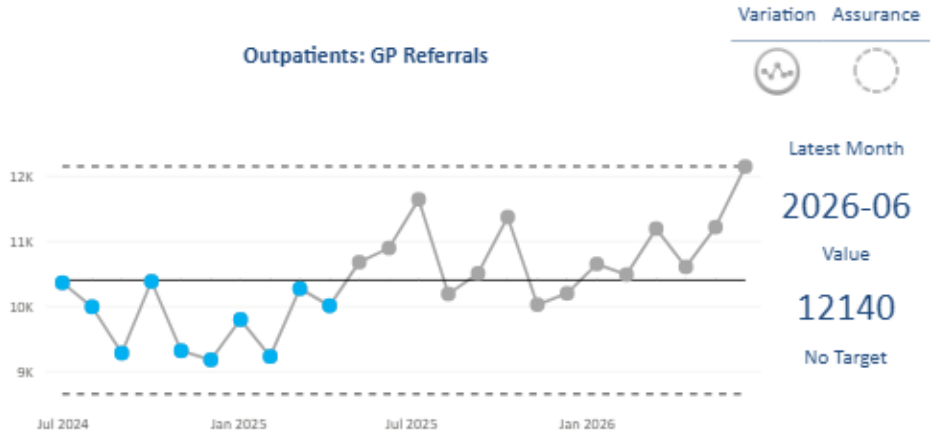
- Reduction in internal demand and reduction in open referrals**.**
- Reduction in GP demand.
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

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 **930.0**.

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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 June 2026 was 79.4%, a 3.4% improvement on the previous month and exceeding the June trajectory of 77%.

- Total waiting list has continued to reduce from 11,981 in May to 11,736 in June, along with further reduction in overall number of 6 week and 13-week breaches. 6-week breaches reduced from 2,870 in May to 2,421 in June, and 13-week breaches reduced from 477 in May to 306 in June. This represents a decrease of 87% in 13-week breaches from June 2025 to June 2026.

- In the latest available national data (April 2026) the Trust ranked 82nd worst out of 118 NHS providers and 8th worst out of 11 in our Model Hospital peer group (March: 81st and 8th respectively).

Factors impacting performance:

- CT has seen significant performance recovery over the past two months, returning to trajectory in June with performance of 87.9% against plan of 87.7%. Waiting list has also reduced by more than half since April (3,371 waiting in April, 1,407 waiting in June) as the service has worked through clearing the backlog.

- Some deterioration in Non-Obstetric Ultrasound (NOUS) 6-week performance during May and June due to Yorkshire Health Solutions being unable to deliver sufficient activity due to their own staffing issues. A tender process has been completed and a new provider is on track to take over from YHS in mid-July. Long wait patients have been prioritised into available capacity wherever possible however 13-week waits have increased in June due to insufficient capacity.

- Clinical space is a challenge for Echocardiography, along with clinical staffing due to vacancies and sickness. Capacity and demand analysis has shown under provision of 30-35% without running additional lists. This is due to a shortfall in staffing for CDCs and room availability at York hospital.

- Staff issues in Urology during 2025/26 led to reduced Urodynamics activity compared to plan due to requirements for additional training and supervision, resulting in a build-up of backlog. Two staff have since left the service in June 2026 which has reduced available capacity. Recruitment is underway with interviews planned mid-July but there is likely to be a deterioration in performance until these posts are filled.

- 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 - DEXA Scan * Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	* Diagnostics - Proportion of patients waiting <6 weeks from referral * Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI * Diagnostics - Proportion of patients waiting <6 weeks from referral - CT * 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 - Sleep studies * Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy * Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	
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

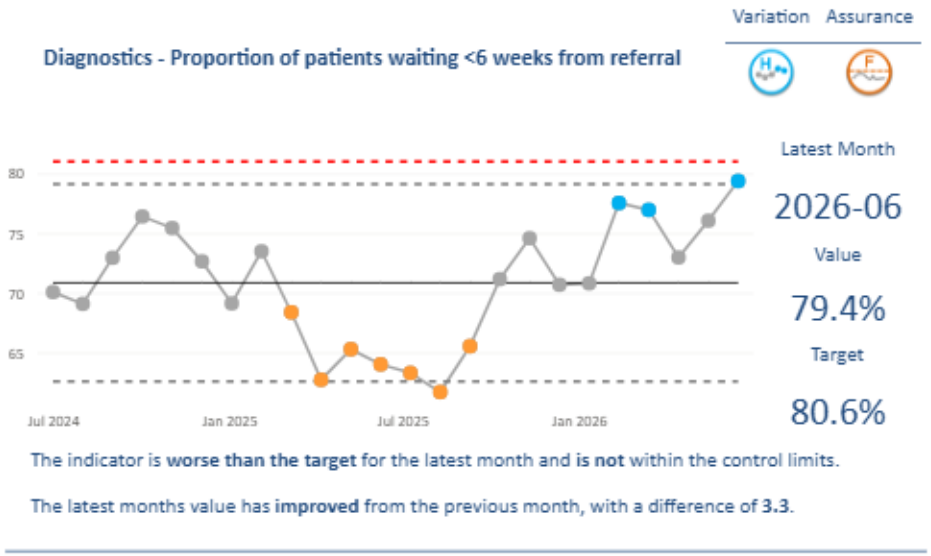
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-06	H	F	79.4%	77%	80.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-06	H	F	94.8%	84.9%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-06	H	F	87.9%	87.7%	91.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-06		?	69.8%	76.5%	77.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-06	H	F	95.5%	85%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-06	H	?	92.5%	86.2%	86.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-06	H	F	84.2%	76%	80%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-06	L	?	31.9%	73.2%	79.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-06	L	?	74.9%	95.5%	95.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-06		?	87.4%	94.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-06	H	F	70.7%	72%	84.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-06	H	F	90.5%	80.9%	86%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-06		?	81.1%	82.7%	85.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-06		?	85.4%	65.5%	69.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-06	H	?	89.1%	83.6%	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: Clinical endoscopist currently in training, due to be signed off in Q3 2026/27, which will provide an additional 4 lists per week at York. Centralised preassessment clinics in Bridlington expected end of Q2 2026, to release 3 RN in York to support staffing of room 7. Originally planned for circa March 2026 but delays in recruitment and relevant training of staff.

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.
Radiographer workforce review and associated action plan have been developed and will go forward through governance routes for discussion and agreement.
Staffing shortages due to Radiographer vacancies, maternity leave, and sickness all led to insufficient capacity to meet CT demand in early 2026. Numerous international new starters commenced in post during June, leading to increased opportunity to run substantive capacity. Handover of CT at Scarborough CDC complete and now fully operational which should help maintain performance.
An area of risk within NOUS is MSK Ultrasound which is provided by the consultant workforce. We have three current NOUS consultant vacancies. Interviews took place in March 2026 but there were no appointable candidates. Recruitment is ongoing but there is a lack of candidates nationally.

Physiological: There is a bank Echocardiographer post out to advertisement for 2 days of capacity resulting in 20 additional slots per week at York. An application has also been made to NHSE for 1WTE Echocardiographer to provide appropriate staffing levels at the CDC and deliver underutilised capacity. Applications are underway within the trust for an additional room / equipment to deliver additional capacity. Urodynamics WLIs to target long waiters were completed in May and June which has sustained performance and led to a small increase, though not returning to trajectory level. Insourcing through Yorkshire Medical Solutions (YMS) is being explored to try to mitigate capacity over the coming months until we can return to establishment.

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 - Patients waiting over 12 hours in department	* Children & Young Persons: ED - Emergency Care Standard - All Types (Aged under 16)
SPECIAL CAUSE CONCERN			

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

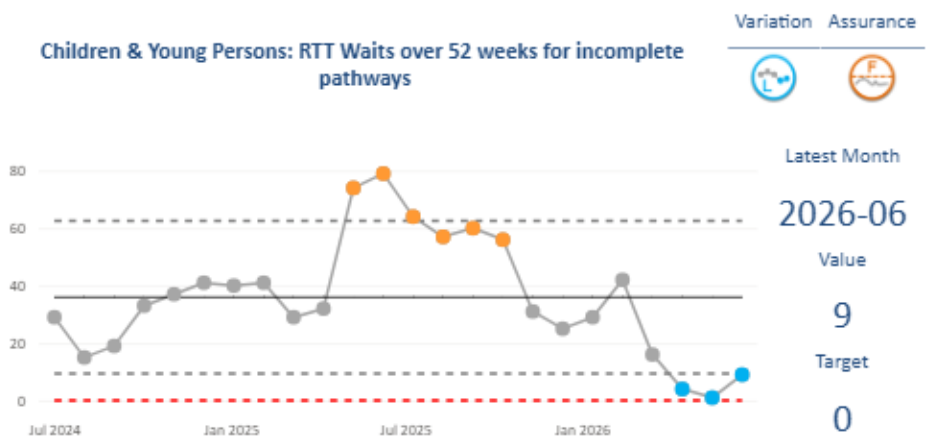
Executive Owner: Claire Hansen

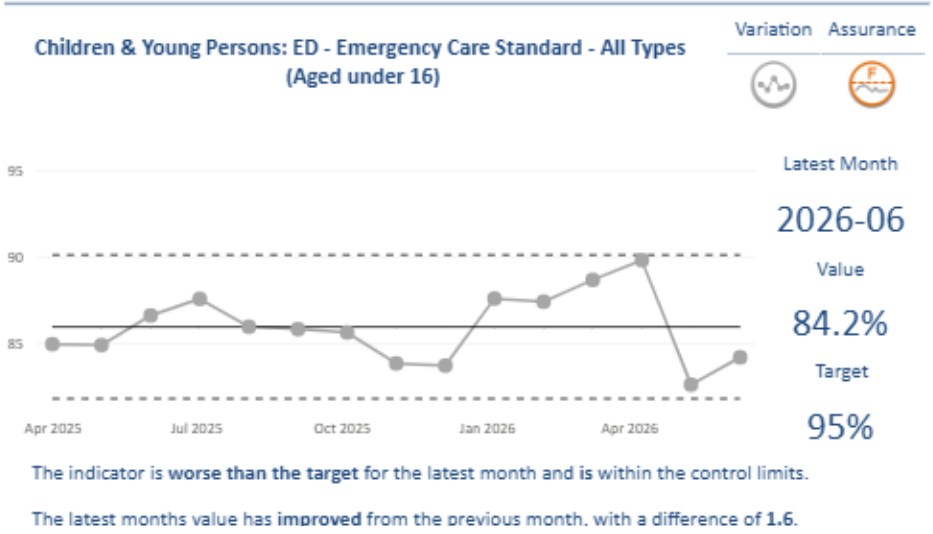
Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2026-06		?	19		0
Children & Young Persons: ED - Emergency Care Standard - All Types (Aged under 16)	2026-06		F	84.2%	93%	95%
Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Aged under 16)	2026-06			81.9%	93%	
Children & Young Persons: ED Attendances - Type 1 only (Aged under 16)	2026-06	H		2287		
Children & Young Persons: RTT - Total Waiting List	2026-06			4340		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-06	H	F	68.6%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-06	L	F	9	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 fifteen at the end of June.

- Head and Neck were planning to deliver zero RTT52 week waiters by the end of June 2026, this was not achieved with nine patients waiting at month end. The services are forecasting delivering zero for the end of July 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	* Number of open Virtual Ward beds	* Proportion of intermediate care beds occupied by people with no criteria to reside * Proportion of Virtual Ward beds occupied * 2-hour Urgent Community Response (UCR) Compliancy % * Attended Community Care Contacts	
SPECIAL CAUSE CONCERN			

COMMUNITY
Scorecard (1)

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	2026-06			16.5%	24.5%	20%
Number of open Virtual Ward beds	2026-06			33	33	33
Proportion of Virtual Ward beds occupied	2026-06			63.6%	82%	82%
Community Response Team (CRT) Referrals	2026-06			551		
Total Urgent Community Response (UCR) referrals	2026-06			543	510	514
2-hour Urgent Community Response (UCR) care Referrals	2026-06			204		
2-hour Urgent Community Response (UCR) Compliancy %	2026-06			75.6%	70%	70%
Attended Community Care Contacts	2026-06			38110	37858	41283
Number of District Nursing Contacts	2026-06			21754		
Number of Selby CRT Contacts	2026-06			2083		
Number of York CRT Contacts	2026-06			3410		
Referrals to District Nursing Team	2026-06			2217		

COMMUNITY
Scorecard (2)

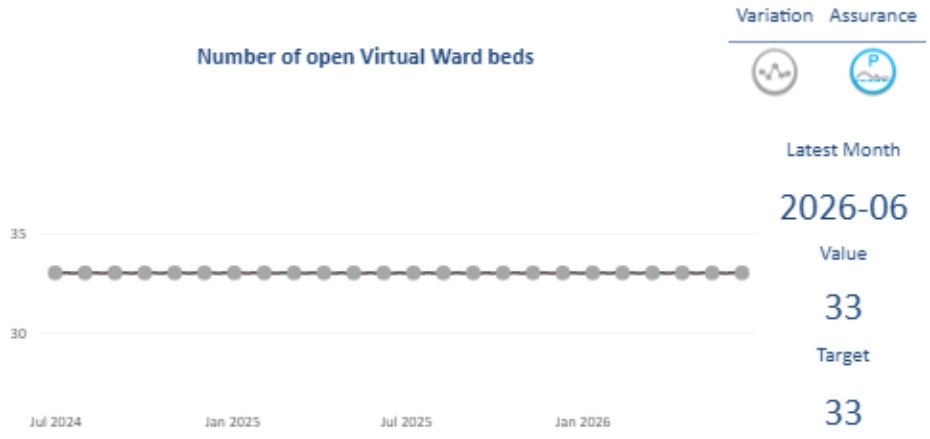
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-06			694		
Number of CYP (0-17 years) on community waiting lists per system	2026-06			1598		
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	2026-06			60%	61.1%	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	2026-06			100%	99.4%	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	2026-06			42.7%	44.1%	63.7%
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-06			515	538	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. **DATA IS A SINGLE DATA POINT SNAPSHOT ON A SINGLE DAY AND NOT REPRESENTATIVE OF OVERALL MONTH PERFORMANCE.**

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 are creating a case for change for a new community model this will see a shift in resource to home based teams which includes hospital at Home expansion.

- 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. Charitable funds have been agreed to fund a further 6 months whilst a business case is completed. This will also incorporate senior medical cover in line with GIRF requirements.

Potential risks to improvement?

- Challenges regarding the medical cover can sometimes cause instability in the service. This is the driver for the reduced occupancy in June as 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 Hospital at Home (H@H) service is not available. The care group are creating a case for change for a new community model this will see a shift in resource to home based teams which includes H@H expansion.

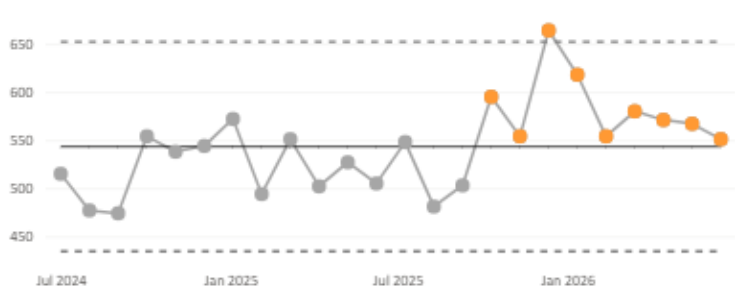
- The system partners are supportive of this approach as part of the Selby neighbourhood model and SHAR.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton

Community Response Team (CRT) Referrals

Variation Assurance

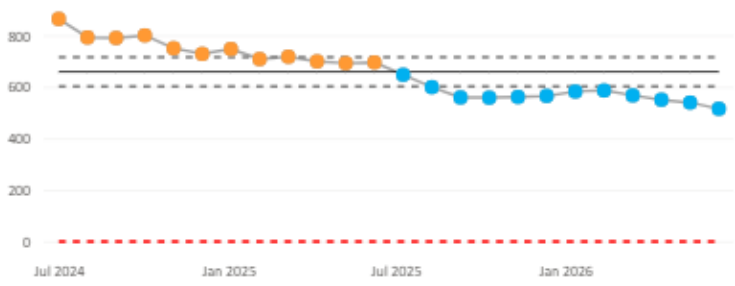


Latest Month
2026-06
Value
551
No Target

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

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

Variation Assurance



Latest Month
2026-06
Value
515
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 **24.0**.

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.

The Trust achieved the 2-hour Urgent Community Response target with performance of 76% against the 70% target. **This is a True North Metric.**

What actions are planned?

SPC1: Referrals for UCR and home-based intermediate care at home remain high. Workforce challenges remain but sickness has improved and is actively managed. Selby UCR continues to work well with the additional medic cover (1WTE) however, there will be a gap in first 2 weeks of August with delays in recruitment and induction period. We are creating a case for change for a new community model this will see a shift in resource to home based teams and address the geographical challenges

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 June (515 against end of month ambition to be at or below 538).

What is the expected impact?

Medical response will be covered by core team whilst recruitment and induction is completed in August . The case for change will see and expansion of the Intermediate care and UCR team resource.

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?

- Reduction in referral acceptance /responsiveness
- National shortage of SLT therapists.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

July 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Karen Stone and Joe Hague

Highlights: IPC

- C. difficile **2 cases under** the year-to-date threshold.
- Klebsiella bacteraemia – **2 cases under** the year-to-date threshold.
- The IPC Hierarchy of Control Audits for all in-patient wards commenced in April 2026
- NHSE IPC lead for the North East and Yorkshire has asked for assurance regarding the increase in C.difficile cases and April and June and is satisfied with the Trust response. There are other Trusts in the region seeing a similar increase.

Concerns / Risks :

- E.coli bacteraemia **11 cases over** the year-to-date threshold
- MSSA bacteraemia **4 cases over** year-to-date threshold.
- Pseudomonas bacteraemia -**7 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.
- A focussed infection review meeting is booked to review C.difficile cases on ward 36 as they have 5 attributed cases, the highest in the organisation.

Highlights: Pressure ulcers

In June, 63 Category 2 pressure ulcers reported, which is above the monthly target of 60. A 20% stretch reduction target has been agreed for 2026/27 to be reported in TPR.
Pressure ulcer rate (all categories) = 3.3 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, Scarborough and Bridlington have been completed and awaiting York site by the 27/07/2026 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.
- 91 patient chairs have been ordered, 61 for YH and 30 for SGH. Delivery date is week commencing 20/07/26.

Quality & Safety
Scorecard (1)

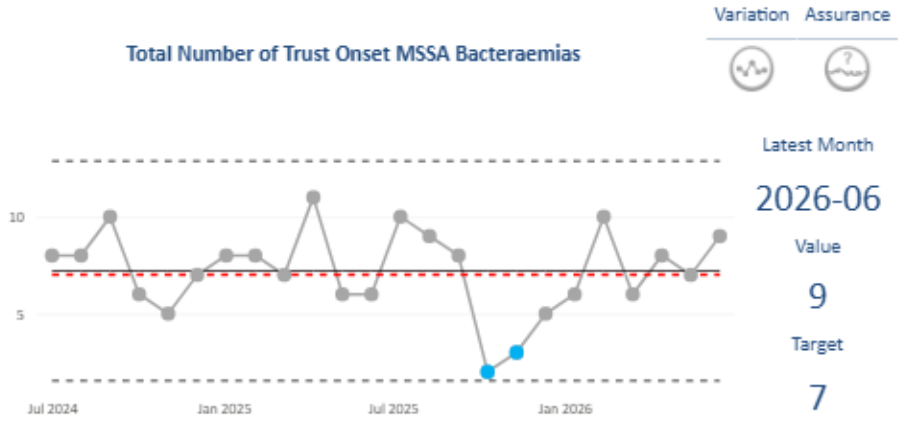
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

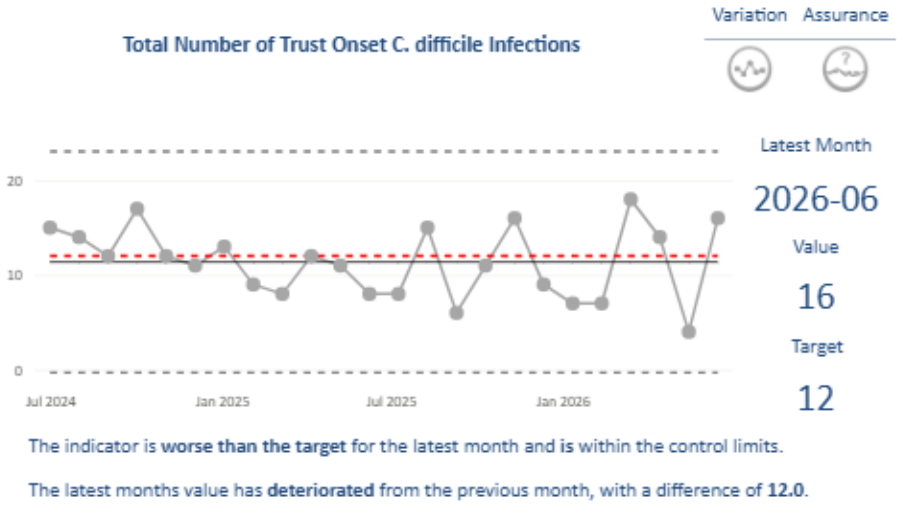
Executive Owner: Joe Hague **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2026-06			9	6	7
Total Number of Trust Onset MRSA Bacteraemias	2026-06			0		0
Total Number of Trust Onset C. difficile Infections	2026-06			16	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-06			14	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-06			4	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-06			3	1	2
Pressure Ulcers per thousand Bed Days	2026-06			3.3		4
Patient Falls per thousand Bed Days	2026-06			5.6		8.7
Medication incidents per thousand bed days	2026-06			6		6

Executive Owner: Joe Hague

Operational Lead: Sue Peckitt





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 **4 cases over** year-to-date threshold.
- E.coli bacteraemia - **11 cases over** the year-to-date threshold
- Pseudomonas bacteraemia - **7 cases over** the year-to-date threshold.

Key assurances/brilliances

- C.difficile **2 cases under** the year-to-date threshold
- Klebsiella bacteraemia **2 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
- The IPC improvement plan has been refreshed for 2026/27 in recognition of the further stretch improvements required.
- NHSE IPC lead for the North East and Yorkshire has asked for assurance regarding the increase in C.difficile cases and April and June and is satisfied with the Trust response. There are other Trusts in the region seeing a similar increase.

Next Key Improvements:

- A focussed infection review meeting is booked to review C.difficile cases on ward 36 as they have 5 attributed cases, the highest in the organisation.
- 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.
- Clinical review of E.coli Bacteraemia and Klebsiella Bacteraemia cases to determine themes has continued with support of Microbiology Registrars.
- Active work moving towards water lite (water safe care) is progressing.

Quality & Safety
Scorecard (2)

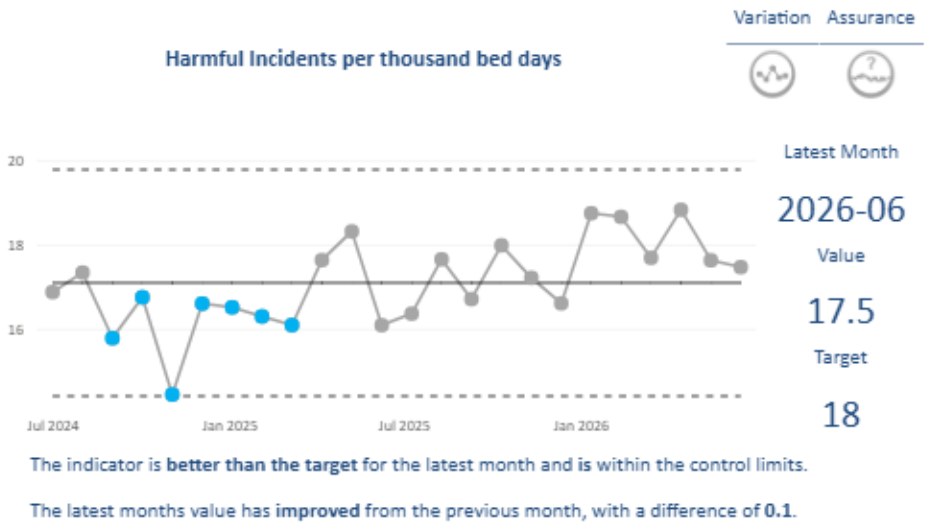
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-06			53.6		56
Harmful Incidents per thousand bed days	2026-06			17.5		18
Total Number of Never Events Reported	2026-06			0		0
In-Hospital Deaths	2026-06			173		
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	2026-06	H		147		
Antepartum Stillbirths	2026-05			0		
Intrapartum Stillbirths	2026-05			0		
Early neonatal deaths (0-7 days)	2026-05			1		
PPH > 1.5L as % of all women - York	2026-05			4.1%		
PPH > 1.5L as % of all women - Scarborough	2026-05			0.9%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-05			40.4%		

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.

Falls Update

In June, 2 falls with harm were reported, which is 4.6 per 1000 bed days, below the monthly target of 6.6. A 15% reduction target has been agreed for falls with harm for 2026/27. Falls (all harm levels) = 7.1 per 1000 bed days, against a target of 8.7.

Patient Safety Incident Data Quarterly Publication for Q4 2025/26

In response to the Patient Safety Incident Data Quarterly Publication for Q4 2025/26. Incident reporting has increased overall, with total incidents rising from 3,723 to 4,249 across the period, peaking at 4,424 in Q3 2025/26 before a slight reduction in the latest quarter. Similarly, the reporting rate per 1,000 bed days showed a sustained upward trend, increasing from 48.6 to a peak of 58.2, before easing to 55.9 in Q4 2025/26. Overall, this indicates strengthened reporting activity compared to the starting point, despite a slight decrease following the peak in Q3 2025/26.

Great-ix

There were 52 Great-ix submissions in June. Some highlights taken from the month's submissions are below.

June Great-ix Highlights:

"This then led to a conversation between the patient, consultant and BSL interpreter where the patient's wishes were finally heard and actioned. What a difference X has made to this patient's journey."

"Despite being pulled in all directions they were an excellent team - they were friendly, approachable and professional throughout"

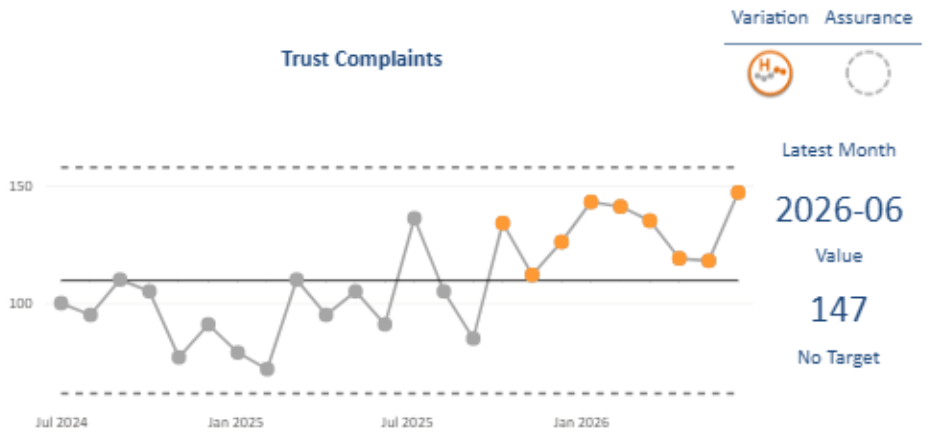
"Your wonderful efforts in getting patients ready at the end of your night shifts has meant that more patients have been ready in the morning to receive therapy! You are making a significant difference in the lives of the patients and your colleagues- Thank you again, You are a STAR!"

"She showed a lovely example of MDT working, even when it wasn't essential"

"Her approach helps us build confidence and enables us to independently apply that learning next time we encounter a similar situation"

Executive Owner: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy



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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 June 2026 with 114 new complaints across the Trust received (in contrast to 118 in May 2026).

66% of complaints were closed in 30 days (compared to 57% in April 2026) and 64% of complex complaints were closed in 45 days (compared to 50% in April 2026) showing increased performance in complaint response times. Performance however remains below the expected compliance rate of 90%.

NOTE: For the period of April - June 2025 vs 2026, there has been an 81.77% increase in the number of concerns and complaints received over the previous year.

Key risks and emerging risks

- 225 cases (87%) of the backlog of concerns have been closed. Of the 29 open cases, 24 relate to surgery.
- Interviews for the new Concern and Complaints Officer will take place in early July as the potential redeployed employee was not a suitable applicant. The secondee to the role returned to their substantive position towards the end of June. Therefore, the PALS team will not have a full complement of staff for around 2 months dependent on the outcome of the recruitment which may impact performance.

Key assurances

- 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 and 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 confirmed at Patient Experience Committee in July 2026.

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:

- July - Focus on bedside handovers and managing concerns at ward level as part Back to the Floor (Year of Quality programme); roll out of the pilot of the customer skills training to support staff addressing culture and communication, promoting addressing concerns in the moment, preventing escalation of complaints and improve patient experience.
- Embedding of bed side handovers to improve communications.
- August - 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.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

July 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	2026-05		P	111		169	Target
No. of women delivered - Scarborough	2026-05		?	109		112	Target
Births - Scarborough	2026-05		?	109		113	Target
Induction of labour - Scarborough	2026-05		?	43.5%		43.9%	Baseline
Elective caesarean - Scarborough	2026-05		?	19.3%		16.5%	Baseline
Emergency caesarean - Scarborough	2026-05		?	30.3%		28.4%	Baseline
BBA - Scarborough	2026-05		?	0		2	Target
Total number of Stillbirths - Scarborough	2026-05			0			No Target
Neonatal Death - Scarborough	2026-05		?	0		0	Target
Number of maternity diverts/unit closures - Scarborough	2026-05			3			No Target
Homebirth service suspended - Scarborough	2026-05		F	30		3	Target
SCBU at capacity - Scarborough	2026-02			0		0	Baseline
% of 3rd and 4th degree tears - Scarborough	2026-05			1.8%			No Target
L/W Co-ordinator supernumerary % - Scarborough	2026-05	H	?	100%		100%	Target
Breastfeeding Initiation rate - Scarborough	2026-05		?	82.4%		75%	Target

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	2026-05			0		0	Target
% of women seen within 15 minutes in triage - Scarborough	2026-05			92.5%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - Scarborough	2026-05			3			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	2026-05			4			No Target
Number of babies born with an Apgar of 7 at 5 mins - Scarborough	2026-05			6			No Target
Number of maternal deaths - Scarborough	2026-05			0			No Target
Number of midwifery red flags - Scarborough	2026-05			2			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - Scarborough	2026-05			0			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - Scarborough	2026-05			0			No Target
Number of planned caesarean sections > 24 hours - Scarborough	2026-05			0			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	
SPECIAL CAUSE CONCERN			* Homebirth service suspended - York

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - York	2026-05			239		295	Target
No. of women delivered - York	2026-05			217		242	Target
Births - York	2026-05			221		245	Target
Induction of labour - York	2026-05			41.9%		41.3%	Baseline
Elective caesarean - York	2026-05			16.1%		16.7%	Baseline
Emergency caesarean - York	2026-05			23.5%		23.8%	Baseline
BBA - York	2026-05			4		2	Target
Total number of Stillbirths - York	2026-05			0			No Target
Neonatal Death - York	2026-05			1		0	Target
Number of maternity diverts/unit closures - York	2026-05			5			No Target
Homebirth service suspended - York	2026-05	H	F	24		3	Target
SCBU at capacity - York	2026-02		P	0		0	Baseline
% of 3rd and 4th degree tears - York	2026-05			1.8%			No Target
L/W Co-ordinator supernumerary % - York	2026-05	H		100%		100%	Target
Breastfeeding Initiation rate - York	2026-05			87.6%		75%	Target

Maternity York
Scorecard (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - York	2026-05			0		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	2026-05			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - York	2026-05			7			No Target
Number of babies born with an Apgar of 7 at 5 mins - York	2026-05			2			No Target
Number of maternal deaths - York	2026-05			0			No Target
Number of midwifery red flags - York	2026-05			0			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - York	2026-05			0			No Target
Number of planned caesarean sections > 24 hours - York	2026-05			1			No Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

July 2026

Executive Owner: Lydia Larcum

1. Highlights

- Workforce size remained stable at 9,964 WTE in May, only -23 WTE below plan and broadly unchanged from the previous year.
- The national resident doctor dispute has been resolved, supporting workforce stability and reducing the risk of service disruption.
- Recruitment activity remains strong, including 207 resident doctors being onboarded, 160 pre-registration nurse interviews scheduled, and recruitment underway across medical, radiography and support worker roles.

2. Concerns

- Sickness absence increased to 497 WTE in May, contributing to an annual absence rate of 5.4%, above the planned trajectory of 5.2%.
- Consultants have voted in favour of industrial action, creating a potential workforce risk, although no action has been announced.
- Reducing temporary staffing remains a priority, with further progress required to meet national expectations for reductions in bank and agency expenditure.

3. Future

- Continued onboarding of resident doctors and recruitment to non-training medical posts will support staffing resilience ahead of the August rotation.
- Planned recruitment within maternity services and further appointments to support worker, nursing and allied health professions will strengthen the substantive workforce.
- The Trust will review the implications of the new NHS Staff Standards and Leadership and Management Framework, with further updates to Board during 2026–27.

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 * Midwifery vacancy rate * AHP vacancy rate * Total Bank Whole Time Equivalent Filled	
SPECIAL CAUSE CONCERN		* Monthly sickness absence * HCSW vacancy rate	* Annual absence rate

Workforce
Scorecard (1)

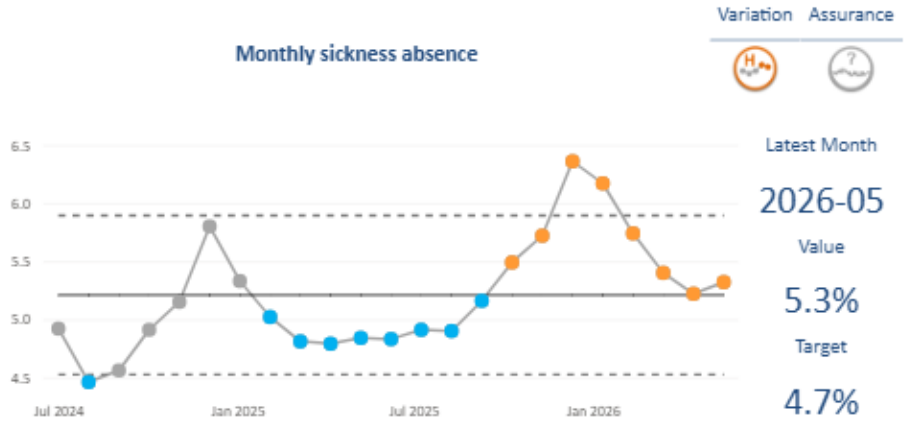
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

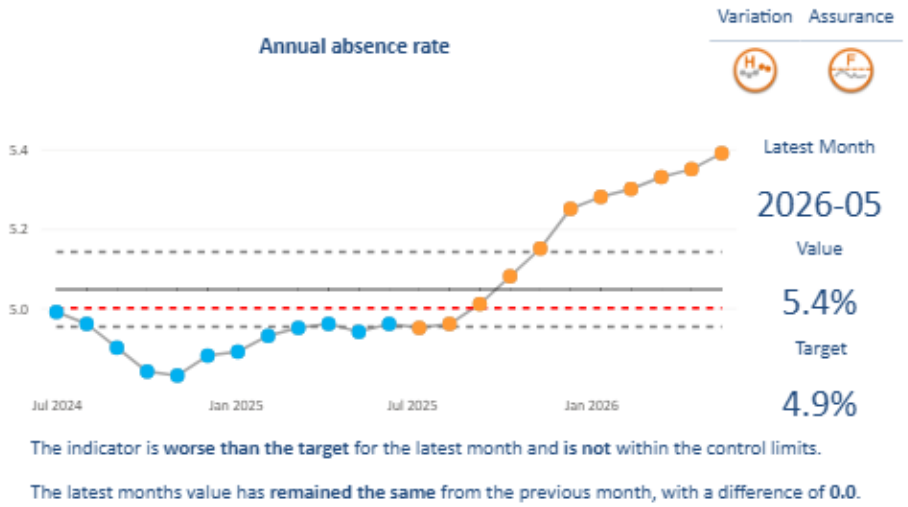
Executive Owner: Lydia Larcum **Operational Lead:** Amy Messenger/Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-05	H	?	5.3%	4.6%	4.7%
Annual absence rate	2026-05	H	F	5.4%	5.2%	4.9%
Total Agency Whole Time Equivalent Filled	2026-05	L	F	46.2	52	52
Total Bank Whole Time Equivalent Filled	2026-05		?	561.6	560	536
12 month rolling turnover rate Trust (FTE)	2026-06	L	?	7.2%		8.5%
Overall vacancy rate	2026-06		?	7.8%		7.7%
HCSW vacancy rate	2026-06	H	?	11.4%		8%
Midwifery vacancy rate	2026-06		?	5.5%		0%
Medical and dental vacancy rate	2026-06	L	?	3.9%		6%
Registered Nursing vacancy rate	2026-06	L	?	3.4%		5%
AHP vacancy rate	2026-06		?	7.2%		7%

Executive Owner: Lydia Larcum

Operational Lead: Nic English





Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.9% annual absence rate (March 2027)

Factors impacting performance and actions:

The level of sickness in May increased by 8 WTE from the previous month, going from 489 to 497 WTE. The main causes of sickness continued to be stress/anxiety (remained at 28% of all absences) and musculoskeletal (decreased from 14% of all absences to 12%).

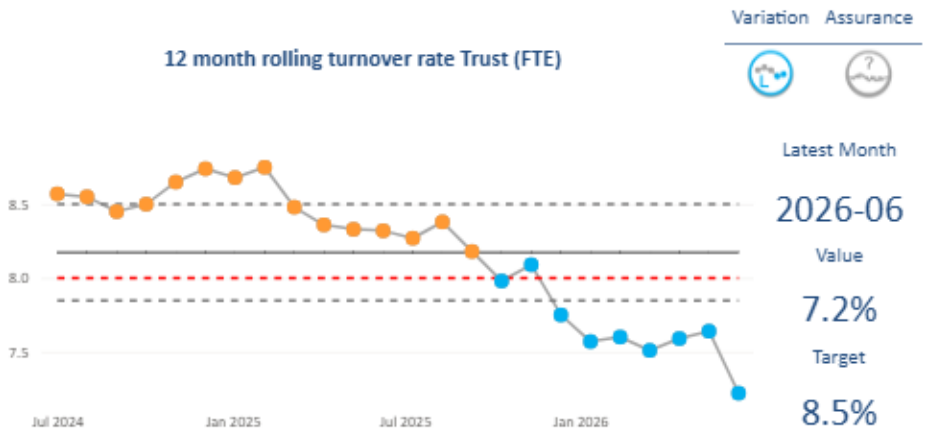
The position in May contributed to an annual absence rate of 5.4% across the Group. This is 0.2% higher than the trajectory in the workforce plan. The Group has planned for a 4.9% absence rate in the 12-months up to and including March 2027.

Resident Doctors in England have voted to accept the Government's pay and jobs offer, bringing an end to the national industrial dispute that has affected NHS services since 2023. The resolution of this dispute is expected to provide greater workforce stability, reduce the risk of service disruption, and support delivery of elective recovery and operational performance priorities across the Trust.

In contrast, the British Medical Association (BMA) has announced that Consultants in England have voted in favour of industrial action following a dispute with Government over pay, contract terms and wider working conditions. The ballot result provides the BMA with a mandate for industrial action for the next 12 months; however, no industrial action has currently been announced, and national discussions are expected to continue while the BMA considers its next steps.

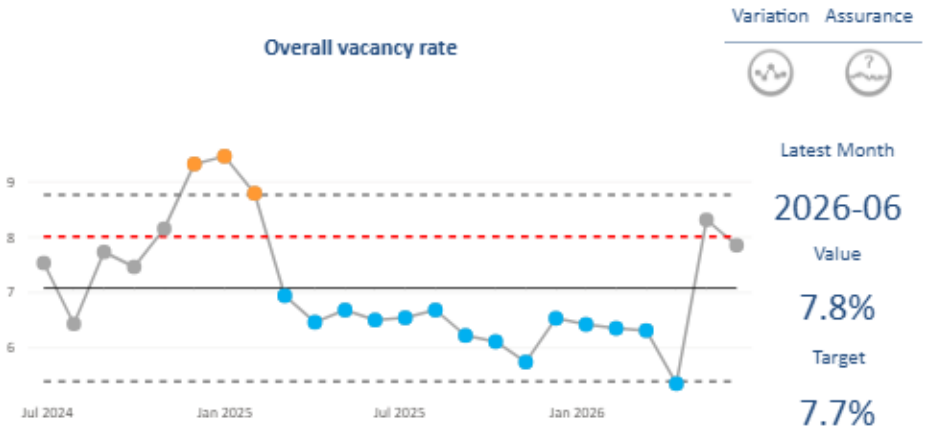
Executive Owner: Lydia Larcum

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 **improved** from the previous month, with a difference of **0.4**.



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

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

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 8.5% Vacancy Rate 7.7%

Factors impacting performance and actions:

In May 2026, the Group's total workforce WTE was 9,964, which was -23 below plan. This breaks down as follows:

Type	May-26 WTE plan	May-26 WTE actual	WTE Variance with plan	May-25 WTE actual for comparison
Substantive	9375	9356	-19	9290
Bank	560	562	+2	591
Agency	52	46	-6	90

The net change in workforce size between April and May 2026 was -23 WTE.

WTE in May was -7 WTE less than in the same month in 2025.

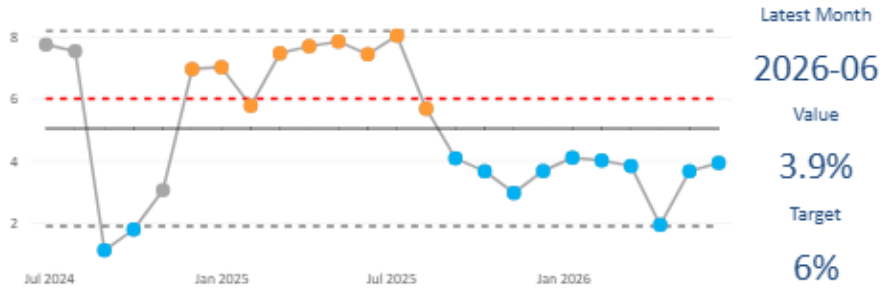
Although the charted vacancy rate shows movement between March and June 2026, the actual number of substantive colleagues has remained relatively consistent throughout this period (9419 in March, 9419 in April, 9384 in May, 9431 in June). This indicates that the denominator used in the rate (recorded budget) changed between March and May.

Executive Owner: Lydia Larcum

Operational Lead: Amy Messenger

Variation Assurance

Medical and dental vacancy rate



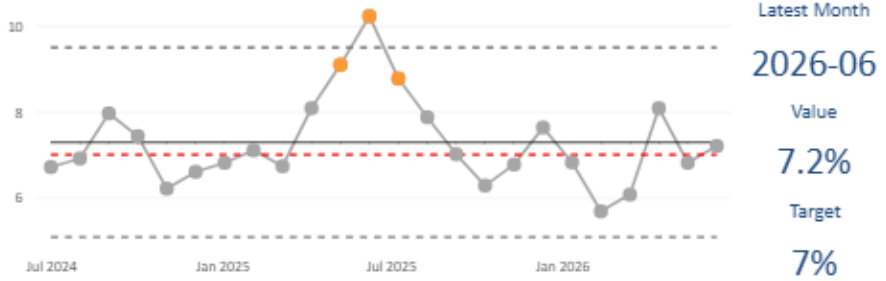
Latest Month
2026-06
Value
3.9%
Target
6%

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**.

Variation Assurance

AHP vacancy rate



Latest Month
2026-06
Value
7.2%
Target
7%

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

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

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 7%

Factors impacting performance and actions:

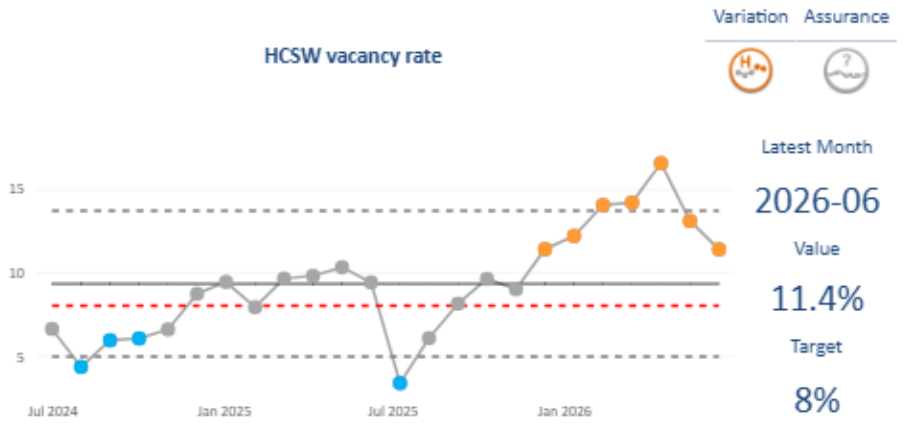
In June, the Trust welcomed eight new medical colleagues, including a permanent Consultant within Radiology. In addition, 10 offers of employment for medical posts were made, including three permanent Consultant posts within Paediatrics and Microbiology.

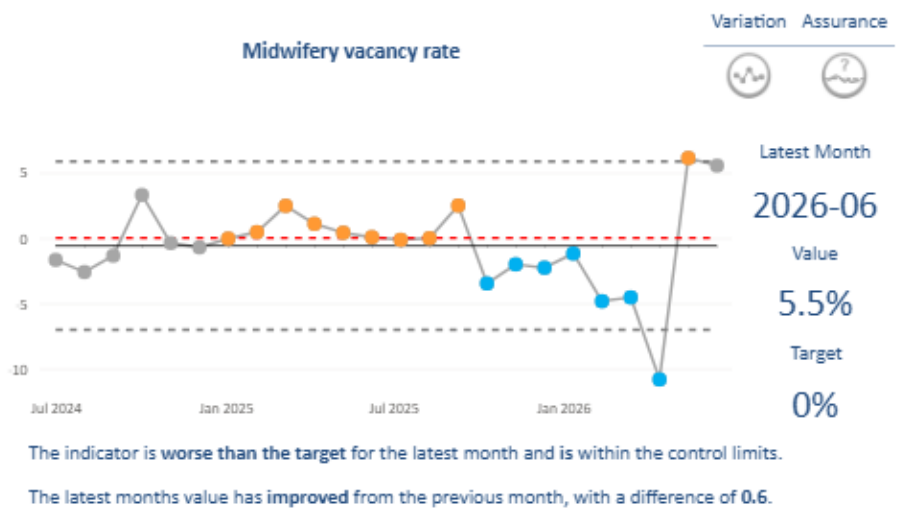
Ahead of changeover in August, the Trust is continuing to onboard 207 Resident Doctors. The numbers have reduced slightly from last month (216) due to withdrawals, and there have been challenges with obtaining timely updates from the organisation overseeing the rotations. The Trust continues to progress recruitment to non-training roles at equivalent grades to address the remaining gaps in rotas.

The organisation is currently in the process of recruiting seven Pre-Registered Radiographers to join its Radiology team.

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:

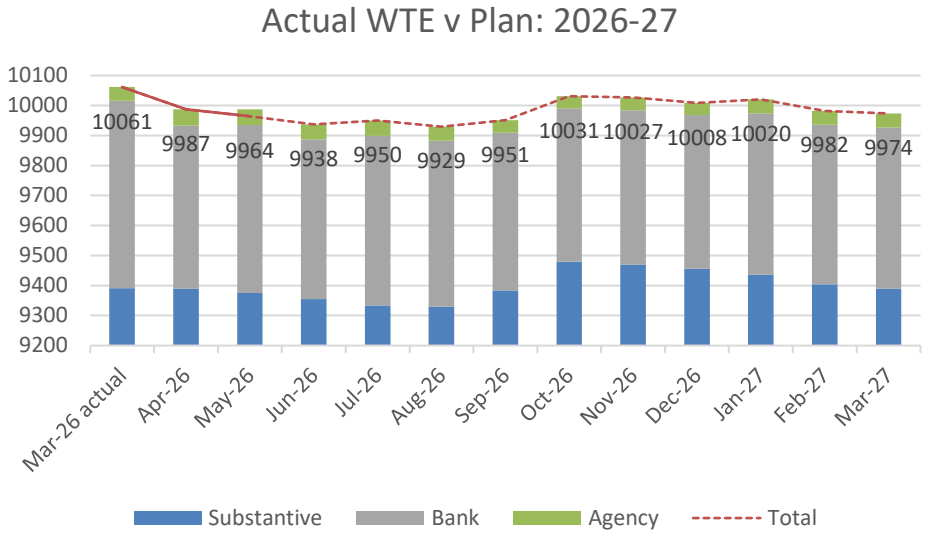
In May, the Health Care Support Worker establishment in the Trust decreased by 68 WTE, leading to a reduction in the vacancy rate. This reflects adjustments to the roster to provide more long day shifts which creates an efficiency. At the same time, the Midwifery establishment increased by 33 WTE, resulting 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 vacancy position has also improved because of the commencement of an additional 24 new colleagues in June. Work continues to reduce the vacancy position through further recruitment. The current pipeline includes 23 WTE undertaking pre-employment checks, and 18 WTE who are booked onto upcoming Academy induction and training sessions.

The number of Nursing Associates within the Trust decreased slightly in June going from 51 to 49 (this number does not include Nursing Associate Apprentices).

As part of the Trust's pre-registered nurse recruitment, 160 interviews have been scheduled. Those individuals who are appointed into vacancies are expected to commence with the Trust in Autumn 2026.

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	May-26 WTE plan	May-26 WTE actual	Variance
Medical and Dental	1,166	1,155	-11
Nursing and Midwifery	2,709	2,704	-5
Support Workers	2,792	2,758	-34
NHS Infrastructure	1,964	1,996	+32
Scientific Therapeutic & Technical	1,344	1,341	-3
Misc (Ambulance roles, Non-Executives)	12	10	-2
Total	**9,987**	**9,964**	**-23**

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 financial year 2026-27. A specific area of focus is medical bank and agency use, with the Trust implementing a WRAP scheme to oversee targeted reduction in this area. To support this, the Trust is implementing Medical Workforce Assurance Meetings to look holistically at the underlying causes of temporary staffing and to work collaboratively with Care Groups to develop sustainable workforce plans. Additionally, the Trust continues to monitor 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 June decreased to an average of 45 shifts a week, down from 50 a week on average in May.

The Trust continues to negotiate with agency providers to reduce rates and convert agency workers on block bookings into bank or substantive positions.

Administrative bank activity in June decreased to 824 shifts worked, compared to the 897 shifts recorded in May but overall use remains high. The Trust continues to focus on this as an area for reduction and increased governance.

Workforce
Scorecard (2)

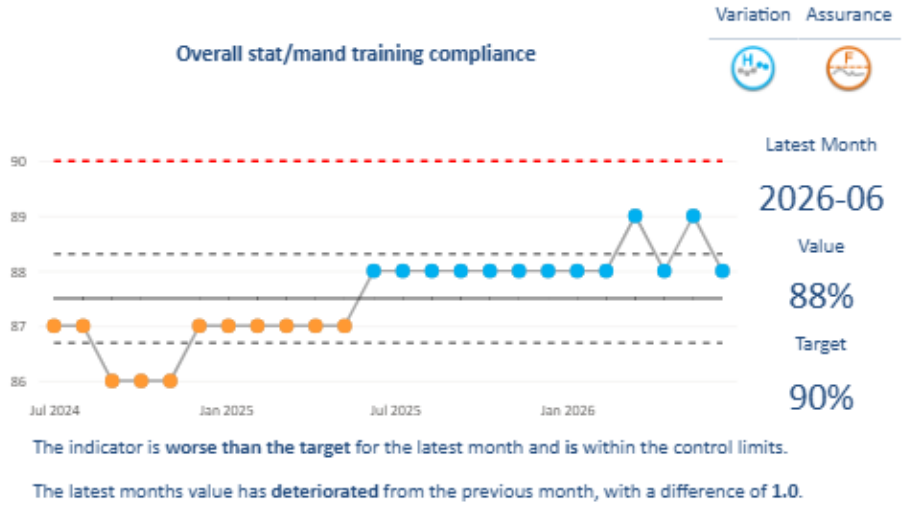
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

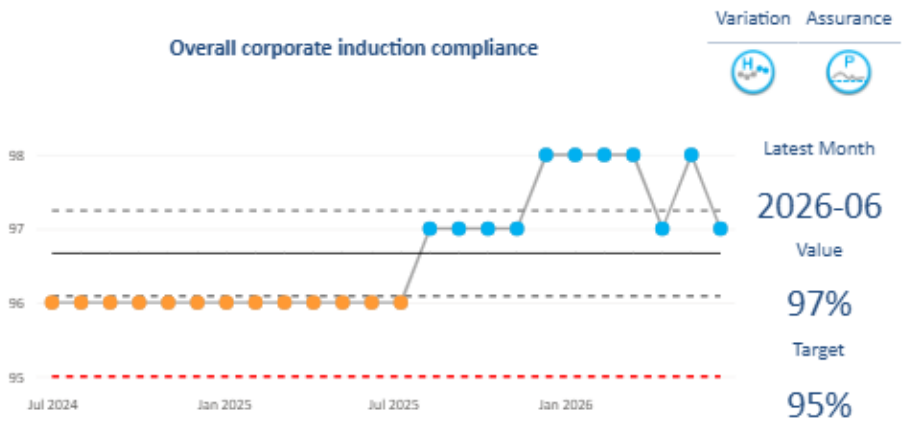
Executive Owner: Lydia Larcum **Operational Lead:** Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2026-06	H	F	88%		90%
Overall corporate induction compliance	2026-06	H	P	97%		95%
A4C staff stat/mand training compliance	2026-06	H	?	90%		90%
A4C staff corporate induction compliance	2026-06	H	P	97%		95%
Medical & dental staff stat/mand training compliance	2026-06	H	F	78%		90%
Medical & dental staff corporate induction compliance	2026-06	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 June, mandatory training compliance returned to 88%.

NHS England has recently launched the NHS Staff Standards and Leadership and Management Framework, establishing a national baseline for staff experience and expectations of leadership and management practice across the NHS. The Trust is reviewing the requirements and assessing alignment with existing workforce, organisational development and management arrangements, with further updates and any required implementation actions to be reported to Board during 2026-27.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

July 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

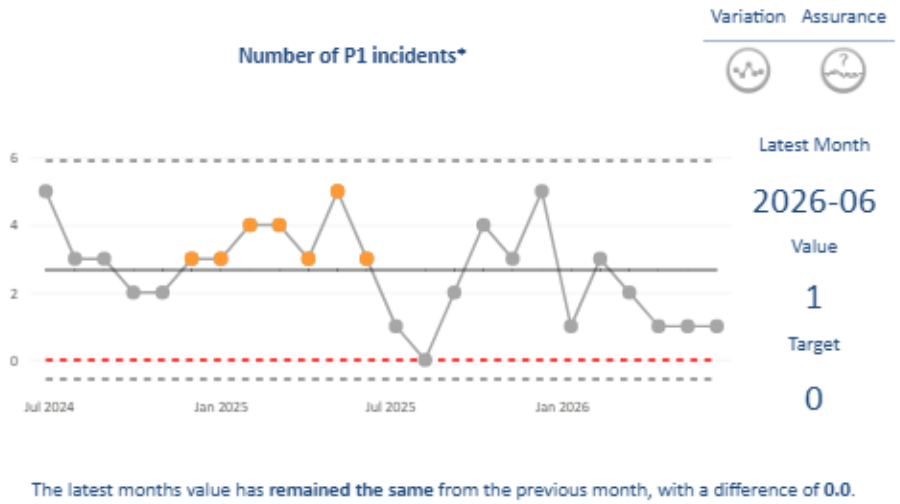
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* Percentage of FOIs and EIRs responded to within 20 working days (monthly)		
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents*	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests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

Executive Owner: James Hawkins

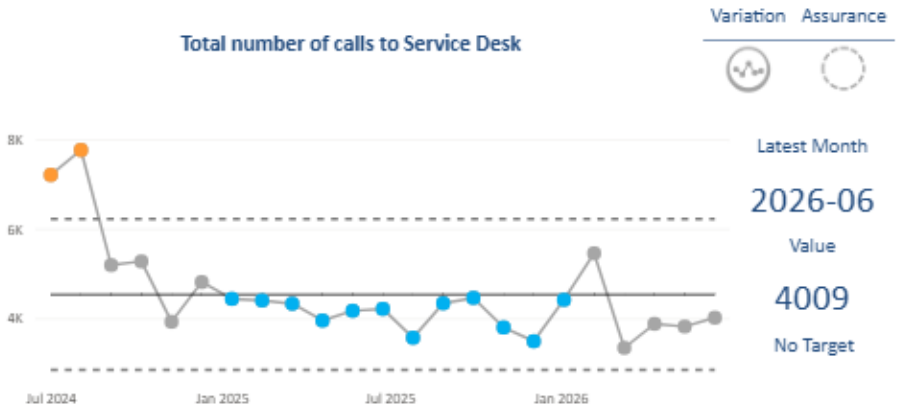
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-06		?	1		0
Total number of calls to Service Desk	2026-06			4009		
Total number of calls abandoned	2026-06			1608		
Number of information security incidents reported and investigated	2026-06			56		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-06			391		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-06			271		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-06	L	?	66%		80%
Number of FOIs and EIRs received (monthly)	2026-06			74		
Number of FOIs and EIRs completed (monthly)	2026-06	L		53		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-06	H	P	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 **deteriorated** from the previous month, with a difference of **197.0**.

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.

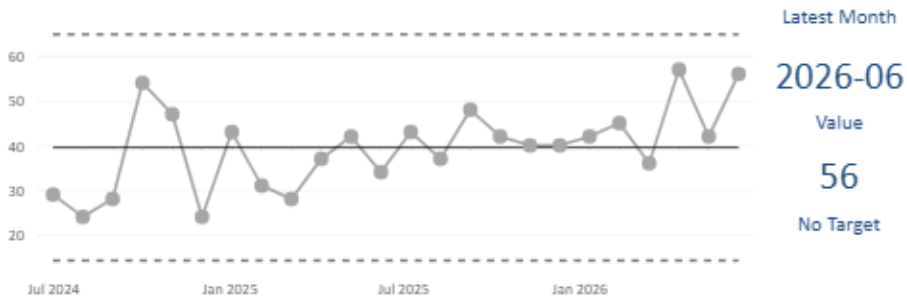
Telephone performance was unchanged, despite the Nervecentre go live. Much of the associated support demand was met via alternate channels:

- 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

Number of information security incidents reported and investigated



The latest months value has **deteriorated** from the previous month, with a difference of **14.0**.

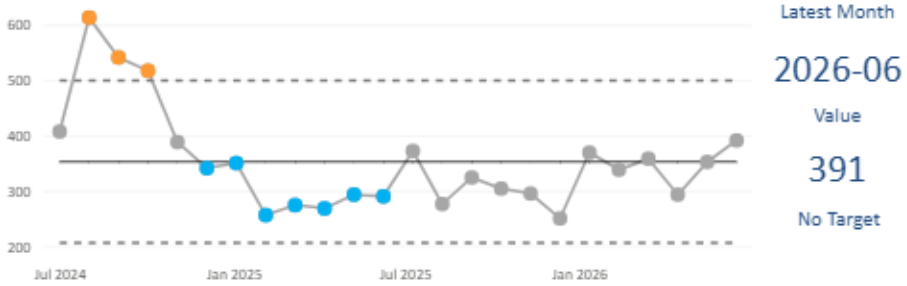
Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

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.

Number of patient Subject Access Requests (SAR) received (monthly)



The latest months value has **deteriorated** from the previous month, with a difference of **39.0**.

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.

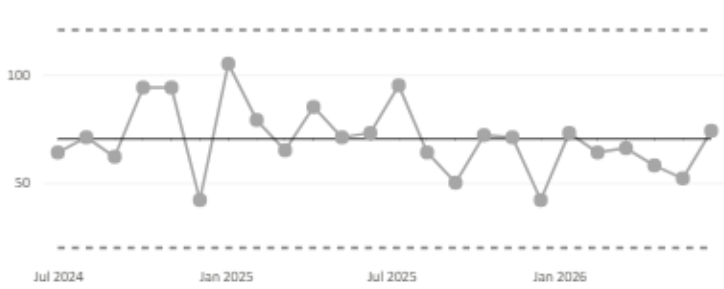
Volumes received have increased; we are still seeing high volumes with other types of information requests. The Trust is currently experiencing a backlog and response times have been impacted. This is being communicated to requesters.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Number of FOIs and EIRs received (monthly)

Variation Assurance

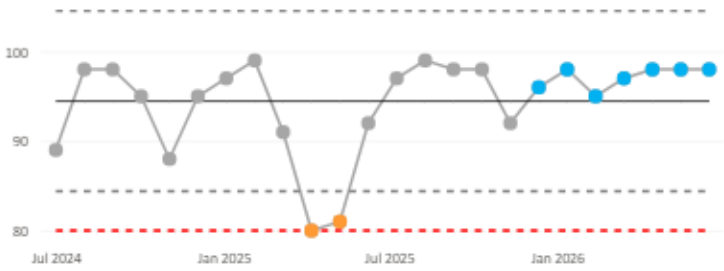


Latest Month
2026-06
Value
74
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **22.0**.

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

Variation Assurance



Latest Month
2026-06
Value
98%
Target
80%

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

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

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

Factors impacting performance:.

Number of FOIs Received

The number of FoIs the Trust received has decreased slightly.

Actions: N/A

Percentage of FOIs responded to within 20 working days

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

July 2026

Executive Owner: Andrew Bertram

Highlights

At the end of June 2026, the Trust is reporting an adjusted year to date deficit of **£9.0m**, compared to a planned deficit of **£6.0m**, resulting in an adverse variance of **£3.0m**. The in-month position for June is **£2.0m adverse**. The year to date position **includes £2.6m of additional income arising from over-performance against plan**, comprising **£2.0m** relating to high-cost drugs and devices and **£0.6m** from variable activity, predominantly day cases. The high-cost drugs and devices overtrade includes **£0.5m** against the Specialist Commissioning contract and **£1.5m** against the Humber and North Yorkshire ICB contract. While the forecast continues to assume delivery to plan, performance in the first three 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 **£23.9m** against a target of **£61.6m** of which **£17.2m is recurrent**. The programme is however behind plan at month 3 with a shortfall of **£3.5m.**

The Group's June closing cash balance was **£10.3m** against a plan of **£5.8m** (£4.5m favourable). The improvement is primarily timing-related: **£6.0m** of supplier payments were held pending confirmation of cash receipts and the final payment run, and the **£2.9m** reclaimable VAT receipt flagged last month was received alongside large receipts from HUTH, Humber FT and Harrogate FT. This was partly offset by the non adjusted adverse I&E position **(£2.4m),** with a further **£1.0m** favourable movement mainly due to debtors and accrued income being below plan. Run-rate forecasts continue to indicate a cash shortfall from September, and a cash support request is being prepared for potential submission in August.

The activity-related investment reserve has been adjusted to **£6.0m** after the **£3.0m** plan adjustment and the **£2.7m** WRAP shortfall at month 2 (M3 shortfall: £3.5m; £0.8m offset by overtrade). Approvals to date total **£2.6m**, leaving **£3.4m** available, subject to savings progressing.

Concerns

The principal risk remains delivery of the WRAP programme. At Month 3, **£10.9m** of year-to-date savings have been delivered against a target of **£14.4m**, leaving a shortfall of **£3.5m**. The shortfall has been managed through deferral of planned investments and the bringing forward of **£2.7m** of income from future months with an overtrade against our HNY ICB variable contract offsetting the remaining **£0.8m** shortfall. 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 **£0.3m year to date** (plan £1.7m), within the **annual limit of £6.3m**. However, bank spend is **£9.3m** year to date against a plan of **£6.5m**, an adverse variance of **£2.8m**. 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 activity, contracting and income reporting. At Month 3, weighted activity across all commissioners is **c.£0.67m above plan**. The HNY ICB position includes an adjustment for a lower excluded-drugs plan, indicating potential pass-through drugs income recovery of **c.£2.0m** across commissioners. This remains provisional, with some activity estimated pending final coding and costing. The Trust should now engage with commissioners on the drivers and management of activity above the Indicative Activity Plan, as any overtrade and associated delivery costs could reduce by year end.

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.

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.

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**

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 **£3.4m** behind plan at M3, mainly due to RAAC schemes running **£4.9m** behind, partly offset by EPR, backlog maintenance, Y&S digital schemes, CT3 and York SCBU running ahead. The forecast is **£62.8m** against the **£63.4m** approved plan, reflecting RAAC pathology reprofiling and Macmillan carry-forward. Slippage and reprofiling have brought several previously overcommitted schemes within forecast, but phasing, cash and delivery need close monitoring.

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.

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 17) & 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 15 • 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) • ICB led contract management meetings to be established.
Cash Position	Risk that the Trust will run out of cash by October 2027	• Weekly Cash Committee to track cash position and escalate key issues • Increased engagement with NHS providers and other debtors to improve cash collection • Extending creditor payment terms whilst prioritising critical suppliers to protect patient services

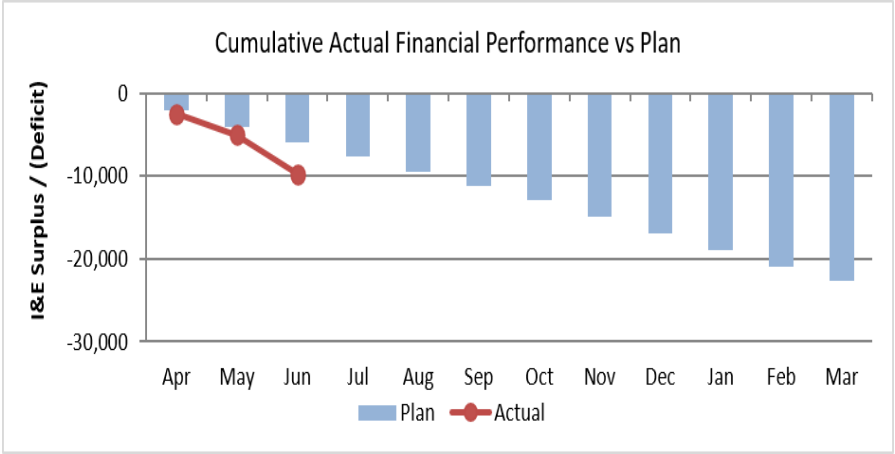
BAF

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.

	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	67,297	70,231	2,934	201,892	207,265	5,373
Other Income	83,443	6,964	7,657	694	20,863	23,621	2,758
Total Income	891,011	74,261	77,124	2,863	222,755	230,886	8,131
Pay Expenditure	-623,169	-50,298	-52,762	-2,464	-151,870	-155,319	-3,449
Drugs	-67,724	-5,558	-6,967	-1,409	-16,954	-20,550	-3,595
Supplies & Services	-98,515	-8,009	-8,243	-233	-24,296	-24,199	97
Other Expenditure	-157,578	-11,733	-11,980	-246	-35,134	-35,288	-154
Outstanding WRAP	37,660	785	0	-785	3,535	0	-3,535
Total Expenditure	-909,325	-74,814	-79,951	-5,137	-224,720	-235,356	-10,636
Operating Surplus/(Deficit)	-18,315	-553	-2,062	-1,509	-1,965	-4,470	-2,505
Other Finance Costs	-12,677	-1,056	-1,057	0	-3,169	-3,082	87
Surplus/(Deficit)	-30,992	-1,609	-3,119	-1,510	-5,134	-7,552	-2,418
NHSE Normalisation Adj	8,346	-272	-846	-574	-816	-1,444	-628
Adjusted Surplus/(Deficit)	-22,646	-1,881	-3,965	-2,084	-5,950	-8,996	-3,046

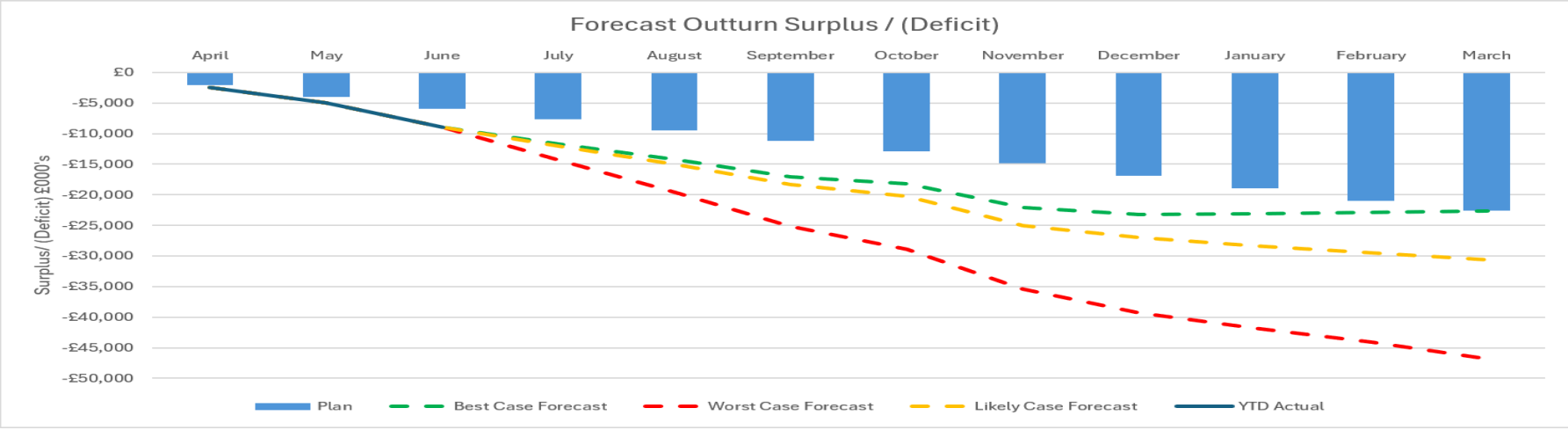
The I&E table confirms an actual adjusted year to date deficit of £9.0m against a planned deficit of £6.0m, leaving the Trust with an adverse variance to plan of £3.0m. The in-month position for June was an adverse variance of £2.0m.

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 June 2026 is an adverse variance to plan of £3.0m



The graph above presents the forecast outturn deficit compared with the planned deficit of £22.6m. It presents the following 3 scenarios:

The best-case scenario assumes that the Trust recovers its financial position and delivers an outturn deficit of £22.6m, in line with plan. This assumes full delivery of the WRAP programme and achievement of financial recovery plans that deliver a further £8m of savings compared with the current run rate.

The most likely scenario is an outturn deficit of £30.7m, which is £8m worse than plan. This assumes the WRAP programme is delivered in full, but that the additional £8m financial recovery plan is not achieved.

The worst-case scenario assumes that the Trust continues its current run rate trajectory, with no further run rate savings over current levels. Under this scenario, the outturn position would be a deficit of £46.9m.

Key Subjective Variances: Trust

Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHSE income	-£9.7m	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	£15.2m	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 and medical staffing pay awards and overtrade on high-cost drugs and variable activity.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27.
Other Income	£2.7m	£2.7 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	-£3.5m	The adverse variance is due to medical bank and extra contractual costs relating to April's industrial action (£0.6m). Pay awards have also been agreed and paid at a higher rate than funded, adding £2.5m to the pay overspend. Income has been accrued to cover the pay increase, but income and expenditure plans have not yet been uplifted because contract variations have not been confirmed by commissioners.	NHSE have confirmed that there will be no funding to cover the cost of industrial action. 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. Overall income and expenditure budgets will be uplifted when contract variations are confirmed by commissioners.
Drugs and Devices	-£3.5m *Net of income: -£1.5m*	Drugs expenditure is £3.5m above plan. £2.0m relates to drugs 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 £0.1m above plan. These are commissioned on a pass-through basis and full reimbursement is assumed within the income position.	Review of WRAP scheme drugs savings to validate cost reductions are delivering in line with expectations. Overtrade on High Cost Drugs has been shared with the ICB and income assumed in the position. The ICB are in the process of establishing a contract management board which will review all overtrades against the agreed plan.
WRAP	-£3.5m	Year to date savings of £10.9m have been delivered compared to a target of £14.4m. This is a shortfall of £3.5m. In full year terms, £24.0m 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	Period
Total	**11,797**	
£3m plan adjustment	- 3,000	
Shortfall of WRAP*	- 2,750	
Revised Reserve	**6,047**	
Approved to date by specialty:		
Acute Medical Model	639	Q1-Q2
Audiology	312	Q1-Q2
Colorectal Surgery	331	Q1-Q2
ENT	286	Q1-Q2
Gynaecology	107	Q1-Q2
Oral Surgery	87	Q1-Q2
Paediatric SaLT	507	Full Year
Pain Management	241	Q2
Respiratory	46	Q2-Q4
Urology	77	Q1-Q2
Total approved as at 31st June 2026	**2,632**	
Remaining Reserve	**3,414**	

*Note: The shortfall of WRAP adjusted against the reserve is held at the M2 position (£2.7m), the remaining WRAP shortfall (£0.8m) is offset against an overtrade on the HNY ICB contract.

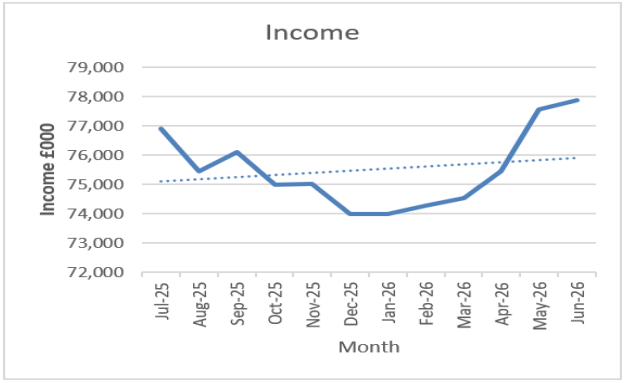
Within the plan, the activity-related investment provision was £11.7m. After the £3m plan adjustment and £2.7m WRAP shortfall, the reserve was revised to £6m. Approvals recorded to date amount to £2.6m, leaving £3.4m available to support further specialty investments.

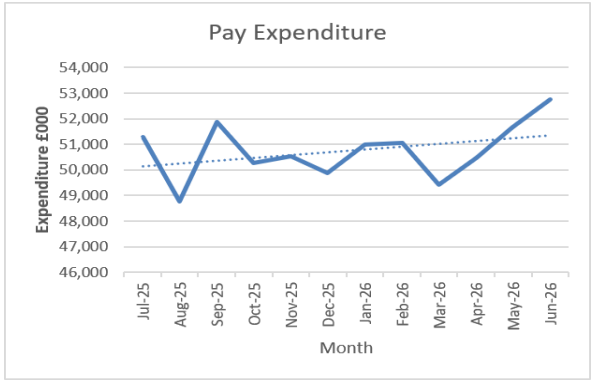
Most investments have been agreed on a non-recurrent, quarter-by-quarter basis and currently extend only to the end of Q2. The exceptions are Paediatric SaLT, which has full-year approval but requires an approved business case before funding can be drawn, and Respiratory, which is approved to year-end to recruit to a specialist nurse role.

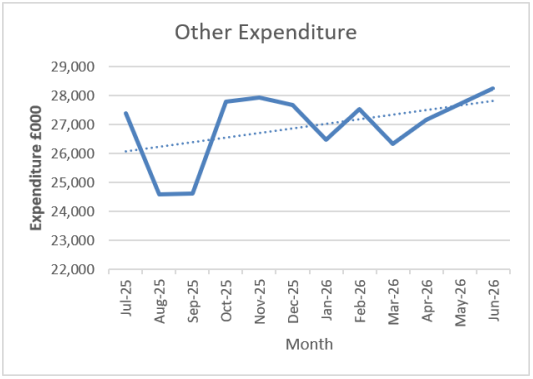
Income and Expenditure Run Rate

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust







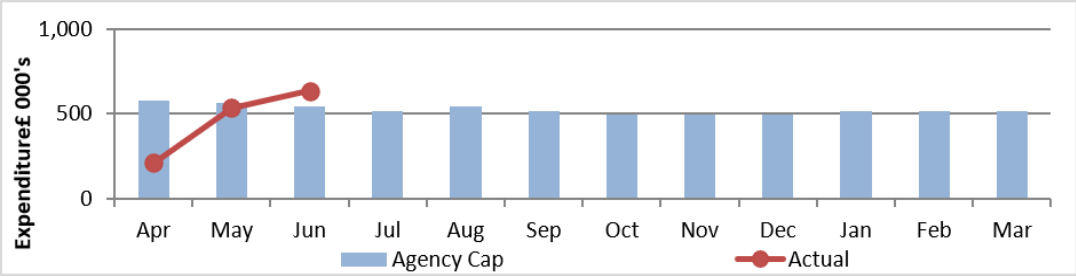
	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD Average	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	76,912	75,443	76,095	74,981	75,011	73,986	74,000	74,268	74,525	75,442	77,557	77,887	75,293	2,594
Pay Expenditure	51,273	48,784	51,884	50,282	50,548	49,895	51,005	51,041	49,416	50,484	51,676	52,761	50,572	2,189
Other Expenditure	27,404	24,599	24,629	27,807	27,945	27,683	26,486	27,538	26,333	27,156	27,718	28,248	26,845	1,403

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 June 2026 was £77.9m, which was £2.5m above the average monthly income for July 2025 to May 2026. This includes £2.7m of income brought forward from future months to offset shortfall in WRAP delivery and £2.6m of overtrade relating to pass through costs and tariff-funded activity.

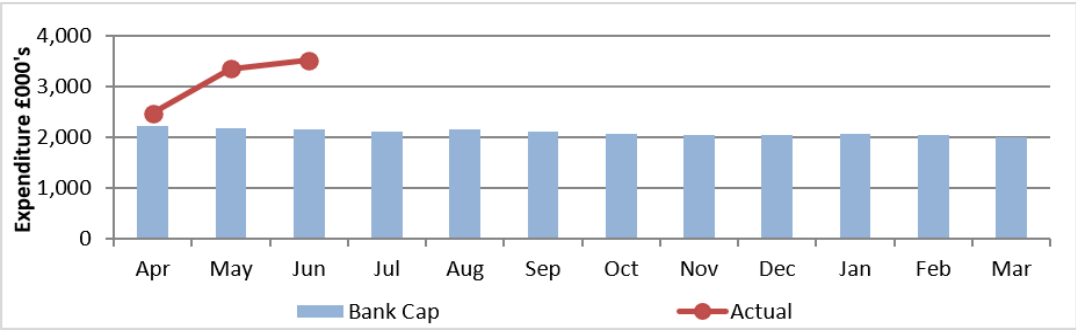
Pay expenditure in June 2026 was £52.7m which was £2.2m above the average monthly pay expenditure for July 2025 to May 2026. The increase was mainly due to the medical staff pay award implemented in June which included backdated pay uplifts from April 2026.

Other expenditure was £28.2m in June 2026, which was £1.4m higher than the average monthly expenditure for July 2025 to May 2026. The increase is due to depreciation charges which were included in plan, increased use of blood products, insourcing and external reporting.



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 June 2026 is £1.4m, compared to a plan of £1.7m, representing a favourable variance of £0.3m.



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 June 2026 is £9.3m, compared to a plan of £6.5m, representing an adverse variance of £2.8m.

	Year to Date Expenditure		
	Budget	Actual	Variance
	£000	£000	£000
Registered Nurses	39,761	40,072	-311
Scientific, Therapeutic and Technical	20,202	20,058	144
Support To Clinical Staff	17,922	15,081	2,841
Medical and Dental	43,142	44,625	-1,483
Non-Medical - Non-Clinical	32,906	34,877	-1,971
Reserves	-2,583	0	-2,583
Other	520	605	-85
TOTAL	151,870	155,318	-3,448

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. Pay awards have also been agreed and paid at a higher rate than funded. This is represented as £2.5m overspend on the Reserves line. Income has been accrued to offset this cost.

Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Trust Variable Activity Performance Report vs Commissioner Values in Contract.

Commissioner	Value VAPR scope Indicative Weighted Values at 26/27 prices	VAPR Month 3 Phase (Av %)	Weighted Activity to Month 3 Actual	Variance - (Clawback Risk) M3
Humber and North Yorks	£192,570,249	£47,308,082	£49,116,834	£1,808,751
West Yorkshire	£1,579,629	£396,482	£445,844	£49,362
Cumbria and North East	£263,424	£71,571	£85,243	£13,672
South Yorkshire	£146,877	£39,789	£48,406	£8,617
All ICBs	***£194,560,179***	***£47,815,924***	***£49,696,326***	£1,880,402
NHSE Specialist Commissioning	£41,389,000 #	£10,148,543	£10,933,388	£784,845 £0
	£285,266	£46,974	£48,886	£1,912
All Commissioners Total	**£236,234,445**	**£58,011,441**	**£60,678,601**	£2,667,160

Note:- Position Includes High Cost Exclude Drugs and Est adjustment for Blended Payment variation

Variable Activity Performance Report

The Trust is monitoring the weighted financial value of activity that falls within the scope of the variable elements 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. It also includes High Cost Excluded Drugs and an estimated impact of the variance for Urgent and Emergency Care activity which is re-imbursed as part of the blended element at 20% marginal rates.

Although the funding for the variable activity is now reimbursed on a cost per case arrangement. HNY ICB has introduced a new Contract Management Framework designed to support the delivery of the agreed activity, performance, quality and financial plans and to strengthen collaboration between the ICB and providers. This approach will also enable timely identification, escalation and resolution of risks and issues.

Any identified "material" variance to the Indicative Activity Plan (IAP) in year may then require a joint Activity Management Plan (AMP) to manage activity levels back within system resource where possible.

At Month 3, across all commissioners, the weighted activity position is above the planned weighted value by circa £2.67m. This include expected additional income for High Cost Excluded drugs and devices and current overtrades in Activity, mainly in Day case Point of Delivery. This position include provisional data and where activity is not yet coded, so the variable position is subject to change when the final Month 3 activity is fully coded and costed. As this is provisional data and is currently higher than plan as part of the New Contract management Framework, the Trust is required to discuss with the HNY ICB and identify the key drivers of the current activity variance.

Trust Waste Reduction and Productivity Programme

Executive Summary

Programme Summary Position

	Full Year	YTD Position
Target	£ 61,639,999	£ 14,424,895
Delivered	£ 23,979,717	£ 10,889,898
Variance	**-£ 37,660,282**	**-£ 3,534,997**
Additional Plans to be delivered		
Planned Low Risk	£ 12,063,088	£ 620,911
Planned Medium Risk	£ 18,184,793	£ 1,016,060
Planned High Risk	£ 5,096,989	£ 65,679
Total Additional Plans	**£ 35,344,870**	**£ 1,702,650**
(Planning Gap)/Over delivery	**-£ 2,315,411**	**-£ 1,832,347**

WTE Plan	194.20	**WTE Delivered**	59.39

Scheme Governance

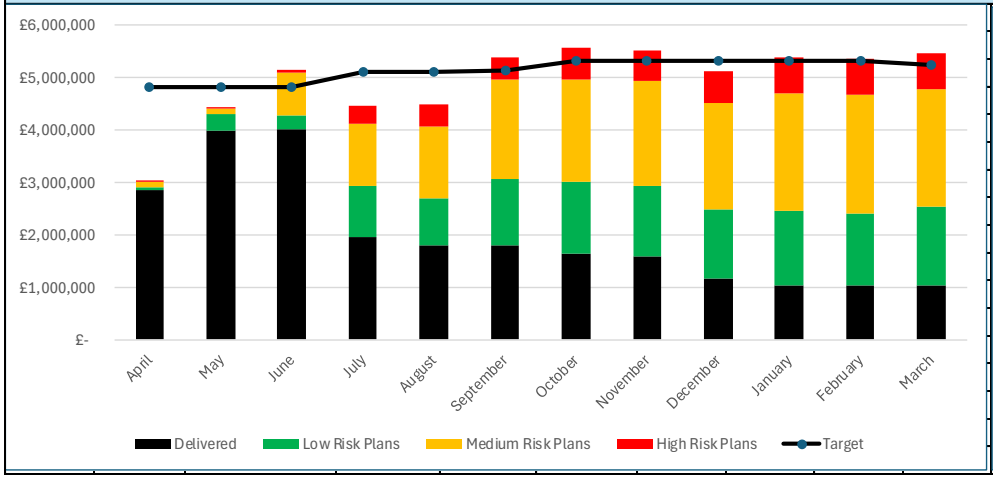
Total Number of Live Schemes	**146**
EQIA Outstanding	42 — 29%
Pre-Pipeline	32 — 22%
Opportunity	14 — 10%
Plan in Progress	11 — 8%
Fully Developed	89 — 61%

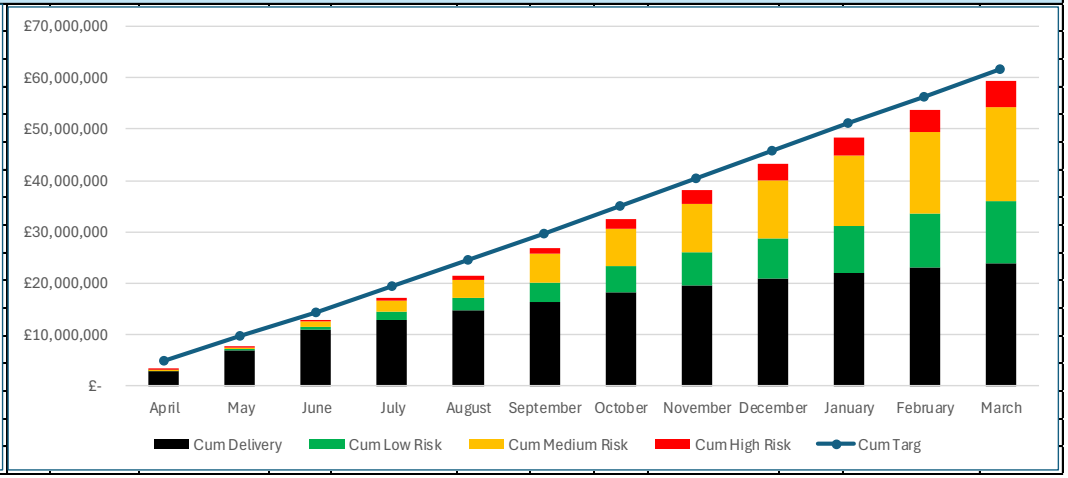
	Plans	%	Delivered	%
Recurrent	£ 39,361,501	64%	£ 17,215,485	28%
Non Recurrent	£ 19,963,087	32%	£ 6,764,232	11%
Total	**£ 59,324,587**	96%	**£ 23,979,717**	39%

	Plans	%	Delivered	%
Pay	£ 26,296,164	43%	£ 8,260,699	13%
Non Pay	£ 32,713,061	53%	£ 15,499,655	25%
Income	£ 315,363	1%	£ 219,363	0%
Total	**£ 59,324,587**		**£ 23,979,717**	

YTD Period Name	June 2026

In Year Plan Profile





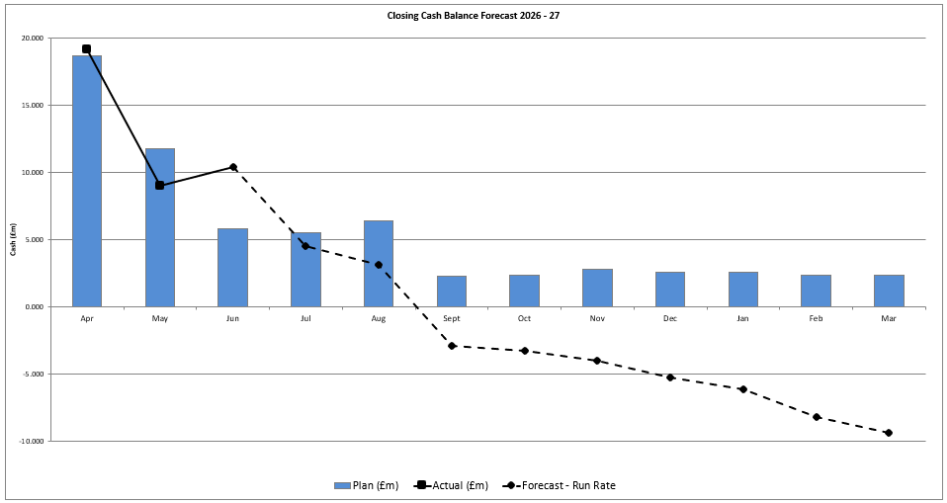
Current Cash Position and Better Payment Practice Code (BPPC)

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.

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	10,304									



Closing cash was £10.3m against a plan of £5.8m, which is £4.5m above plan.

Due to the uncertainty of cash receipts approaching month end & the timing of the final supplier payment run, £6m of invoices due for payment were held to ensure sufficient cash resources were available before payment could be released.

In the final days of the month, the £2.9m reclaimable VAT flagged previously was received alongside large value key receipts from organisations including HUTH Trust, Humber FT & Harrogate FT increasing the closing cash position.

The significant factors creating the variance are:

£2.4m – Adverse variance in I&E position.

£6m – Favourable variance due to timing of supplier payments described above.

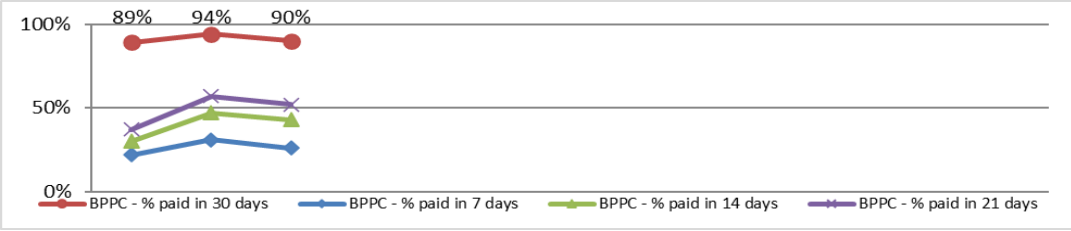
£1m – Favourable variance mainly due to debtors & accrued income below planned values.

The run rate forecast, is based on continuation of cash receipts & payment run rates in line with current levels and any known adjustments. The run rates are extrapolated to give an indication of emerging cash pressures which continue to indicate a cash shortfall from September. A cash support request is been prepared for potential submission in August to meet regional and national deadlines.

<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 June the Group managed to pay 90% 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

The board approved capital plan for 2026/27 is £63.4m. RAAC eradication & pathology build on the Scarborough site are the largest value schemes in the plan.

The forecast has reduced by £0.6m to £62.8m. This is due to a £1.9m decrease from the RAAC pathology scheme, with expenditure and PDC funding reprofiled between financial years. There is a £1.3m increase due to the Macmillan cancer care centre not completing in the previous financial year. This scheme is charitably funded and therefore does not impact on the overall capital program funding.

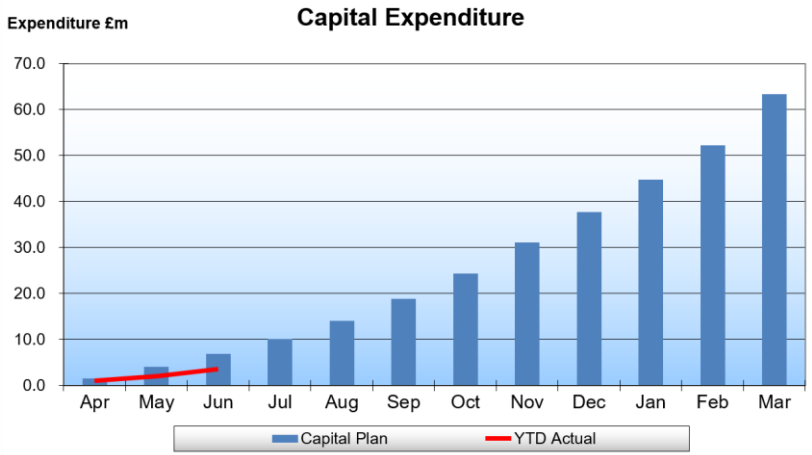
Capital Position	Plan	Forecast Outturn	YTD Plan	Actual YTD Expenditure	Variance to YTD Plan
	£000's	£000's	£000's	£000's	£000's
Internally Funded Schemes					
Electronic Patient Record (EPR)	7,200	7,200	-	570	570
York - PACU / Hybrid Theatre	2,850	1,750	225	347	122
Histopathology Refurb Completion	1,800	600	200	-	- 200
Salix Decarbonisation - Trust Contribution	1,459	1,459	-	-	-
Minor Works Schemes	559	589	-	47	47
Estates Backlog Maintenance & EDI	1,150	1,150	150	336	186
Y&S Digital Capital Projects	1,000	1,000	100	167	67
Medical Equipment Purchase/Lease	5,600	5,600	100	108	8
Capitalised Staff / Project Fees	2,100	2,100	447	483	36
Other Capital Projects	499	- 111	-	374	374
CIR - Refurb & Extension of SCBU York	-	1,080	-	142	142
Upgrade of CT (CT3) - York	-	700	-	416	416
Renal Ward York - Water ring upgrade	-	300	-	-	-
MRI 4 Relocatable	-	400	-	-	-
Ward 16 York	-	400	-	-	-
Total Internally Funding Schemes	**24,217**	**24,217**	**1,222**	**2,990**	**1,768**
PDC, Charitable and Grant Funded Schemes					
RAAC - Scarborough Pathology - PDC	16,458	14,604	2,966	-	- 2,966
RAAC - Scarborough Theatres - PDC	8,737	8,737	2,007	58	- 1,949
Constitutional Standards Schemes - PDC	6,150	6,150	-	-	-
Safer Estates Schemes - PDC	3,655	3,655	-	-	-
Charitable & Grant Schemes	4,160	5,460	767	500	- 267
Total Externally Funded Schemes	**39,160**	**38,606**	**5,740**	**559**	**- 5,181**
Total Capital Programme	**63,377**	**62,823**	**6,962**	**3,548**	**- 3,414**

Due to slippage and reprofiling of schemes including histopathology refurbishment scheme & York hybrid theatre scheme, several schemes that were presented from the capital prioritisation work as an overcommitment are now funded within the forecast.

These include York SCBU, completion of CT3, renal water ring main upgrade, MRI 4 relocatable and commencement of Ward 16 towards the end of the financial year.

The M3 position is £3.4m behind plan.

This is mainly due to the RAAC schemes running behind the original planned phasing (£4.9m), offset by several schemes running ahead of the monthly planned phasing but within the total annual agreed allocations. These include EPR, backlog maintenance, Y&S digital schemes, CT3 and York SCBU.



M2 System Position
Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

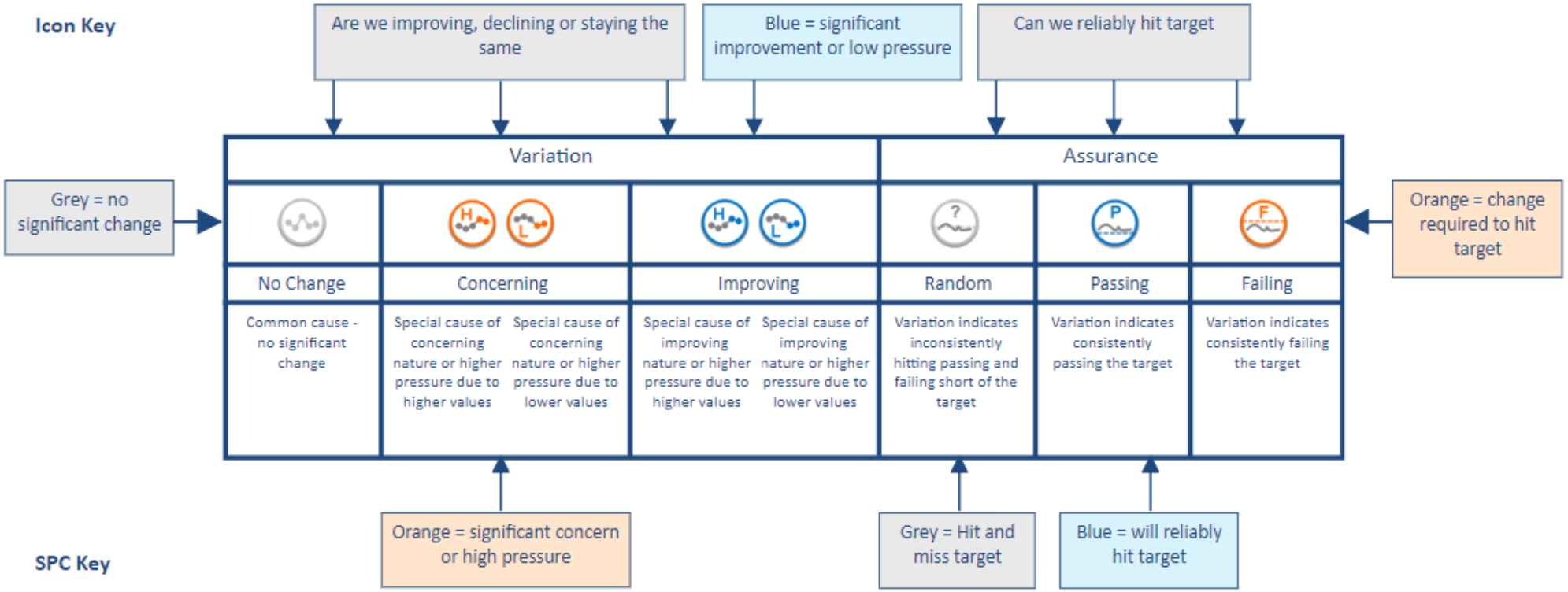
HNY Finance Summary - M2			Surplus / (Deficit) Including DSF						Surplus / (Deficit) Excluding DSF					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire														
QOQ	NHS Humber and North Yorkshire ICB	ICB	0	(1,808)	(1,808)	0	0	0	(1,814)	(1,808)	6	(10,883)	(10,883)	0
RCD	Harrogate and District NHS Foundation Trust	Provider	(3,321)	(8,525)	(5,204)	(15,279)	(15,279)	0	(3,321)	(8,525)	(5,204)	(15,279)	(15,279)	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	(10,312)	(15,214)	(4,902)	(39,400)	(39,400)	0	(10,312)	(15,214)	(4,902)	(39,400)	(39,400)	0
RV9	Humber Teaching NHS Foundation Trust	Provider	0	0	0	0	0	0	0	0	0	0	0	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	(5,145)	(6,215)	(1,070)	(23,665)	(23,665)	0	(5,145)	(6,215)	(1,070)	(23,665)	(23,665)	0
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	(4,068)	(5,031)	(963)	(22,646)	(22,646)	0	(4,068)	(5,031)	(963)	(22,646)	(22,646)	0
Humber and North Yorkshire Provider Total		**QOQ**	**(22,846)**	**(34,985)**	**(12,139)**	**(100,990)**	**(100,990)**	**0**	**(22,846)**	**(34,985)**	**(12,139)**	**(100,990)**	**(100,990)**	**0**
Humber and North Yorkshire Total		**QOQ**	**(22,846)**	**(36,793)**	**(13,947)**	**(100,990)**	**(100,990)**	**0**	**(24,660)**	**(36,793)**	**(12,133)**	**(111,873)**	**(111,873)**	**0**

HNY Efficiency Summary - M2			Total Efficiencies					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	10,875	10,842	(33)	81,468	81,468	0
RCD	Harrogate and District NHS Foundation Trust	Provider	4,589	2,148	(2,441)	32,000	32,000	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	9,108	3,981	(5,127)	72,881	72,881	(0)
RV9	Humber Teaching NHS Foundation Trust	Provider	2,354	2,355	0	14,353	14,353	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	6,188	2,109	(4,079)	46,223	46,223	0
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	9,616	6,866	(2,750)	61,640	61,640	0
Humber and North Yorkshire Provider Total		**QOQ**	**31,855**	**17,458**	**(14,397)**	**227,097**	**227,097**	**0**
Humber and North Yorkshire Total		**QOQ**	**42,730**	**28,300**	**(14,430)**	**308,565**	**308,565**	**1**

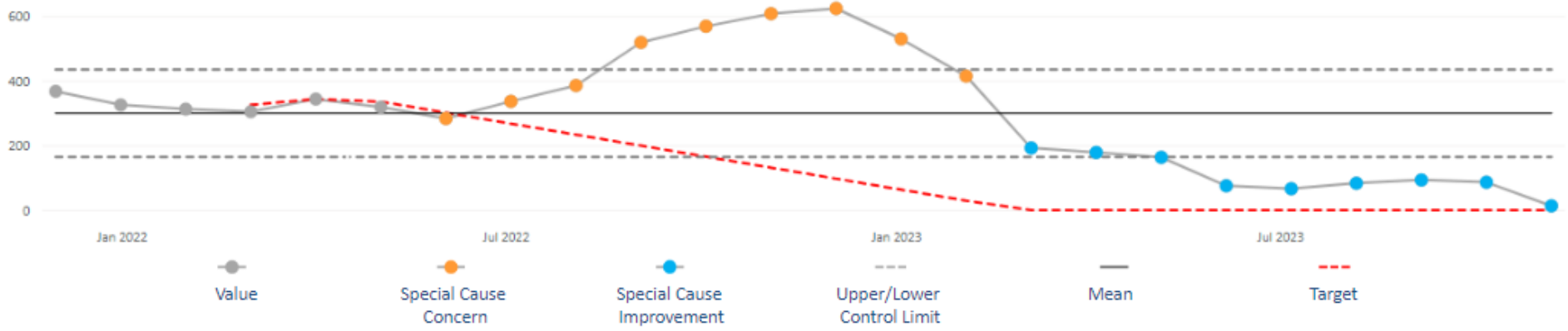
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



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

Icon Descriptions

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NHS Foundation Trust

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

Report to:	Board of Directors
Date of Meeting:	29 July 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

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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 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 and the announced IR(ME)R inspection of NHS Breast Screening Programme service at York Hospital on 24th June 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.

Following the inspection, the CQC requested additional evidence which was submitted by the deadline of 8 June 2026 apart from two requests which were submitted later following clarification from the CQC.

The draft CQC inspection report is awaited.

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. Following this meeting additional information was requested which has been submitted to the CQC.

The draft CQC inspection report is awaited.

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 has been drafted with approval scheduled through the Executive Committee on 15th July 2026. This has been delayed due to recent inspection activity.

1.7 York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER) Inspection : Breast Screening Programme (June 2026)

The CQC conducted an onsite inspection of the Breast Screening Programme at York Hospital on 24 June 2026 as part of its Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) programme.

A pre inspection evidence request, including a self assessment questionnaire, was received and was submitted prior to the deadline of 15 June 2026. Following the inspection further information was requested which has been submitted to the CQC.

The draft report is awaited.

1.8 Ongoing CQC Engagement

Quarterly engagement meetings are planned with our CQC colleagues and a workplan for 2026 has been developed. An engagement meeting has not taken place since the previous update report and the next meeting is in the process of being arranged.

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 1 July 2026, there are 19 open CQC cases. 9 cases have had responses submitted, and we are awaiting feedback from the CQC. One further case has been closed / put on hold by the CQC pending receipt of the SJCR investigation.

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.

3. CQC Updates / Local Inspections

Calderdale and Huddersfield NHS Foundation Trust Well Led Inspection: Published 18th June 2026

Overall, the trust was rated as Good for Well Led.

The CQC undertook a trust-level assessment (well-led review) of the trust which included an on-site visit on 2 – 5 March 2026. Prior to the assessment the CQC observed the trust's board and quality committee meetings on 15 January and 3 February 2026. The trust's partners were also asked for feedback.

The CQC assessed all eight of the quality statements in the well-led key question used when assessing an NHS trust in the Single Assessment Framework. The trust-level assessment followed several assessments of the trust's assessment service groups (frontline services) in January and February 2026. The CQC undertook these assessments to ensure they had a thorough understanding of the full range of services provided by the trust ahead of our trust-level assessment.

The CQC also noted that local surveys showed consistently high levels of satisfaction with the trust's services for both inpatient and community services, particularly in cancer patient care and radiology services.

As well as the trust-level assessment, the CQC also assessed the following service groups:

- Community health services for adults, also rated as Good
- Community health services for children, young people and families
- Medical care (including older people's care)
- Outpatients
- Urgent and emergency care

The report can be found here: Calderdale and Huddersfield NHS Foundation Trust HTML report for assessment AP18481 - Care Quality Commission

Huddersfield Royal Infirmary (Calderdale and Huddersfield NHS Foundation Trust) Outpatient Services – Published 29th June 2026

The CQC assessed the outpatients service as part of a comprehensive trust and well led assessment from 12 January to 5 February 2026. This was in response to concerns raised to us around safe care and treatment.

The overall rating was Good and the report can be found here: Huddersfield Royal Infirmary HTML report for assessment LAP-02987 - Care Quality Commission

Doncaster Royal Infirmary (Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust) Urgent and Emergency Care (UEC) – Published 15th May 2026

The CQC carried out an assessment UEC at Doncaster Royal Infirmary. The assessment commenced on 8 December 2025, with an unannounced visit to urgent emergency care (UEC) on 8 and 9 December 2025 and 6 January 2026.

The overall rating was Requires Improvement and the report can be found here: Doncaster Royal Infirmary HTML report for assessment LAP-01931 - Care Quality Commission

3.2 Updates from the CQC

- **CQC statement on the Supreme Court's judgment on deprivation of liberty (30th June 2026)**

The CQC have issued a statement in response to a Supreme Court judgment handed down earlier this month which changed the definition of deprivation of liberty.

The judgment has immediate effect and has an impact on people who use services, providers and local authorities. Providers will need to familiarise themselves with this legal development and adjust their practice accordingly.

The CQC recognises that this judgment may lead to questions about how the different factors should be interpreted and applied in practice. They advise that providers should read the update published by the Department of Health and Social Care in advance of additional interim guidance. The update is available below:

- GOV.UK: DHSC update on changes to the definition of deprivation of liberty

The CQC advise that they will adopt a proportionate approach in their assessments while they work with partners in the health and care system to determine the practical impact of this revised position.

- **Priorities for delivering more assessments and tackling aged ratings (26th May 2026)**

The CQC is prioritising assessment activity to address aged ratings and unassessed services, with a target of publishing at least 9,000 assessments by September 2026. Focus is on higher-risk areas, including long-unassessed or never-assessed services, independent sector provision, and providers seeking foundation trust status. From September 2026, NHS oversight will expand to include trust-level assessments and targeted review of winter pressures, particularly discharge pathways and end-of-life care. In primary and community care, priority is given to high-risk, unassessed, or outdated-rated services, alongside follow-up of enforcement actions. The CQC is also strengthening its approach through increased use of specialist advisors and executive reviewers to improve consistency, expertise, and confidence in regulatory judgements.

Date: 1 July 2026

Report to:	Board of Directors
Date of Meeting:	Wednesday 29 July 2026
Subject:	Freedom to Speak Up
Director Sponsor:	Clare Smith, Chief Executive
Author:	Stefanie Greenwood, Freedom to Speak Up Guardian

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

During Q1 2026/27, 52 concerns were raised through Freedom to Speak Up compared with 101 in Q4 2025/26. Whilst overall activity reduced, the pattern of concerns provides important intelligence regarding organisational culture, leadership behaviours, psychological safety and patient safety.

More than half of concerns involved workers reporting that concerns had not been adequately addressed through existing routes. This suggests that Freedom to Speak Up continues to act as an important escalation mechanism when staff lack confidence that concerns will be resolved locally.

Concerns relating to management behaviours, colleague behaviours, psychological safety, discrimination and inappropriate behaviours remain prominent. These themes highlight the continuing relationship between organisational culture and patient safety and reinforce the importance of visible leadership, effective feedback mechanisms and local resolution of concerns.

The Board is asked to take assurance that Freedom to Speak Up continues to provide valuable workforce and patient safety intelligence, whilst recognising the need for continued organisational focus on psychological safety, leadership behaviours, inclusion and demonstrating that concerns raised result in visible action and learning.

Recommendation:

The Board is asked to:

- Note the Freedom to Speak Up activity and themes arising during Q1 2026/27.
- Note the continued prominence of concerns relating to psychological safety, leadership behaviours and concerns not addressed through existing routes.
- Take assurance that Freedom to Speak Up continues to provide an effective source of workforce and patient safety intelligence.
- Support continued organisational focus on psychological safety, speaking up culture, leadership behaviours and visible learning from concerns raised.

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

No ☒ Yes ☐

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

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation

Freedom to Speak Up

1. Introduction and Background

The Freedom to Speak Up Guardian provides a vital, independent, confidential route for staff to raise concerns where they may feel unable to do so through local management structures. This enables earlier identification and escalation of patient safety risks, workforce, behavioural and, including issues that may otherwise remain hidden due to fear of detriment or retaliation. Without this role, there is a heightened risk that patient safety risks and unsafe behaviours, poor culture go unreported until harm occurs, limiting the Trust's ability to act preventatively and undermining Board assurance.

2. Key Learning

Q1 data demonstrates that culture is a patient safety issue. The key question is not simply how many concerns were raised, but what they tell us about staff experience, psychological safety and organisational responsiveness. The concerns raised continue to highlight barriers to local resolution, behavioural concerns and the importance of psychological safety.

Staff are frequently speaking up about the conditions that support safe care rather than solely about individual incidents. Leadership behaviours, workplace culture, psychological safety and the effectiveness of local responses to concerns remain important influences on staff experience and patient safety.

Where concerns are not effectively addressed through local routes, there is a risk that staff confidence in organisational processes is undermined, resulting in increased escalation through Freedom to Speak Up, formal processes, regulators or external whistleblowing routes, reducing opportunities for local resolution and organisational learning.

Many concerns related to psychological safety, leadership behaviours and local responses to concerns; these factors influence staff confidence to speak up and therefore the organisation's ability to identify and manage risks to patient care.

The predominant themes identified in Q1 relate not to isolated incidents, but to the organisational conditions that enable staff to speak up, concerns to be addressed and patient safety risks to be identified early.

The Board should therefore view FTSU as an important source of assurance regarding organisational culture, workforce experience and patient safety.

3. What has changed since Q4 2025-26?

- FTSU concerns reduced from 101 to 52.
- Medical and Dental concerns increased from 4 to 11.

4. FTSU activity Q1 2025-26

Whilst overall Freedom to Speak Up contacts reduced during Q1 2026/27, the concerns have highlighted patient safety risks and provided valuable insight into organisational culture and staff experience. Worker safety, including psychological safety, remained the dominant theme, alongside concerns relating to bullying and harassment, inappropriate behaviours and workplace culture.

Of the 52 concerns raised during Q1 2026/27, the most common underlying issues related to:

- **Concerns not addressed through other routes (28 cases)**
- **Management and senior leadership behaviours (20 cases)**
- **Colleague behaviours (14 cases)**

Concerns relating to management and senior leadership behaviours and colleague behaviours continue to feature strongly. When considered alongside concerns relating to psychological safety, bullying and harassment, inappropriate behaviours and culture, this suggests that leadership behaviours and workplace culture remain important influences on staff experience.

4.1 Where concerns are being raised and what this may tell us

Nursing remains the largest professional group speaking up, indicating continued use of the FTSU route by nursing colleagues.

- **Medical and Dental contacts increased from 4 to 11**, despite the overall number of cases reducing. This should prompt curiosity about whether this reflects increased confidence, improved visibility of FTSU, emerging concerns, or a combination of these.
- **AHP contacts reduced from 12 to 1**, which should be interpreted cautiously. This may reflect fewer concerns, use of different routes, or reduced visibility/trust in FTSU among AHP colleagues.
- **Admin/Clerical contacts reduced significantly** but remained one of the larger reporting groups in Q1.

- Medicine remained the highest reporting area in both quarters.
- CSCS remained broadly stable, reducing only from 13 to 12 cases, despite the overall reduction in FTSU activity.
- Corporate and YTHFM saw notable reductions, but reductions should not automatically be interpreted as improvement without triangulation.
- Surgery remained one of the higher reporting areas in Q1, although contacts reduced from Q4.

4.2 Equality, Diversity, Inclusion and Sexual Safety

During Q1 2026/27, concerns relating to equality, diversity and inclusion remained evident within Freedom to Speak Up activity.

- 7 concerns related to an EDI issue.
- 5 concerns related to racism or race discrimination.
- 4 concerns related to sexually inappropriate behaviour.

The Board should note that concerns relating to discrimination, racism and sexual safety often represent high-impact cultural indicators. Whilst volumes are low, they can have a disproportionate effect on psychological safety, staff retention, staff experience and organisational reputation. These themes should therefore be considered alongside wider workforce, speaking up and staff survey intelligence.

5. Areas for Board Assurance

- The effectiveness of local resolution processes and whether workers who raise concerns through management, HR and governance routes feel their concerns are heard, acted upon and feedback is provided.
- The increase in Medical and Dental colleagues accessing Freedom to Speak Up and whether this reflects increased confidence to speak up, emerging concerns or both.
- Management and leadership behaviours remain prominent themes influencing psychological safety and staff confidence to speak up.
- Behavioural and culture-related concerns remain significant despite reduced overall activity.
- The data continues to demonstrate the relationship between organisational culture, psychological safety and patient safety, reinforcing the importance of visible leadership and effective local resolution of concerns.
- How Freedom to Speak Up intelligence is triangulated alongside Staff Survey, Workforce, WRES and Patient Safety data to provide assurance regarding organisational culture and safety.

6. Summary

The findings from Q1 reinforce the importance of Freedom to Speak Up as a source of organisational intelligence regarding culture, workforce experience and patient safety, whilst recognising the continued need to strengthen local resolution, visible learning, leadership behaviours and psychological safety so that staff can speak up with confidence and concerns are addressed at the earliest opportunity.

Date: 18 07 2026

Report to:	Trust Board of Directors
Date of Meeting:	29 July 2026
Subject:	Trusts response to Nottingham Maternity Enquiry and the Fuller 2 recommendations: Board Assurance Paper
Director Sponsor:	Karen Stone, Medical Director
Author:	Karen Priestman, Associate Chief Operating Officer, CSCS Care Group Dave Oglesby, Director of Operations, Scarborough, Hull and York Pathology Service (SHYPS)

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☒

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

The purpose of this paper is to provide the Board with assurance on the Trust's planned response to the national requirements arising from the Nottingham maternity review findings on post-death care, the Human Tissue Authority regulatory requirements and the recommendations from the Fuller Inquiry relating to mortuaries, related storage areas and wider arrangements for the care of people after death.

Recommendation:
The Board is asked to confirm executive ownership and oversight arrangements, and support submission of the required Board Assurance Statement by the national deadline.

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

Trust response to post death care and key actions following the Fuller enquiry
Board Assurance Statement

1. Introduction and Background

In March 2022, NHS England commissioned an independent review into maternity services at Nottingham University Hospitals NHS Trust, led by Donna Ockenden. Separately, concerns about post-death care identified through the David Fuller Inquiry highlighted the need for all NHS provider trusts to review and strengthen arrangements for caring for patients after death, ensuring appropriate governance, security, dignity, and oversight.

As a result, NHS England issued a Board Assurance Statement for NHS provider trusts (Annex 3). All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by Friday 31 July 2026.

The assurance process is intended to support Boards in demonstrating that lessons from both the Nottingham Maternity Review and the Fuller Inquiry have been considered and appropriately addressed within local arrangements.

The completed Board Assurance Statement below sets out the Trust's assessment against the national assurance requirements. Completion of the statement provides assurance that relevant risks have been reviewed, governance controls are in place, and any identified actions are being managed through established improvement processes.

2. Purpose of the Paper

This paper sets out the Trust’s plan to address the actions required in relation to mortuary services, Human Tissue Authority compliance and wider post-death care following national findings from the Nottingham review and the Fuller Inquiry. It describes the proposed programme of work, governance arrangements, key risks and the actions required to provide Board-level assurance.

3. National Context

NHS England’s June 2026 letter requires all provider trusts with a mortuary, related storage area or routine responsibility for caring for people after death to complete a Board Assurance Statement by 31 July 2026. The requirement follows further concerns identified in the Nottingham maternity review and reinforces the need to act on the Fuller Inquiry findings, which highlighted the importance of clear governance, robust security, safeguarding, estates controls, incident reporting and dignity after death.

The Human Tissue Authority has also confirmed a requirement for mortuaries to review HTA reportable incident records from 2015 to 2026, ensuring that all reportable incidents have been appropriately logged and that any omissions are retrospectively reported. The Trust must therefore demonstrate that its internal records, reporting processes and governance routes are sufficiently robust.

4. Trust Response and Proposed Programme of Work

The Trust should establish a time-limited Mortuary and Post-Death Care Assurance Programme, chaired by the Medical Director who is responsibility for the service and reporting through the relevant quality, safeguarding, estates and Board governance routes.

The programme will bring together pathology, mortuary services, estates and facilities, safeguarding, bereavement, security, risk management, clinical governance and corporate services.

The programme will focus on priority areas highlighted in the Fuller Inquiry, Phase 2 report: governance and accountability; HTA and Mortuary roles and responsibilities, security and access control, dignity, safeguarding and staff training; HTA compliance and incident reporting; and estates, environment and capacity.

Each area will have named senior responsible officers, clear milestones and evidence requirements to support Board assurance. In addition, the programme will provide a structured approach to provide assurance to the licence holder that post-mortem activities are carried out in line with the Human Tissue Act 2004, HTA Codes of Practice and HTA Post-Mortem Sector Guidance.

An action plan has been developed.

5. Retrospective Identification of HTA Reportable Incidents.

In response to the Nottingham Maternity Enquiry the HTA have issued a notice informing trusts that they will undertake an Evidence Compliance Assessment (ECA) of licensed premises. For YSTHFT the premises under license include the mortuaries at York Hospital and Scarborough Hospital, Maternity services, and the Histopathology laboratories in SHYPS. Details of this ECA will be sent on 10th August and must be completed by 18th September. The HTA Designated Individual (DI) for the trust will be required to review trust incident records between 1/4/15 and 30/6/26 and declare any unreported incidents or near-miss incidents.

An early assessment of incidents that meet the Human Tissue Authority Reportable Incident (HTARI) categories has been carried out. Since 2015 there have been 20 incidents that may be considered an HTARI, 10 have been reported to the HTA with 10 requiring an in-depth assessment and retrospective reporting to the HTA.

6. Key Actions Required

Action area	Required action	Lead	Timescale
Board assurance	Complete the Board Assurance Statement and submit by the national deadline, supported by an agreed action plan.	Executive Director, Corporate HTA License Holder	By 31 July 2026
Fuller Inquiry recommendations	Map the Trust's position against the 29 NHS-relevant recommendations and identify any gaps requiring improvement.	HTA Designated Individual	July to August 2026
HTA incident audit	Review HTA reportable incident records from 2015 to 2026 and confirm	HTA Designated Individual	18th September 2026

	that all reportable incidents have been appropriately logged or retrospectively reported.		
Security and access	Review access arrangements, swipe card controls, visitor logs, CCTV coverage, contractor access, and escalation processes across all relevant areas.	Security and Mortuary	31 August 2026. This action is part of the routine monthly security audit.
Roles and responsibilities	Confirm and document responsibilities across pathology, mortuary, bereavement, estates, safeguarding, security, and corporate teams.	HTA Designated Individual	31 August 2026
Training and culture	Review training requirements for staff involved in post-death care, including dignity after death, safeguarding, incident reporting, and escalation.	HTA Designated Individual	30 September 2026
Premises assurance	Complete self-assessment against the NHS Premises Assurance Model and ensure Board sign-off before submission.	YTHFM	By 8 September 2026
HTA Assurance Framework	In addition to the actions outlined to meet the 29 Fuller Inquiry recommendations CSCS care group will amend the existing governance arrangements in Mortuary to provide assurance on compliance to the	HTA Designated Individual	31 August 2026

	HTA Post-Mortem sector standards		

7. Governance and Oversight

Oversight will be provided through a dedicated programme group with monthly reporting to the relevant executive-led governance forum. The Regulations and Accreditation Group will receive updates from the HTA DI. Exception reports will be escalated to the Quality Committee and Board where risks, delays or gaps in compliance are identified. The action plan will remain open until all actions are evidenced as complete and embedded into business-as-usual governance.

8. Risks and Mitigations

The principal risk is that the Trust is unable to provide sufficient evidence of consistent controls across all areas involved in post-death care. This will be mitigated through a single evidence repository, named action owners, executive oversight, routine audit and clear escalation. Any residual risks relating to estates, security, staffing, training or compliance will be recorded on the appropriate risk register and monitored through established governance routes.

9. Equality, Diversity and Inclusion Considerations

The programme will ensure that arrangements for post-death care are respectful of religious, cultural and individual requirements. Bereavement and mortuary procedures will be reviewed to confirm that families are supported with compassion, dignity and sensitivity, and that any equality impacts are identified and addressed.

10. Next Steps

Subject to Board approval, the Trust will finalise and submit the Board Assurance Statement, establish the Mortuary and Post-Death Care Assurance Programme, complete the HTA retrospective incident assessment, undertake the Fuller Inquiry recommendations gap analysis and provide a further assurance update to the Board once the initial phase of actions has been completed.

11. Board Assurance Statement

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	RAG, PESC and Mortuary Governance Committee
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	Self-Assessment to be carried out by YTHFM

12. Recommendations

Trust Board is asked to:

- Review the completed Board Assurance Statement.
- Assign the Medical Director as the Executive lead for the Mortuary and Post-Death Care Assurance Programme
- Note the assurance provided regarding compliance with the requirements arising from the Nottingham Maternity Review and the Fuller Inquiry relevant to arrangements after a patient has died.
- Approve and sign off the attached Board Assurance Statement.

Date: 21 07 2026

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

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

26 June 2026

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. **NHS Premises Assurance Model (PAM)** (15 April 2026)

The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. **Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services** (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. **Insightful provider board guide** (November 2024)

Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).

For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. **Assessing provider capability: guidance for NHS Trust Boards** (August 2025)

Assessing provider capability: guidance for NHS trust boards provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

5. **Advanced Foundation Trust Programme** (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

6. **NHS Safeguarding accountability and assurance framework** (April 2026)

The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)
The full text of these recommendations can be found in the Phase 2 Report (pp.264-265).
Supporting guidance
NHS Premises Assurance Model (see entry 1 in Annex 1).
Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).
Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)
The full text of these recommendations can be found in the Phase 2 Report (p.265).
Supporting guidance
Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
The Insightful provider board guide (see entry 3 in Annex 1).
Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).
Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the Phase 2 Report (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the Phase 2 Report (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the Phase 2 Report (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the Phase 2 Report (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

Annex 3 – **Board Assurance Statement for NHS Provider Trusts.** Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.		
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.		
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

Report to:	Trust Board of Directors
Date of Meeting:	29 July 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Joseph Hague, Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team. The performance metrics shared are for the month of May 2026 and for workforce, unit diverts and homebirth service provision the month of June 2026.

Key Assurance

- No reportable neonatal deaths occurred during May 2026 and no cases met the criteria for referral to the Maternity and Newborn Safety Investigation (MNSI) programme during the reporting period. There are currently two ongoing MNSI investigations.
- Workforce growth continues following the additional maternity investment approved in April 2026. Recruitment activity is progressing, with Phase 1 investment posts entering the recruitment process in July and additional NHS England funding available to support newly qualified midwife recruitment and workforce expansion.
- Training compliance remains on track to achieve required standards, with outstanding staff booked onto future training sessions and monthly multidisciplinary training programmes established across both sites.
- Significant improvement activity has been delivered during June including completion of benchmarking against the AMOS 10 Point Plan, appointment of the Deputy Director of Midwifery, implementation of cross-site PACU services, review of all off-pathway preterm cases, development of a bereavement care pathway action plan, and continued delivery of the Maternity and Neonatal Single Improvement Plan.
- The Postpartum haemorrhage rate for the service has improved to 1.4% (5 cases) in the month of May showing further sustained improvement. Nationally benchmarking shows, the trust is middle of the range to other trusts of similar size. Postpartum risk assessments continue to be monitored, and work is in progress to develop this within Signal.

Key Risks

- Homebirth service provision was impacted throughout June 2026 due to safe staffing however only one homebirth was unable to be supported due to staffing pressures in York and Selby. No women were affected during any maternity unit divert periods.
- Workforce vacancies and staff unavailability continue to require mitigation through temporary staffing arrangements while recruitment to newly funded posts progresses. Until substantive recruitment is embedded, there remains a residual risk to service resilience and sustainable staffing levels.

Key Concerns

- The planned disestablishment of the Local Maternity and Neonatal System (LMNS) from 31 July 2026 presents a risk to continuity of maternity system leadership, oversight and service user engagement arrangements. Significant concern remains regarding the future provision of Maternity and Neonatal Voices Partnership (MNVP) services across the Integrated Care Board footprint.
- Delivery of the Maternity and Neonatal Single Improvement Plan remains challenging, with 55 milestone actions currently off-track. Whilst recovery plans are in place for a proportion of these actions, 28 require further review and support to achieve completion.

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 May 2026, and data for June 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 Oversight Model

The introduction of the Perinatal Quality Oversight Model (PQOM) has strengthened governance and assurance arrangements by replacing the previous Perinatal Quality Surveillance Model with a more structured and proactive approach to monitoring quality and safety. The model provides enhanced oversight of key performance indicators, patient outcomes, safety concerns, and improvement actions, enabling earlier identification of risks and more robust escalation processes. In line with PQOM, the Service is required to report the information outlined in the data measures monthly to the Trust Board and to NHS England quarterly. The PQOM data for May 2026 is provided in a separate paper.

Perinatal Deaths

There were no reportable neonatal deaths in May 2026 – there were, however, two babies who delivered at York and Scarborough but were subsequently transferred to a tertiary unit and were reported to have died. Baby 1 was 25+4 (extreme prematurity) and Baby 2 34+3 (congenital abnormality).

There were two reviews of perinatal deaths (1 stillbirth 38+2 and 1 neonatal death 23+1) completed in May 2026 Both were graded B (some issues with care that may have made a difference to the outcome) – the neonatal death is being further reviewed as a PSII due to delay in theatre admission. The stillbirth was referred to MNSI and now closed – there were no safety recommendations but some learning for safety prompts around antenatal discussions and DNA processes.

Annual rolling mortality data is shown in Appendix 1

Maternity and Newborn Safety Investigations (MNSI)

No cases met the criteria for reporting to the Maternity and Newborn Safety Investigation (MNSI) programme during May 2026. There is currently two ongoing MNSI cases being investigated.

Moderate Harm Incidents and above

There were 17 incidents graded moderate or above in May 2026 along with 3 red flags as per NICE guidance reported. One was a delay to planned Caesarean birth due to capacity and acuity in the service. There were 2 delays of more than 30 minutes in providing pain relief. All red flag incidents are reviewed to identify any immediate learning and improvement.

Maternity Unit diverts/ closures and suspension of services

In June there were three diverts from Scarborough and four 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

June 2026	East Coast	York & Selby
24hours Homebirth Service Provision **Partial night cover either Team A or Team B** **Day service**	0 6 22 (at least 3 PNV working)	1 5 9 (at least 3 Earlies)
Number Homebirth completed by Community midwives	0	0
Number of attendances at home with transfer in (with reason)	0	0
Number of homebirths not supported due to staffing	0	1
Number of Homebirths where independent midwives have been engaged to provide service	0	0
BBA	0	1
Free Labour/Birth due to Homebirth services not available	1	0

Midwifery Workforce

The midwifery and maternity support workforce continue to grow with active recruitment underway to fill the roles vacant following the investment on the 1st April 2026.

A Newly Qualified Midwife (NQM) non-recurrent Recruitment Support Offer from NHSE in 2026/27 is available to help maternity providers recruit newly qualified midwives into additional Band 5 posts. These posts must be over and above planned recruitment and funded establishment, ensuring that this year's graduates have increased opportunities to enter the NHS and receive high-quality early-career support. Providers can receive up to £10,000 per additional midwifery post which is a contribution towards the cost of creating an additional Band 5 NQM role and supporting the educator capacity required for safe preceptorship. In 2027/28, a share of additional recurrent funding will be provided to support sustainable workforce growth and accelerate progress towards Birthrate Plus.

The table below shows the funded establishment variance to staff in post (substantive vacancy) for roles Band 3 to 6, which is predominantly frontline roles. It also shows the unavailability of staff due sickness, maternity leave and supernumerary hours. Maternity leave is backfilled to 100% and recruited to on top of the establishment budget. Other unavailability is covered using bank shifts first and then if unable to meet safe staffing levels midwives from an agency. Due to an increase in investment and following recruitment, we expect to see a reduction in bank/agency use.

June 2026 Band 6 to 3 midwifery vacancy and recruitment position:

	Band 5/6	Band 3/4
Establishment budget	174.61 WTE	42.96 WTE
Staff in post	162.65 WTE (of which 27.25 WTE are band 5)	42.07WTE
Substantive Vacancy	11.96 WTE	0.89 WTE
Maternity Leave	7.80 WTE (4.67 WTE York & 3.13 WTE Scarborough)	2.00 WTE (1.00 WTE York & 1.00 WTE Scarborough)
Recruitment vacancy	19.76	2.89
Supernumerary	7.10 WTE	
Sickness	8.40 WTE	
Roster vacancy	35.26 WTE	

Training and development

Compliance with training requirements is on track to be met. All staff who are yet to complete training are booked to attend and there are monthly training opportunities across both sites. The following shows a breakdown of training compliance as of June 2026.

York & Scarborough %	PROMPT	NLS	Fetal Monitoring	SBLv.2 (6x e-learning courses)	Smoking in pregnancy (e-learning)	Reducing smoking in pregnancy	BSOTS
Midwives (265)	87% (230/265)	86% (228/265)	87% (231/265)	77% (204/265)	99% (262/265)	86% (229/265)	91% (242/265)
HCA/MSW - (58 - 43 MSW/ 15 MA)	84% (49/58)	N/A	N/A	N/A	N/A	74% (32/43)	84% (49/58)
Obs Cons (25)	88% (22/25)	N/A	96% (24/25)	80% (20/25)	100% (25/25)	92% (23/25)	96% (24/25)
Tier 2 (Reg/ST) (22)	100% (22/22)	N/A	91% (20/22)	50% (11/22)	95% (21/22)	95% (21/22)	N/A
Tier 1 (F2/GP Trainees/SHO) (15)	80% (12/15)	N/A	N/A	N/A	N/A	100% (15/15)	N/A
Tier 1 & Tier 2 combined (37)	92% (34/37)	N/A	95% (35/37)	50% (11/22)	95% (21/22)	97% (36/37)	79% (23/29)
Anaes Cons (19)	74% (14/19)	N/A	N/A	N/A	N/A	N/A	N/A
All other Anaes Docs (53)	68% (36/53)	N/A	N/A	N/A	N/A	N/A	N/A
ODP (82)	59% (48/82)	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Nurses (41)	N/A	73% (32/44)	N/A	N/A	N/A	N/A	N/A

Improvement and Transformation

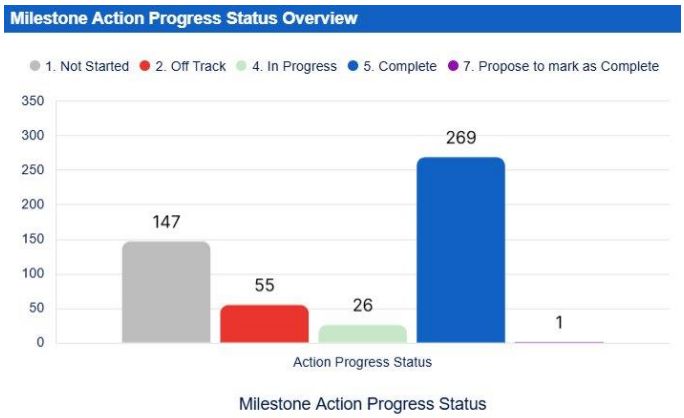
The following is a summary of June improvement activity:

- An audit of the current birth reflections service user pathways has been completed to inform future service modelling.
- Following a review of the final AMOS report, a benchmarking exercise against the 10 Point Plan for maternity and neonatal services was complete and action plan developed. All new Action Requirements have been completed and incorporated into the Single Improvement Plan.
- Listening events to support all staff following the publication of the Final AMOS report and Nottingham enquire will be scheduled throughout July.
- An action plan to align the current bereavement service with the national bereavement care pathway requirements was developed and will be shared for review and approval in July.
- Phase 1 of the Midwifery Workforce Investment was communicated out to staff; jobs will be uploaded to Trac in July.
- Deputy Director of Midwifery commenced in post on the 1st June.
- A PMA Rota has been developed and is shared weekly with staff. There is a robust process whereby the PMA of the week shares comms with all staff to introduce themselves and share contact information.
- All off-pathway preterm cases to date have been reviewed by the MDT team.
- The MEWS guidelines and OSCE were approved at the Audit and Guideline Group. Will now be shared with the deteriorating patient group with anticipated launch date of July.
- The G2 Nurses Station has been refurbished.
- PACU went live cross-site on the 1st June.
- The ANC Kitchen at York was refurbished and is awaiting clear water testing results before opening.
- All Transitional Care equipment received.
- Process to reintroduce self-administration of drugs agreed.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

The programme risks for the delivery of the single improvement plan have been reviewed and updated. An overview of the programme risk titles; descriptions and scores are below as of June 2026.

- 5 new High-Level Actions have been added into Workstream 1 following the release of the AMOS interim letter relating to oversight of equity / equalities data, anti-racism and cultural competency training and inclusive language and care environment; with 18 Milestone Actions developed to support delivery.



Milestone Action Progress Status

- 269 out of 495 milestone actions have been completed to date (4 completed in June 2026)
- 26 milestone actions are in progress
- 55 milestone actions are off-track as the delivery date has passed, and the action has not been completed
- 13 off-track actions with plans in place to deliver these in July 2026.
- 14 off-track actions with plans in place to deliver these in August or September 2026.
- 28 off-track actions require further review and support to achieve completion.
- 147 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 delivery	There is a risk that key programme actions may not be completed within planned timelines due to factors such as interdependencies with other services, delayed decision-making, delayed governance processes, resource constraints, extended stakeholder reviews, or unforeseen operational pressures. These delays can cause slippage across key milestones, affecting the ability to meet overall delivery timelines.	12 *Impact: High* *Likelihood: Medium*
Insufficient investment to support programme and project delivery	There is a risk that the Maternity & Neonatal Service will not receive the required financial investment, resource uplift, or capital funding needed to progress key improvement plan actions	16 *Impact: High* *Likelihood: High*
Expansion of programme scope	There is a risk that the programme's scope expands beyond what was originally agreed, due to informal requests, evolving expectations, national context or pressure from stakeholders to include additional work.	16 *Impact: High* *Likelihood: High*
Loss of key staff impacting programme delivery	There is a risk that key members of the programme leadership team (SRO's, Workstream leads, subject matter experts, programme team, MNVP etc.) may: leave the organisation, move roles, be reallocated to support alternative programmes of work or may not have an identified recurrent funding source. Loss of key staff may lead to gaps in expertise, reduced institutional knowledge, delays in decision making and reduced programme level strategic oversight which will decrease 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

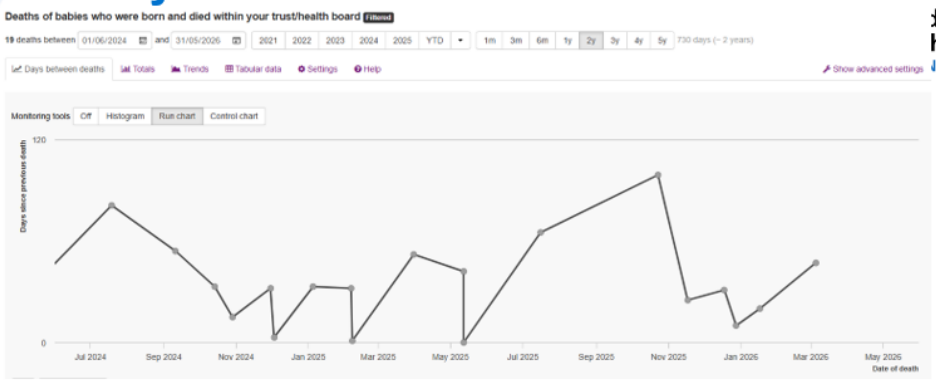
Date: July 2026

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

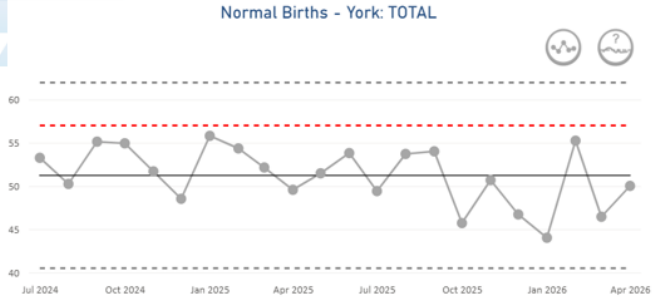
Maternity Quality and Safety Metrics
(May 2026 data)

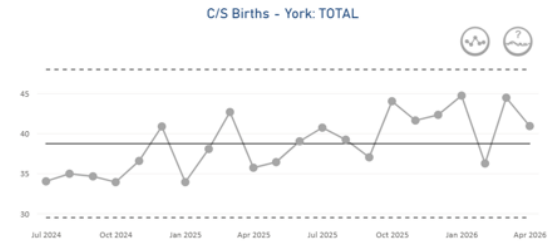
Stillbirths May 2026

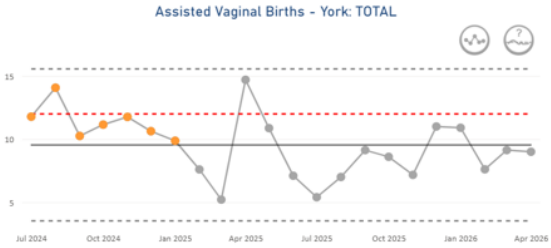


Summary based on 2024 completed data.	Action:	Assurance:
•Trust stillbirth rate – 2.84/1000 births, this is around average for similar Trusts •Trust neonatal mortality rate –1.1 /1000 births, this average for similar Trusts •Trust perinatal mortality rate –3.95 /1000 births, this is around average for similar Trusts There were no stillbirths (meeting MBRRACE-UK reporting criteria) in May 2026	All early neonatal deaths and stillbirths are reviewed using the Perinatal Mortality Review Tool and are presented at the monthly Perinatal Mortality Meeting.	A quarterly PMRT report and action plan is presented at private Board. These will provide details of themes and trends and provide assurance around actions taken. Where the criteria is met, all stillbirth and early neonatal deaths are reported to MNSI for external investigation. Data: MBRRACE-UK

Dashboard Summary – York

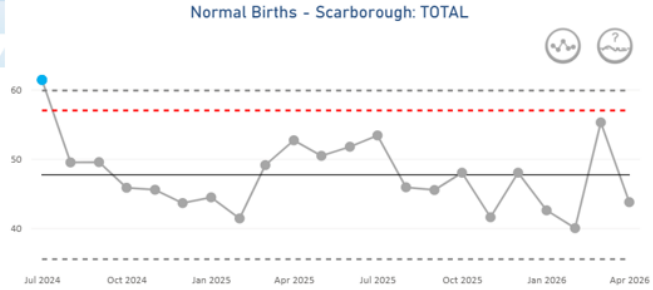


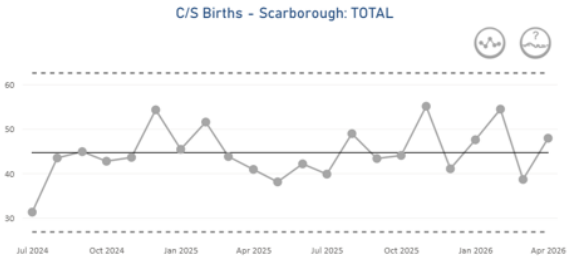


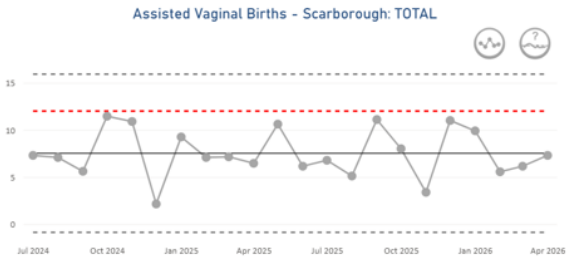


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for vaginal births, assisted births and caesarean births. The data is extracted from Signal.	No actions required	The national maternity digital dashboard highlights for quality metrics Robson Group 1, and 3 the Trust is below the national.

Dashboard Summary – Scarborough





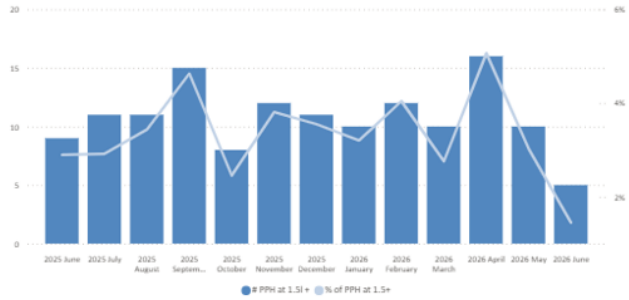


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for vaginal births, assisted births and caesarean births. The data is extracted from Signal.	No action required	The national maternity digital dashboard highlights for quality metrics Robson Group 1, and 3 the Trust is below the national. When

PPH ≥1500mls May 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust

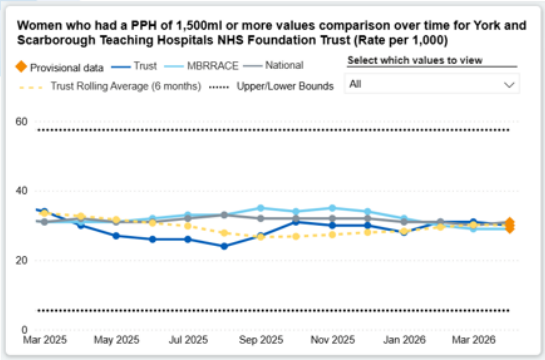
	SGH		YD		Total	
	#	%	#	%	#	%
2026 06	2	1.9%	3	1.2%	5	1.4%
2026 05	1	0.9%	9	4.1%	10	3.0%
2026 04	3	3.2%	13	5.9%	16	5.1%
2026 03	3	2.6%	7	2.8%	10	2.8%
2026 02	4	4.6%	8	3.8%	12	4.0%
2026 01	2	2.0%	8	3.8%	10	3.2%
2025 12	6	6.1%	5	2.4%	11	3.5%
2025 11	2	2.2%	10	4.4%	12	3.8%
2025 10	1	1.0%	7	3.1%	8	2.5%
2025 09	8	8.6%	7	3.0%	15	4.6%
2025 08	1	1.0%	10	4.5%	11	3.4%
2025 07	1	0.8%	10	3.9%	11	2.9%
2025 06	1	0.9%	8	4.0%	9	2.9%
Total	35	2.7%	105	3.6%	140	3.3%

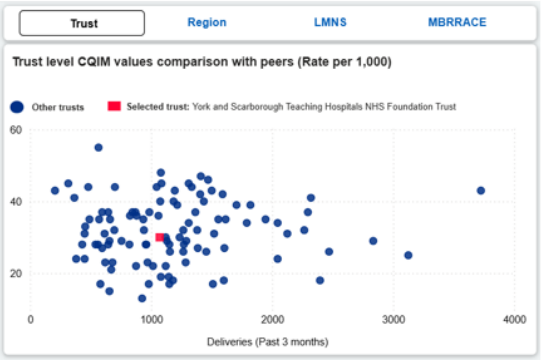


Summary:	Action:	Assurance:
The national digital dashboard demonstrates a decrease in the Trust rolling average The data is extracted from Signal	Ongoing monitoring and reporting of PPH >1500ml Audit metric currently being reviewed	All PPH over 1500mls are reviewed by the MDT in the Maternity Case Review meeting held three times a week

PPH >1500mls National digital dashboard

York and Scarborough Teaching Hospitals NHS Foundation Trust

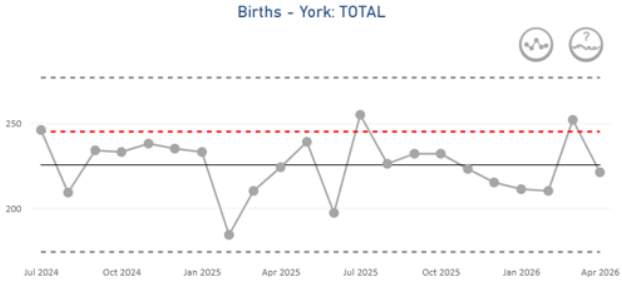


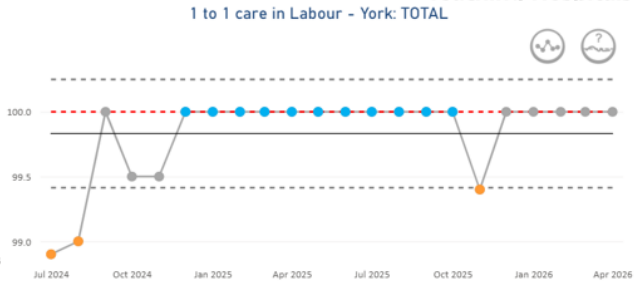


Summary:
The national digital chart demonstrates the Trust is not an outlier compared to all Trusts in England, the Trust have been below the reginal and national average since April 2025. In addition, the data demonstrates there has been a reduction in the Trust rolling average over 12 months, for PPH ≥1500mls from the national digital dashboard.

Dashboard 1:1 Care in Labour – York

NHS
York and Scarborough Teaching Hospitals

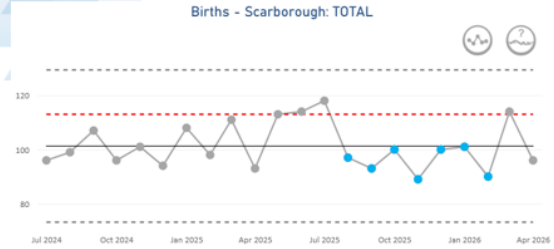


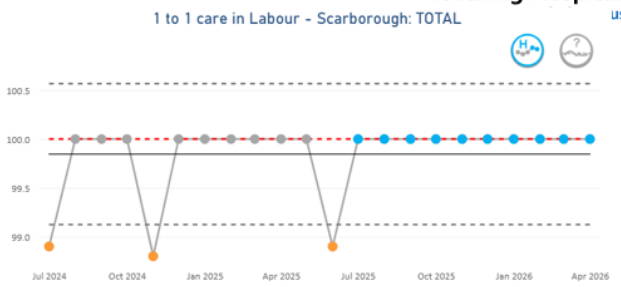


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for births and a special cause for improvement for 1:1 care in labour. The data is extracted from Signal	There is a review of the Maternity Escalation Policy and acuity tools in place. Specialist Midwives, Managers and Matrons 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 1:1 Care in Labour – Scarborough

NHS
York and Scarborough Teaching Hospitals

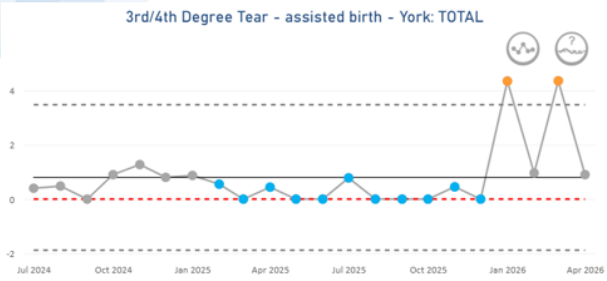


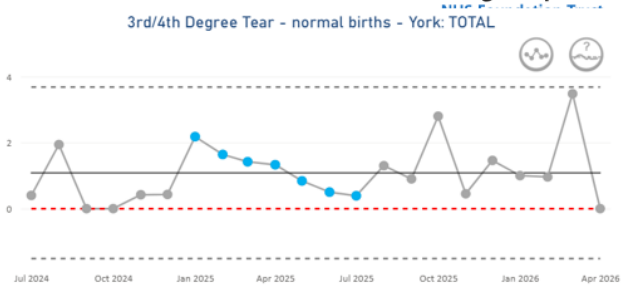


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for births and 1:1 care in labour The data is extracted from Signal	There is a review of the Maternity Escalation Policy and acuity tools in place. Specialist Midwives, Managers and Matrons are deployed to work clinically when 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 3rd/4th degree tears – York

NHS
York and Scarborough Teaching Hospitals

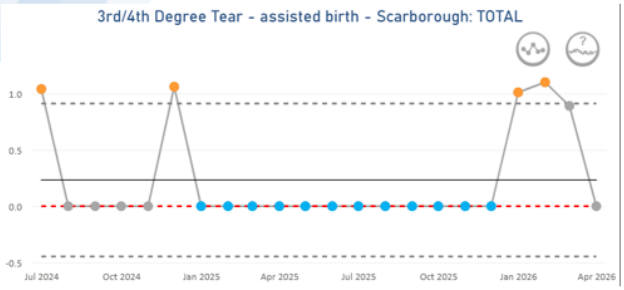


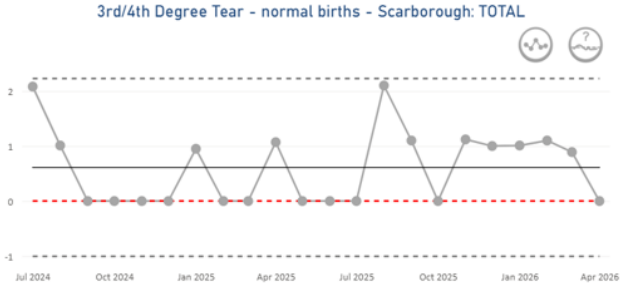


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for third- and fourth-degree tears from assisted and un-assisted births The data is extracted from Signal	There are no new actions	The data from the national digital dashboard for all 3rd/4th degree tear rates demonstrates the Trusts 12 month rolling average is below the national

Dashboard 3rd/4th degree tears – Scarborough

NHS
York and Scarborough Teaching Hospitals

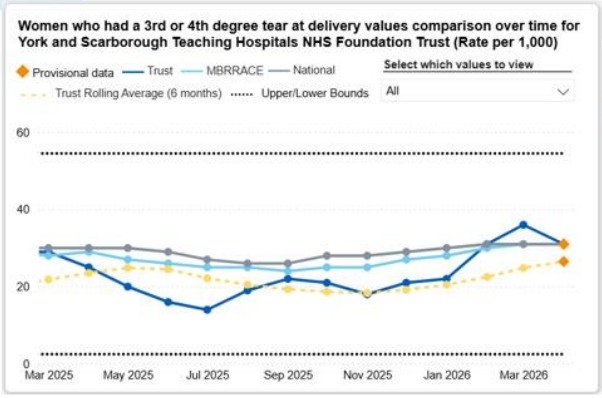


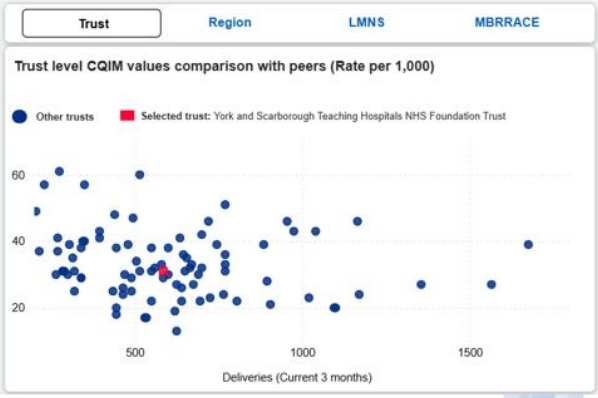


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for third- and fourth-degree tears from assisted and un-assisted births The data is extracted from Signal	The are no new actions	The data from the national digital dashboard for all 3rd/4th degree tear rates demonstrates the Trusts 12 monthly rolling average is below the national

National digital dashboard 3rd/4th degree tears from all births

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

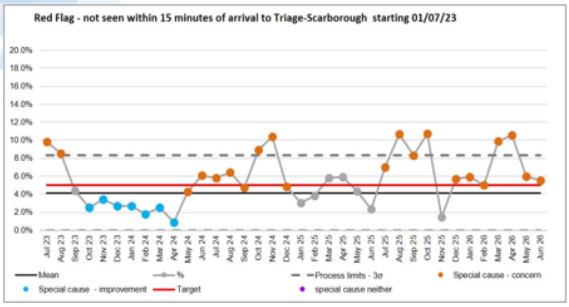




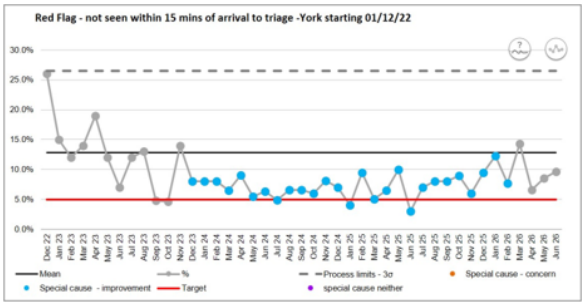
Maternity Triage – June 26

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Scarborough



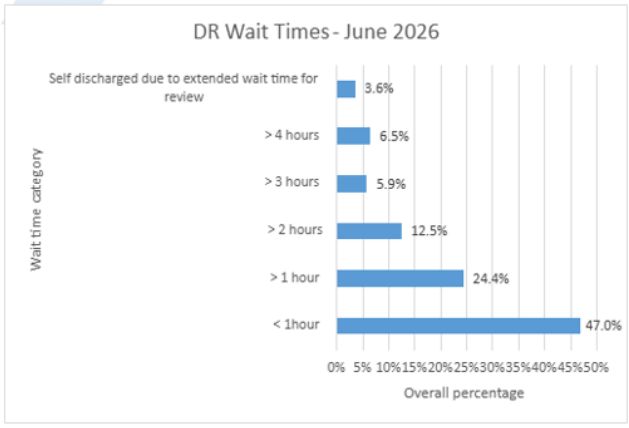
York



Summary:	Actions:	Assurance:
• Increase in compliance at SGH alongside reduction in relocation to labour ward • Decrease in compliance at York, in particular week commencing 01/6/26 - short term sickness • Red Flags: SGH – 1.48% • Red Flags: York – 3.25%	• Daily discussions with LWC in relation to location of Triage. • Heat Map used from BI to understand peak times • Considering the Introduction of a Triage specific OPEL score to allow timely and appropriate escalation. • Benchmarking exercise to take place against new National Recommendations • Telephone line being upgraded – collaborative working commenced with IT	• **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 – Rostering now for additional shifts**

Medical Review Wait times – York

York and Scarborough Teaching Hospitals NHS Foundation Trust



Focus on Doctor wait times as anticipated outcome from Nottingham Report.

Findings:

- 16% of attendances waited over 3 hrs for review or self-discharged due to long waits.

Action:

- For discussion at Clinical Governance on 15/7/26.
- Continue to audit and introduce audit for SGH
- Benchmark against National Maternity Triage Specification (NHSE, July 26)

Report to:	Trust Board of Directors
Date of Meeting:	29th July 2026
Subject:	The National Maternity Review: Amos Final Report and Recommendations
Director Sponsor:	Joe Hague, Chief Nurse and Executive Maternity and Neonatal Safety Champion
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health

Status of the Report

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 Trust Board Briefing

The Independent Investigation into Maternity and Neonatal Services in England has published its final report, drawing on evidence from women, families, staff, professional bodies and healthcare organisations across England. The report highlights persistent systemic challenges within maternity and neonatal services and concludes that, despite the commitment and professionalism of staff, fundamental improvements are required to deliver consistently safe, equitable and person-centred care.

Recommendation: For information for the Board to read and discuss.

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
Maternity safety Champions meeting	1st July 2026	For noting and discussion
Maternity Directorate	13th July 2026	For noting and discussion
Maternity and neonatal Assurance group	14th July 2026	For noting and discussion

Independent Investigation into Maternity and Neonatal Services in England – Key Executive Summary

1. Introduction and Background

The Baroness Amos Independent National Maternity Investigation identifies that variation in the quality and safety of maternity and neonatal care remains significant across England. Whilst many women and families receive excellent care, there continue to be instances where poor communication, failure to listen to concerns, fragmented care and organisational defensiveness contribute to avoidable harm and poor experiences. Families frequently described difficulties obtaining answers, being fully involved in decision-making and receiving timely explanations following adverse events.

The report concludes that many of the issues identified in previous national reviews and inquiries remain evident, indicating that learning has not always translated into sustainable improvement. Concerns relate to culture, leadership, accountability, variation in service provision, workforce pressures, health inequalities and the effectiveness of governance and learning systems.

The report emphasises that Boards have a critical role in:

- Ensuring women, babies and families remain central to service design, delivery and improvement.
- Providing visible leadership that promotes openness, compassion, psychological safety and learning.
- Seeking assurance not only that investigations are completed, but that learning leads to measurable improvements in outcomes and experience.
- Reducing unwarranted variation in quality and safety across services.
- Addressing inequalities that contribute to poorer outcomes for some women and babies.
- Ensuring workforce capacity, capability and wellbeing are viewed as core patient safety priorities.

2. Considerations

The report aligns strongly with the priorities already being pursued through the Trust's Maternity and Neonatal Single Improvement Plan, including:

- Strengthening governance and oversight.
- Developing a positive safety culture.
- Listening to women and families.
- Improving multidisciplinary working.
- Enhancing workforce support and wellbeing.
- Embedding learning from investigations, reviews and national recommendations.
- Delivering sustainable quality improvement and assurance processes.

The report reinforces the importance of maintaining Board oversight of progress against maternity improvement programmes and ensuring assurance mechanisms evidence impact rather than simply completion of actions. This is consistent with national expectations that learning from MNSI, PMRT, Early Notification investigations and other safety reviews should result in demonstrable improvements in care and outcomes.

3. Current Position/Issues

On 3oth June 26, NHSE wrote to trusts sharing a 10-Point Plan for maternity and neonatal services, taking those elements from Baroness Amos' national investigation and Donna Ockenden's recent review that we must focus on delivering now. This is a set of urgent actions in response to the recommendations in both reports that NHSE are asking trusts and the wider system to prioritise. Appendix 1 outlines and high-level overview of the actions to be taken and the current position against the 10-Point Plan.

4. Summary

The investigation is a significant national review that reiterates the need for sustained leadership focus on safety, culture, equity, workforce and learning. Although many of the findings reflect challenges seen across the NHS, the report provides assurance that the priorities within the Trust's Maternity and Neonatal Single Improvement Plan remain aligned to national expectations and offers a further opportunity to demonstrate measurable improvement in outcomes, experiences and organisational learning.

5. Next Steps

The report provides an opportunity for the Board to consider:

1. How effectively the voices of women, families and staff inform strategic decision-making.
2. Whether existing governance arrangements provide assurance on outcomes and impact, rather than process compliance alone.
3. The extent to which organisational culture supports openness, learning and speaking up.
4. Progress in reducing inequalities and unwarranted variation in outcomes across maternity and neonatal services.
5. The sustainability of current workforce, leadership and improvement arrangements

Date: 01 07 2026

Appendix 1

Action No.	Urgent Action	Key Requirements / Expectations	Lead	Updates
1	**Listening to women and families through Martha's Rule**	Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27. Building on the learning and insights from the recent pilot, this next phase will support implementation in all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings. Implementation will be led by the national Martha's Rule programme team, working closely with patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. We will contact provider organisations in the coming weeks to confirm expectations, resources and timelines.	Acute/Inpatient Matron, Transformation Lead, Anaesthetic Lead, Neonatal Lead	Add into workstream 1. Scope trust wide process for wider implementation across maternity and neonates. Work with critical care to develop maternity and neonatal specific process to support independent clinical reviews. Review trust wide communication and education and work with MNVP's to co-produce inclusive resources for use across maternity. Work with National Marthers Rule Programme team and patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. Evaluate implementation and collect robust data on escalations and outcomes.

2	**Use real-time patient outcomes, experience and audit data at Board level**	All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards, using locally meaningful measures like the friends and family test, selected elements of PREM (when available) and insights from maternity and neonatal voices partnerships (MNVPs). This should include regularly listening to women, families and neonatal parents at different points in the pathway, publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds. This will ensure the voices and experiences of women and families are heard, scrutinised and acted upon by boards. As part of this, trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings. The aim is to support this approach through national webinars.	Deputy Director of Midwifery (DDOM), Digital Midwife, Senior Digital Project Engagement Manager, Governance Lead Obstetrician, Neonatal Consultant Lead	Development of the Maternity and Neonatal dashboard is captured in workstream 3. This work is being prioritised to be delivered at pace subject to the provision of analytical support. A review of the annual reporting requirements is underway which will be align with Perinatal Oversight Model, AMOS and Ockenden. An Audit Lead midwife to be recruited to provide leadership for ongoing audit oversight.

3	**Dual Board-level accountability for maternity and neonatal care**	All trusts must establish clear joint accountability at board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed. This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership.	Director of Midwifery (DoM), Obstetric Clinical Director, Family Health Quality and Governance Lead, Chief Nurse and Medical Director	Currently in place through the Maternity Assurance Group (MAG) as part of ongoing improvement plan work. DOM and CD attending Boards to raise and discuss maternity and neonatal matters is well embedded.

4	**Amos into Action staff listening exercise**	Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in maternity and neonatal services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system. It will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national conversation about what trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).	DoM, DDOM, ACOO, CD	Staff communications have been disseminated to the Care Group. Drop in listening events are in the process of being arranged. Regular floor to board walk arounds take place as part of the maternity safety champion programme. Explore potential for culture programme to be delivered across the care group.

5	**Address inequalities in maternity and neonatal outcomes**	We can now confirm the timeline for national rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All boards must ensure that provision is in place to allow enough staff to be released to complete the Perinatal Equity and Anti-discrimination Programme, with full participation expected across multi-disciplinary teams. Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the trust board on implementation.	Transformation Lead Midwife, MNVP Lead	Commence the Perinatal Equity and Anti-discrimination Programme in September 2026. A review of the AMOS interim report enabled us to strengthen and develop actions around racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism.

6	**Ensure 24/7 safety and responsiveness of maternity and neonatal services**	All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups. Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available. Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.	Deputy DoM, Obstetric Clinical Director, Transformation Lead Consultant, Maternity workforce lead.	Covered in Workstream 2. Regular workforce reviews and are reported to Trust board and Perinatal Quality Oversight Model (PQOM). Escalation process in place to respond to high acuity and activity. DOM working with local commissioners to address local gaps. Reevaluate Birth Rate + position and ensure budgets are aligned to deliver workforce to recommended safe staffing standards.

7	**Review homebirth services**	Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer for England asked trusts to urgently review the safety and quality of their homebirth services. Trusts should ensure that this review has been undertaken and reported to their board and that any safety concerns requiring urgent attention have been actioned. They should ensure that improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team. NHS England is working with partners to develop homebirth standards and a homebirth framework, to support women's autonomy, choice and personalised care, and to help services provide safe homebirth care.	Community Matron, Transformation Lead Consultant	The provision of choice and access to, home birth services choosing that model of care. To revise the SIP to reflect the ongoing work undertaken by the community matron and identify any gaps following the release of the AMOS report and the national prevention of future death report. GR to meet with Susie K to include her work into the plan

8	**Respond to incidents, complaints and concerns with humanity, candour and trauma-informed practice**	Trust boards should review how they are responding to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour. We will work with trusts, in alignment with the work of the national taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care.	Family Health Quality and Governance Lead, Deputy DoM	Align with governance team around current launching of DoC process and explore the trauma informed services available within the organisation. Work with the national task force to implement the blueprint for responding to patients when things go wrong

9	**Deliver safe and effective maternity triage**	All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week. This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and bed capacity, with clear escalation routes in place at all times, including overnight and at weekends. Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable trusts to identify risks, address delays and provide women with timely,	ANC Ward Managers, Triage Manages, Obstetric Clinical Director Audit Midwife - To be recruited	Complete a benchmark assessment against National maternity triage principles and a supporting measurement framework and develop a plan to address any gaps once complete. Develop a Board Level Audit for maternity guidance in line with NHSE guidance, due to be published. BSOTS is in place cross-site. Interdependent with Workstream 1 & 3

		consistent and high-quality triage care. The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS. National maternity triage principles and a supporting measurement framework will be provided to trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, regional and national improvement.		

10	**Post-death care**	All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years. Every board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.	Medicine ACOO, DOM, CNO, MD	Implement actions set out in System Letter to review and ensure completeness of incident records to the Human Tissue Authority over the past 10 years. Trust Board to respond to board assurance statement by 31 July 2026.

To:
- NHS trust and ICB:
  - chief executives
  - chairs
  - chief nursing officers
  - medical directors
  - chief operating officers

cc.
- NHS England region
  - regional chairs
  - regional directors
  - medical directors
  - chief nursing officers
  - chief midwifery officers
  - regional obstetricians

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

30 June 2026

Dear colleagues,

Publication of Baroness Amos' independent investigation into maternity and neonatal services in England

Thank you for joining today's event and contributing to our conversation about maternity and neonatal services. I don't think anyone who attended today could have been anything other than deeply moved by what we heard and discussed.

This is a moment in our history that requires our collective leadership to act with real urgency in addressing the failings and harm experienced by women, babies and families and improve maternity and neonatal care.

None of this is going to be easy, but we all agreed today that this must be a turning point for maternity and neonatal services in the NHS. Women, babies, and families deserve better, as do our colleagues working in these services.

As set out during the event today, we have created a 10 Point Plan for maternity and neonatal services (see Annex 1), taking those elements from Baroness Amos' national

investigation and Donna Ockenden's recent review that we must focus on delivering now. This is a set of urgent actions in response to the recommendations in both reports that we are asking trusts and the wider system to prioritise.

These urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December. Further information and a reporting template will be shared soon.

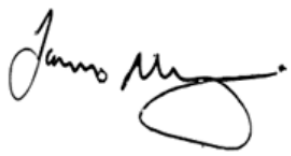
In response to the Amos report, the government has also announced NHS England will make £10.6 million available in 2026/27 to support the recruitment of newly qualified midwives, helping them enter and remain in the NHS while strengthening frontline maternity capacity. See Annex 2 for further information.

The government also announced the creation of the UK's first ever Maternity and Neonatal Commissioner, providing an independent voice to strengthen focus on safety, experience, equity and accountability for women, babies and families. Alongside this, an additional £41 million will be invested to improve the safety and quality of the maternity and neonatal estate, supporting better environments for those using and working in maternity and neonatal services.

As we heard today, this must be a turning point for the NHS. Trusts and systems have already prioritised improving maternity and neonatal care, and progress has been made through the commitment and hard work of staff. We cannot allow failures in care to persist and be followed by reviews that continuously highlight the same themes.

Thank you for your leadership as we respond and move forward together with urgency to deliver lasting change for women, babies and families, and rebuild trust and confidence in maternity and neonatal care.

Yours sincerely,



Sir James Mackey
Chief Executive Officer

Annex 1

Urgent Actions

Action	Description
Listening to women and their families by rolling out Martha's Rule	Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27. Building on the learning and insights from the recent pilot, this next phase will support implementation in all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings. Implementation will be led by the national Martha's Rule programme team, working closely with patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. We will contact provider organisations in the coming weeks to confirm expectations, resources and timelines.
Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards, using locally meaningful measures like the friends and family test, selected elements of PREM (when available) and insights from maternity and neonatal voices partnerships (MNVPs). This should include regularly listening to women, families and neonatal

	parents at different points in the pathway, publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds. This will ensure the voices and experiences of women and families are heard, scrutinised and acted upon by boards. As part of this, trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings. The aim is to support this approach through national webinars.
Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	All trusts must establish clear joint accountability at board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed. This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership.
'Amos into action' staff listening exercise	Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in maternity and neonatal services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system. It will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national

	conversation about what trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).
Addressing inequalities in maternity and neonatal outcomes	We can now confirm the timeline for national rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All boards must ensure that provision is in place to allow enough staff to be released to complete the Perinatal Equity and Anti-discrimination Programme, with full participation expected across multi-disciplinary teams. Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the trust board on implementation.
Ensuring 24/7 safety and responsiveness of maternity and neonatal services	All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups. Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in

	bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available. Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.
Trusts to review their homebirth services	Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer for England asked trusts to urgently review the safety and quality of their homebirth services. Trusts should ensure that this review has been undertaken and reported to their board and that any safety concerns requiring urgent attention have been actioned. They should ensure that improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team. NHS England is working with partners to develop homebirth standards and a homebirth framework, to support women's autonomy, choice and personalised care, and to help services provide safe homebirth care.
Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Trust boards should review how they are responding to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour.

	We will work with trusts, in alignment with the work of the national taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care.
Deliver safe and effective triage in maternity services (already committed by Government)	All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week. This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and bed capacity, with clear escalation routes in place at all times, including overnight and at weekends. Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable trusts to identify risks, address delays and provide women with timely, consistent and high-quality triage care. The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS. National maternity triage principles and a supporting measurement framework will be provided to trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, regional and national improvement.

Post death care (already committed by Government)	All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years. Every board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

ANNEX 2

Support for the recruitment of newly qualified midwives

The government has invested in expanding midwifery training, resulting in a strong pipeline of newly qualified candidates. Maternity services have also undertaken significant work to recruit, support and retain newly qualified midwives, including through preceptorship and flexible workforce models. There is now an opportunity to maximise the benefit of this investment by ensuring newly qualified midwives are able to enter employment promptly and contribute to increasing frontline capacity.

National offer for 2026/27

NHS England will make £10.6 million available in 2026/27 to enable the recruitment of newly qualified midwives. £9 million of this funding will be recurrent and incorporated into provider baselines from 2027/28 to support ongoing workforce growth and service stability.

The funding is intended to support providers to create additional temporary Band 5 midwifery roles, over and above planned recruitment. It should support recruitment ahead of future turnover and, where appropriate, enable temporary recruitment above establishment to increase clinical capacity and support safe staffing.

As in 2025/26, providers should explore the temporary uplift and utilisation of vacant maternity support worker roles to enable the creation of additional Band 5 midwifery posts, providing a structured route for newly qualified midwives to transition into substantive employment as vacancies arise.

Funding must be used to deliver additional employment opportunities and should not be used to fund posts already planned within existing workforce plans or budgets.

NHS England regional teams will work with systems and providers to support delivery and ensure the offer reflects local workforce needs.

Expectations of systems and providers

Providers should continue to strengthen early career support, including high-quality preceptorship, supervision and pastoral support, to improve retention and support early career development. This investment should also inform longer-term workforce planning, supporting sustainable growth in midwifery capacity.

Organisations should work in partnership with staff side representatives and maintain clear communication with students and graduates to support confidence in NHS employment pathways.

Implementation, monitoring and assurance

Funding will be distributed through existing mechanisms, with further detail to follow. Regional teams will work directly with systems and providers to support implementation and ensure funding is applied effectively.

A national monitoring and assurance approach will track delivery and impact, focusing on evidence of additional employment opportunities, increases in frontline workforce capacity and improvements in newly qualified midwife employment outcomes.

Progress will be monitored through established workforce reporting arrangements and used to inform future workforce planning and policy development.

Next steps

Further operational guidance, including allocation details and reporting requirements, will follow shortly.

Organisations are asked to begin early planning and engagement locally to ensure rapid mobilisation following publication of Baroness Amos' investigation report.

Report to:	Trust Board of Directors
Date of Meeting:	29th July 2026
Subject:	Nottingham Review Findings, Conclusions and Essential Actions
Director Sponsor:	Joe Hague, Chief Nurse and Executive Maternity and Neonatal Safety Champion
Author:	Sascha Wells-Munro OBE, Director of Midiwfery and Strategic Clinical Lead for Family Health

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 Briefing Paper
Findings, Conclusions and Essential Actions
Independent Review of Maternity Services – Nottingham University Hospitals NHS Trust (Ockenden Report, June 2026)

Introduction

Since the publication of the Morecambe Bay Report (2015), there has been a succession of maternity reviews highlighting systemic failings in safety, culture, and leadership. These include:

- Ockenden Review – Shrewsbury & Telford (2022)
- Reading the Signals – East Kent (2022)
- The forthcoming National Maternity Review (Amos Report, June 2026)

The Nottingham Review represents the largest maternity and neonatal review undertaken in the UK, involving over 2,000 families and more than 800 staff with cases covering the period from 2012-2025.

The report (400+ pages) provides a stark account of the harm that occurs when leadership, governance and culture are not robust, when poor practice is not identified, investigated or learned from, and the profound consequences for women, babies and families during a period of heightened vulnerability.

Purpose and Methodology

The review was commissioned in June 2022 to determine whether care provided contributed to adverse outcomes. Cases were assessed using CESDI grading methodology:

- Grade 2–3: cases where outcomes were potentially avoidable
- 21% of maternity cases were graded as potentially avoidable
- 6% of neonatal cases were graded as potentially avoidable

Aggregation of cases enabled identification of systemic patterns of failure, rather than isolated incidents.

Key Themes from the Report

The report reinforces consistent findings across previous national reviews:

Systemic Failures
- Long-standing issues known but not addressed
- Failure to learn from incidents
- Repetition of harm

Culture and Behaviour
- Women and families not consistently listened to or believed
- Poor communication and involvement in decision-making
- Evidence of toxic behaviours and psychological unsafety

Workforce and Training
- Inadequate staffing and skill mix
- Poor access to mandatory and multi-professional training

Governance and Leadership
- Weak oversight and lack of accountability
- Ineffective escalation and assurance processes

Immediate and Essential Actions (IEAs)

The report identifies 18 Immediate and Essential Actions, grouped under eight headings:

1. Listening to Women and Families
2. Workforce Planning and Safe Staffing
3. Training and Multi-Professional Learning

4. Risk Assessment Throughout Pregnancy
5. Incident Investigation and Family Involvement
6. Governance and Board Accountability
7. Culture, Teamwork and Psychological Safety
8. Mothers who have Died and Post-Death Care

Central Principle – Martha's Rule

A key underpinning principle is the implementation of Martha's Rule, ensuring:

- Women, families and staff can request urgent clinical review
- Escalation pathways are clear, accessible and responsive
- A shift toward open, responsive and patient-centred safety systems

This represents a fundamental cultural shift in escalation and safety.

Recommended Actions for Humber Health Partnership

The report is explicit that these findings are not unique to Nottingham and should be used by all maternity systems as a framework for self-assessment and improvement.

a. Implement Martha's Rule Across Perinatal Services
- Establish a standardised escalation process across all sites
- Ensure awareness among:
  - Women and families
  - Frontline staff
- Monitor utilisation and impact

b. Benchmark Against National Expectations
- Undertake a systematic review of compliance against:
  - Previous Ockenden actions
  - Current Immediate and Essential Actions (IEAs)
  - Forthcoming Amos National Maternity Review
- Identify gaps and areas of risk

c. Identify Local Priorities Based on Risk
- Align initial improvement priorities to themes identified from
  - Incident reviews
  - Complaints and litigation
  - Service user feedback

d. Strengthen Governance and Assurance
- Ensure Board-level oversight with:
  - Clear maternity safety metrics
  - Triangulated data (clinical outcomes, workforce, experience)
- Strengthen assurance on:
  - Learning implementation
  - Cultural indicators
  - Escalation effectiveness

f. Prepare for National Direction
- Anticipate further requirements following:
  - Amos Report (June 2026)

- Potential policy mandates and funding announcements

Conclusion

For Humber Health Partnership, this report should be treated as a critical call to action to and should be responded to with careful consider and reflection to ensure we:

- Strengthen safety, culture and accountability
- Ensure women's voices are central to care and escalation
- Deliver consistent, high-quality maternity services across all sites

Recommendation:

For information for the Board to read and discuss.

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
Maternity safety Champions meeting	1st July 2026	For noting and discussion
Maternity & Neonatal Directorate	13th July 2026	For noting and discussion
Maternity and Neonatal Assurance group	14th July 2026	For noting and discussion

Report to:	Trust Board of Directors
Date of Meeting:	29th July 2026
Subject:	Maternity Feedback Survey
Director Sponsor:	Joe Hague, Chief Nurse and Executive Maternity and Neonatal Safety Champion
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical lead for Family Health 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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☒ Effective Governance

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

A new Maternity Feedback Survey, co-produced with the Maternity and Neonatal Voices Partnership (MNVP), has received six responses to date. Whilst the sample size remains small and findings should therefore be interpreted with caution, the responses provide valuable qualitative insight into women's recent experiences across the maternity pathway.

Overall feedback is positive, with women consistently identifying continuity of care, compassionate staff, personalised support, and feeling safe during labour and birth as significant strengths within maternity services. Women described particularly positive experiences where they were able to develop relationships with known midwives and where care was individualised to meet their needs.

The most prominent area for improvement relates to communication. Respondents reported examples of conflicting information from different professionals, concerns regarding induction discussions, uncertainty regarding appointments and results, and variable experiences during postnatal discharge and community follow-up.

Overall, the survey provides positive assurance regarding the quality, safety and compassion of maternity care provided by YSTHFT. Continuity of care, personalised support and compassionate staff interactions were consistently associated with positive experiences. Communication, particularly in relation to induction discussions, information sharing and postnatal pathways, emerged as the principal opportunity for improvement. Findings will continue to be reviewed through routine governance arrangements and used to inform ongoing quality improvement activity.

Recommendation:

The Maternity Directorate Meeting, Maternity Assurance Group, Quality Committee and Trust Board are asked to:

1. Receive this report for assurance.
2. Note the early findings from the Maternity Feedback Survey.
3. Support continued promotion of the survey to improve response rates and representation.
4. Endorse the proposed review of communication, induction information and postnatal pathways through existing improvement workstreams.

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

Meeting/Engagement	Date	Outcome/Recommendation

Maternity Feedback Survey

1. Introduction and Background

The Maternity Feedback Survey has been developed jointly by York and Scarborough Teaching Hospitals NHS Foundation Trust and the Maternity and Neonatal Voices Partnership (MNVP) to capture women's experiences across the antenatal, intrapartum and postnatal pathway.

The survey is intended to:

- Support ongoing quality improvement.
- Provide assurance regarding women's experiences of care.
- Identify emerging themes and opportunities for improvement.
- Inform maternity safety, quality and equity workstreams.

2. Approach and methodology

Survey Development and Design

The Maternity Feedback Survey was co-produced by York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) and the Maternity and Neonatal Voices Partnership (MNVP) to capture the experiences of women and birthing people across the maternity pathway. The survey was designed to gather feedback relating to antenatal, intrapartum and postnatal care, with a particular focus on personalised care, decision making, safety, communication, continuity of care and postnatal support.

The survey consists of a combination of quantitative and qualitative questions, enabling respondents to rate their experiences using structured response scales whilst also providing free-text comments describing what worked well and where improvements could be made. This mixed-methods approach allows both measurable trends and detailed patient narratives to be captured.

Data Collection

The survey is hosted on Microsoft Forms and is available to women who have recently received maternity care through YSTHFT. There is a QR code in the personalised care plan which all women receive that links to the survey, and it is discussed by the community midwife at the postnatal discharge appointment. Responses are submitted anonymously to encourage openness and candour.

Respondents provided feedback across the whole maternity journey including:

- Access to maternity services and booking processes.
- Antenatal care and continuity of care.
- Shared decision making and personalised care planning.
- Labour and birth experiences.
- Postnatal inpatient and community care.
- Infant feeding support.
- Digital services and information provision.
- Overall experiences and suggestions for improvement.

Demographic Profile

Six responses have been received to date.
Birth Location

- York: 4 responses (67%)
- Scarborough: 2 responses (33%)

Year of Birth

- 2025 births: 2
- 2026 births: 4

Mode of Birth

- Planned caesarean birth: 50%
- Spontaneous vaginal birth: 33%
- Forceps birth: 17%

Age Profile
Responses were received from women aged:

- 18–25 years
- 26–30 years
- 31–35 years
- 41–45 years

Ethnicity
An initial review of respondent demographics demonstrates that all respondents who disclosed ethnicity identified as White British/White background. Whilst the sample size is small, this highlights the importance of continued promotion of the survey amongst ethnically diverse communities and other underserved groups to ensure experiences are representative of the maternity population served by YSTHFT.

Governance

Findings have been synthesised to provide assurance regarding the quality and safety of maternity services, whilst highlighting opportunities for service improvement. Themes identified through the survey will be reviewed alongside other sources of patient experience information, including complaints, compliments, incidents, MNVP feedback and local quality metrics.

3. Key findings

Continuity of care remains a significant strength
The strongest positive theme identified was continuity of care.
Women consistently described:

- Seeing the same midwife throughout pregnancy.
- Feeling known as an individual.
- Receiving reassurance and personalised support.
- Developing trusting relationships with staff.

Several respondents specifically attributed positive pregnancy experiences to continuity of care and identified named midwives who had significantly improved their experience of maternity services. This aligns with national evidence demonstrating the positive impact of continuity on both experience and outcomes.

Positive experiences during labour and birth
Feedback regarding labour and birth was predominantly positive.

Women described:

- Feeling safe during labour.
- Being supported to make decisions.
- Compassionate and calm care during complex situations.
- Positive involvement of birth partners.

Several responses highlighted examples of outstanding multidisciplinary working and staff compassion during periods of anxiety, theatre procedures, induction and delivery. These findings provide positive assurance regarding safety culture, compassionate care, and personalised care planning.

Communication identified as primary improvement theme

Communication was the most common area for improvement raised throughout the survey.

Examples included:

- Receiving conflicting information from different professionals.
- Uncertainty regarding induction pathways.
- Variable explanations from consultants and clinicians.
- Confusion regarding appointments, results and next steps.

Women particularly highlighted induction discussions as an area where information was inconsistent and personal preferences were not always perceived to be fully explored. Whilst no themes indicating widespread safety concerns were identified, communication issues have the potential to impact patient confidence, informed decision making and overall experience. The improvement plan will be reviewed with the transformation team to ensure appropriate actions are in place to support improvement in this workstream. The embedding of the recently launched personalised care plan and launch of the supporting choices guideline which is currently in draft form both supports improving communication, particularly inconsistency of information.

Variable experiences of postnatal care

Many women reported highly positive postnatal experiences, particularly where compassionate staff support was provided.

However, respondents also identified:

- Delays in discharge.
- Communication issues.
- Administrative delays.
- Variability in ward experiences

Women reported the greatest variation in experience after birth compared with other areas of the pathway. The survey provides assurance that many women receive high-quality postnatal care but highlights variation in service delivery and discharge experience. This will be monitored through existing governance arrangements and considered within ongoing postnatal improvement work. Current quality improvement work is focused on improving pain relief and supporting birthing partner's access to the ward.

Community postnatal support

Community postnatal care received generally positive feedback, with women valuing home visits, follow-up support and continuity from known midwives.

Several respondents reported:

- Limited home visits.
- Attendance at clinics shortly after operative birth.
- Reduced continuity following discharge.

- Logistical difficulties accessing appointments

The findings provide assurance that community postnatal care is largely valued by women but suggest opportunities to improve accessibility, personalisation and continuity. Findings will be reviewed with the community midwifery leadership team to ensure postnatal services continue to meet women's individual needs, particularly following operative birth.

Feeding Support

Women generally reported feeling supported in their infant feeding choices and appreciated non-judgemental approaches to feeding discussions.
Some respondents identified:

- Variable practical feeding support.
- Delays within specialist feeding pathways.
- Limited information regarding formula feeding.
- Issues with follow-up feeding referrals.

Overall feedback provides assurance that infant feeding support is viewed positively. However, opportunities exist to improve consistency of support across feeding methods and ensure timely access to specialist services where required and will be discussed with relevant teams. Improvement actions to support expansion of the infant feeding team and access to equitable specialist services are captured in the single improvement plan.

Digital experience – BadgerNotes

Women valued having access to their maternity information electronically however, several respondents highlighted concerns relating to:

- Difficulty understanding appointment purpose.
- Limited notification functionality.
- Confusion regarding appointment locations and timing.
- Inconsistent information across communication systems.

The findings suggest digital systems are supporting access to information but that improvements in usability and communication functionality may further enhance women's experience. Findings will be reviewed with the Digital Midwifery Team to identify opportunities to improve appointment information, notifications and overall user experience within Badger Notes.

4. Next steps

- Continue promotion of the survey through community midwifery teams, inpatient services and the MNVP.
- Increase engagement with ethnically diverse communities and underserved groups.
- Review findings monthly.
- Share positive feedback with staff and teams.
- Incorporate improvement actions into the Maternity and Neonatal Single Improvement Plan.
- Report progress through Maternity Directorate Meeting and Maternity Assurance Group.

5. Summary

The survey provides encouraging early assurance that women and birthing people continue to experience safe, compassionate and personalised maternity care across YSTHFT. Whilst findings are based on a small sample, continuity of care, compassionate staff interactions and personalised support consistently emerged as strengths. Communication and consistency of information represent the most significant opportunities for improvement and will continue to be monitored and addressed through established governance and improvement processes.

Date: 9th July 2026

Report to:	Trust Board of Directors
Date of Meeting:	29th July 2026
Subject:	Perinatal Equity and Anti-Discrimination Programme (PEADP)
Director Sponsor:	Joe Hague, Chief Nurse and Executive Maternity and Neonatal Safety Champion
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health Jo Hadley, Deputy Director of Midwifery

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 Perinatal Equity and Anti-Discrimination Programme (PEADP) is a national NHS England (NHSE) improvement programme focused on reducing health inequalities and inequities in perinatal outcomes, addressing racism, discrimination and variation in care experience and embedding sustainable culture and behaviour change across maternity and neonatal services. PEADP represents a high-impact opportunity to strengthen Trust compliance to address inequalities highlighted in national reviews and improve both clinical outcomes and workforce culture.

Recommendation:
The Board is asked to agree and endorse the five recommendations noted in the report and note the intensive resource required to deliver the programme and lack of national funding to support delivery.

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
Maternity & Neonatal Directorate	13th July 2026	For noting and discussion
Maternity and Neonatal Assurance group	14th July 2026	For noting and discussion

Perinatal Equity and Anti-Discrimination Programme (PEADP)

1. Introduction and Background

The Perinatal Equity and Anti-Discrimination Programme (PEADP) is a national NHS England (NHSE) improvement programme focused on reducing health inequalities and inequities in perinatal outcomes, addressing racism, discrimination and variation in care experience and embedding sustainable culture and behaviour change across maternity and neonatal services. PEADP represents a high-impact opportunity to strengthen Trust compliance to address inequalities highlighted in national reviews and improve both clinical outcomes and workforce culture.

The programme aligns with national policy drivers including Workforce Race Equality Standard (WRES); Maternity Incentive Scheme (MIS); findings from national investigations (e.g. upcoming Nottingham Ockenden and Amos review); and existing safety and quality improvement programmes. Expected benefits of the programme are:

- Improved equity of outcomes and experience for Black, Asian and ethnically minoritised women and families
- Improved staff experience and culture
- Increased leadership capability in anti-racism and inclusive leadership
- Stronger use of data and lived experience to inform decision-making
- Clear, prioritised and evidence-based local improvement plans

2. Considerations

In the UK, successive maternity safety reports and inquiries have highlighted culture and team working as key contributory factors to avoidable harm to women, babies, and their families (Draper et al 2019; Knight et al 2019; Rowe et al, 2020; NHS Resolution 2019; Ockenden 2022; Kirkup 2022). The independent Ockenden (2022) review of maternity services at the Shrewsbury and Telford Hospital NHS Trust and the investigation led by Kirkup (2022) into maternity and neonatal services in East Kent each made specific recommendations about improving leadership, communication, and culture as a core part of the wider work of improving safety in maternity and neonatal services. As of September 2024, the Care Quality Commission (CQC) reported that the safety of maternity services in England ‘remained a key concern’, with 65% of services rated as ‘inadequate’ or ‘requiring improvement’ – and no services rated as ‘outstanding’ for safety. More recently, the Secretary of State for Health and Social Care announced a rapid, national, independent investigation into NHS maternity and neonatal services. The interim report reflects what families, staff and others have told the investigation team, identifying striking shortcomings relating to organisational culture, and throughout the investigation, they have heard about unacceptable racism and discrimination across the maternity and neonatal system.

3. Current Position/Issues

The following risks and mitigations have been identified:

- Programme Non-Completion / Reputational Risk - Failure to sustain engagement and complete the programme could result in limited impact, reduced credibility with NHS England, and potential identification of the Trust as an outlier in relation to equity improvement expectations. Mitigation: Strong Executive sponsorship and SRO oversight, clear delivery plan with milestones, regular assurance through governance structures, and proactive escalation of risks to maintain engagement and programme momentum.

- Resource Implications – No funded backfill for key clinical and leadership roles to support attendance and engagement (approximately 23-29 hours commitment per attendee over a 10-month period). Mitigation: Operational/coordination lead to support delivery and engagement, senior programme leads to support programme delivery and overall ownership of progress with the programme and realigning existing improvement work to support with scheduling and reprioritisation of priorities.

- Workforce Capacity and Competing Priorities - Operational pressures (e.g. workforce gaps and safety demands) may limit engagement. Mitigation: Executive/SRO prioritisation, clear mandate, alignment with existing work, and accountability through governance and leadership forums with clear escalation routes.

- Fragmentation with Existing Initiatives - Duplication or misalignment with current programmes (e.g. safety, equality, MNVP work). Mitigation: Explicit alignment with existing improvement plans and governance and use of PEADP to enhance current work.

- Cultural Resistance and Change Fatigue - Potential sensitivity and resistance when addressing racism and discrimination. Mitigation: Structured leadership training and facilitated discussions, use of data and lived experience to build shared understanding and visible senior leadership commitment.

- Sustainability Beyond Programme Period - Improvements may not be sustained after programme completion. Mitigation: Embedding actions in formal governance and policy, development of local capability and leadership ownership and use of action learning and continuous improvement approaches to monitor sustainability.

4. Summary

PEADP uses a structured improvement approach, including:

- Understanding and naming inequity and discrimination

- Using local data, staff and service-user insight

- Developing evidence-based priorities

- Driving leadership-led cultural change

- Embedding improvements through existing governance structures

Delivery of the programme is resource-intensive and requires visible Board-level commitment and oversight to be effective. Participation requires multi-disciplinary leadership engagement, including:

- Senior leaders (7 per site) – e.g. Director/Head of Midwifery, obstetric, neonatal and operational leads

- Governance/guideline leads (4) – maternity and neonatal

- Clinical leaders (18) – ward/community leaders driving day-to-day culture

This model ensures system-wide leadership accountability and implementation. NHSE do not, however, provide any funding stream to support with engagement and implementation, which is a major risk of the programme. Appendix 1 includes an analysis of the cost pressure of releasing the team to participate in the programme. **This equates to a total of 691 hours, at a cost of £38,253.**

Ongoing support provided by NHSE includes data coaching, shared learning across organisations and support with embedding into existing improvement plans.

5. Next Steps

The Board is asked to:

- Agree participation in PEADP as a strategic priority in line with NHS England expectations and inclusion in the Amos 10 Point Plan.

- Confirm Executive sponsorship and Senior Responsible Officer (SRO) to champion programme, ensure alignment with Trust priorities and provide organisational oversight.

- Endorse delivery of the programme within existing workforce capacity, with clear prioritisation and alignment to current roles, supported by Executive oversight.

- Endorse alignment with existing safety, equity and culture programmes.

- Agree required assurance reporting and frequency on engagement and participation, escalation parameters, progress against objectives and impact on outcomes and experience.

Date: 16/06/2026

Appendix 1: Analysis of investment time and costs of participation

Band / Grade	Standard	Inner London	Outer London	Fringe
Band 5	£ 22.51	£ 27.08	£ 25.94	£ 23.65
Band 6	£ 27.52	£ 33.10	£ 31.58	£ 28.92
Band 7	£ 33.98	£ 39.77	£ 38.04	£ 35.48
Band 8a	£ 39.59	£ 45.38	£ 43.66	£ 41.10
Band 8b	£ 46.53	£ 52.32	£ 50.59	£ 48.03
Band 8c	£ 55.43	£ 61.22	£ 59.49	£ 56.93
Band 8d	£ 65.88	£ 71.67	£ 69.94	£ 67.38
Band 9	£ 78.74	£ 84.53	£ 82.81	£ 80.25
F1 (Weekday 8am-5pm)	£ 64.00	£ 64.00	£ 64.00	£ 64.00
F2 (Weekday 8am-5pm)	£ 74.00	£ 74.00	£ 74.00	£ 74.00
CT 1-2 (Weekday 8am-5pm)	£ 85.00	£ 85.00	£ 85.00	£ 85.00
ST 3-5 (Weekday 8am-5pm)	£ 96.00	£ 96.00	£ 96.00	£ 96.00
ST6-8 (Weekday 8am-5pm)	£ 106.00	£ 106.00	£ 106.00	£ 106.00
BMA consultant minimum extracontractual rate card (Weekday 7am-7pm)	£ 188.00	£ 188.00	£ 188.00	£ 188.00
BMA SAS minimum extra-contractual rate card for England (Weekday 7am-7pm)	£ 133.00	£ 133.00	£ 133.00	£ 133.00

Backfill calculator (based on 2026/2027 paypoints)

Although we are unable to provide funding for backfill, you may wish to use the below calculator to estimate the cost for colleagues to attend this training. Please note that this calculator supports you to estimate the potential cost but may not be accurate for your individual service. The calculations are based on the above hourly rates which have been taken from AfC salary paypoints and BMA rate card. If you pay a higher hourly rate than stated, please adjust the figure above and this will be pulled through to the calculator.

To calculate the backfill cost, choose from the dropdown lists in columns **A**, **B** and **C** below. The calculation for baseline participation hours is based on the hours set out to the left. If a staff member needs cover for more than the baseline hours, enter in column **D** the total hours backfill required.

Participant Name	(A) Do you require Backfill	(B) Banding or Grade	(C) Pay scale HCAS Weighting	Baseline Hours	(D) overwrite hours	Cost for each senior leader
[redacted]	Yes	[redacted]	Standard	8		£ 629.92
	Yes		Standard	8		£ 316.72
	Yes		Standard	8		£ 527.04
	Yes		Standard	8		£ 1,504.00
	Yes		Standard	8		£ 1,504.00
	Yes		Standard	8		£ 443.44
	Yes		Standard	8		£ 316.72
				8		£ -
	Yes		Standard	8		£ 316.72
	Yes		Standard	8		£ 316.72
0				8		£ -
0				8		£ -
0				8		£ -
0				8		£ -

Participant Name	(A) Do you require Backfill	(B) Banding or Grade	(C) Pay scale HCAS Weighting	Baseline Hours	(D) overwrite hours	Cost for each senior leader
	Yes		Standard	21		£ 1,164.03
	Yes		Standard	21		£ 3,948.00
	Yes		Standard	21		£ 3,948.00
	Yes			21		£ 713.58
	Yes		Standard	21		£ 831.39
	Yes		Standard	21		£ 831.39
				21		£ -
	Yes		Standard	21		£ 1,653.54
	Yes		Standard	21		£ 1,383.48
	Yes		Standard	21		£ 3,948.00
	Yes		Standard	21		£ 3,948.00
				21		£ -
0				21		£ -
0				21		£ -
					Total:	£ 22,369.41

Participant Name	(A) Do you require Backfill	(B) Banding or Grade	(C) Pay scale HCAS Weighting	Baseline Hours	(D) overwrite hours	Cost for each senior leader
	Yes		Standard	23		£ -
	Yes		Standard	23		£ 632.96
	Yes		Standard	23		£ 632.96
	Yes		Standard	23		£ 632.96
					Total:	£ 1,898.88

Participant Name	(A) Do you require Backfill	(B) Banding or Grade	(C) Pay scale HCAS Weighting	Baseline Hours	(D) overwrite hours	Cost for each senior leader
[redacted]	Yes	[redacted]	Standard	23		£ 781.54
	Yes		Standard	23		£ 781.54
	Yes		Standard	23		£ 632.96
	Yes		Standard	23		£ 632.96
	Yes			23		£ -
	Yes		Standard	23		£ 1,702.00
	Yes		Standard	23		£ 517.73
	Yes		Standard	23		£ 632.96
	Yes			23		£ -
	Yes		Standard	23		£ 781.54
	Yes		Standard	23		£ 781.54
	Yes		Standard	23		£ 4,324.00
				23		£ -
	Yes		Standard	23		£ 632.96
	Yes		Standard	23		£ 632.96
	Yes		Standard	23		£ 632.96
	Yes			23		£ 517.73
	Yes			23		£ -
					Total:	£ 13,985.38

£ 38,253.67

Report to:	Trust Board of Directors
Date of Meeting:	29th July 2026
Subject:	Bi-annual Maternity, Obstetric, Anaesthetic and Neonatal Workforce Report Oct – December 2025 Q3 Jan - March 2026 Q4
Director Sponsor:	Joseph Hague, Chief Nurse and Executive Maternity and Neonatal Safety Champion
Author:	Sascha Wells-Munro – Director of Midwifery Jo Hadley – Deputy Director of Midwifery Gill Locking – Cross-site Outpatient Matron Nicola Dean – Clinical Director, Obstetrics James Wright – Consultant Anaesthetist Medhat Ezzat – Cross-site Neoantal Lead Katie Mortimer – Cross-site Neoantal Matron Gail Lindley – Neoantal Ward Manager - York Jen Robinson – Neoantal Ward Manager - Scarborough Sophie Keely – Acute Maternity Matron Hanna Harness – Acute Maternity Matron Leonis Taenas – Deputy Finance Manager, Family Health

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

☒ To provide timely, responsive, safe, accessible effective care at all times.
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☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☒ To use resources to deliver healthcare today without compromising the health of future generations.
☒ To be well led with effective governance and sound finance.

Board Assurance Framework	**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*
☒ Effective Clinical Pathways ☒ Trust Culture ☒ Partnerships ☒ Transformative Services	☐ Yes

☐ Sustainability Green Plan ☒ Financial Balance ☒ Effective Governance	☒ No ☐ Not Applicable

Executive Summary:

This bi-annual Safe Staffing Report provides Board oversight of multidisciplinary (MDT) workforce and capacity across Maternity and Neonatal services. As detailed in Safety Action A of the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS), the report provides a full review of the staffing requirements against nationally recognised workforce standards covering all areas outlined in Appendix 5.

Key areas of compliance to note are:

- ≥80% obstetric consultant presence in defined acute care situations is fully met between January 2026 to current date.
- The rotas and skill mix on both sites for obstetric staffing on the labour ward are in line with RCOG guidelines.
- For all obstetric locums on the register, eligibility is verified before first engagement and reviewed annually.
- QIS compliance across both sites is well above the recommended 70% requirement at 79.7% at York and 79% at Scarborough.
- Birth to midwife ratio in line with national average of 1 clinical midwife per 28 births.
- One to one care in labour achieved 100% of time.
- Anaesthetic workforce standards in line with MIS are met.
- Scarborough is fully compliant with neonatal medical workforce standards in line with British Association of Perinatal Medicine (BAPM).

The Board is asked to note the following escalations to ensure full compliance with national workforce standards:

- Neonatal nursing in York and Scarborough is non-compliant with minimum safe staffing levels as outlined by BAPM. A business case has been developed and is under review in the care group.
- Scarborough is not compliant with training for Resuscitation Council NLS with 5 members of staff awaiting course places. Mitigations are in place with appropriately trained medical and midwifery staff in attendance at neonatal resuscitations. The neonatal staffing position is impacting this.
- As at Q4, the funded midwifery staffing deficit to Birthrate Plus is 38.98 WTE which is set to reduce in the next quarter. There is a 58.76 WTE deficit roster vacancy to BR+, which will reduce to a deficit of 29.98 following investment in April 2026.

Underfunded gap to BR+	-38.98	
Maternity leave	-19.52	
LTS/SN	-17.12	-75.62
Over recruitment		16.86
Roster to BR+ gap		-58.76
Investment April 2026		28.78
		-29.98

- Tier 1 and Tier 2 neonatal medical staffing is non-compliant at York with BAPM standards.
- Plans to uniform the on-call rota for all York site consultants, so all consultants will work the same on-call/out of hours non-resident rota have been drawn up and the Board is asked to support these recommendations.

Recommendation:
The Committee is asked to note the contents of the report and formally record to the committee minutes the escalations noted above.

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

Bi-annual Midwifery, Maternity and Neonatal Staffing Report
October – December 2025 Q3 and January – March 2026 Q4

1. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements (2016).

National and local reviews (including Ockenden, Kirkup, MBRRACE, NHS Resolution claims) repeatedly highlight that workforce shortfalls (including rota gaps, lack of trained multi-professional team and insufficient senior presence) and capacity constraints resulting in delays to planned caesarean births are key contributors to avoidable harm, and poor experiences for women, babies, and staff. Workforce pressures affect staff morale, retention, and the ability to deliver high-quality care.

The NHSR MIS requires Board oversight of effective multidisciplinary (MDT) workforce and capacity planning. Ensuring the maternity and neonatal service have funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meeting nationally recognised workforce standards.

All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups (Baroness Amos' independent investigation into maternity and neonatal services in England, 2026).

2. Executive Summary

In line with MIS Safety Action A (Workforce and Capacity) this bi-annual Safe Staffing Report provides Board oversight of multidisciplinary (MDT) workforce and capacity across Maternity and Neonatal services. Appendix 5 outlines the requirements to be met against nationally recognised workforce standards to meet minimum requirements and achieve compliance with MIS year 8 thus providing Board assurance.

Several nationally and locally agreed quality and safety indicators are regularly monitored and triangulated against workforce and capacity data – these are included in Appendix 6 and considered when reviewing safe staffing establishments.

3. Obstetric workforce

The contracted obstetric staffing split by site is summarised below:

	York		Scarborough	
Grade	WTE	Headcount	WTE	Headcount
Consultant	17.9	18	8.7	9
Resident Doctor – Tier 2	10.7	14	9	9
Resident Doctor – Tier 1	9	9	7	6

Currently the York site consultants have a mix of resident night and non-resident consultants covering acute work over the weekday nights. There are plans to change this working pattern and uniform the on-call rota for all York site consultants, so all consultants will work the same on-call/out of hours non-resident rota. This aligns with the Scarborough consultant on-call rota. The change will ensure that the consultant hours on labour ward remain within the nationally recommended consultant presence RCOG requirements, whilst releasing consultant's time (PAs) to provide more daytime elective activity (both for obstetrics and Gynaecology).

The rota and skill mix on both sites for obstetric staffing on the labour ward are in line with RCOG guidelines for entrustability and include the use of occasional locum staff where necessary to ensure rotas do not have gaps. Non-resident consultants will come on to site if there are gaps which cannot be mitigated with locum staff.

The Trust follows the RCOG guidance on compensatory rest where consultants and Senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours. The rotas allow for a non-clinical day following an on-call shift for most consultants. The daily handovers have the operational administration team in attendance to support any changes to the rota that, may be required to support the provision of compensatory rest at short notice.

3.1 Consultant attendance: Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations

There is daily monitoring of compliance with consultant attendance on labour ward and at the twice daily clinical ward rounds. Attendance rates are reviewed, audited and monitored through the Consultant meeting with escalation where needed from the Clinical Director to the Maternity Senior Leadership Team weekly to support any actions as required. This oversight is shared through the QPAS monthly report and the Quality and Regulatory Assurance Framework Workforce Report with the Board champions. The audit undertaken from January to current date demonstrates full compliance, which is reported in the Perinatal Quality Surveillance Model Report.

3.2 Short-term locum certification (obstetric workforce): Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas and eligibility must be verified before first engagement and reviewed annually for all locums on the register

The onboarding of locum medical staff is overseen by the Trust medical staffing team and is supported by a defined SOP which ensures all qualifications and competency is reviewed.

All short-term locum doctors in Obstetrics and Gynaecology are currently working in our unit or have worked in the trust within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP). Therefore, an audit was not required as all are compliant with RCOG guidelines.

During the reporting period there were no long-term locums employed within the Trust. Ordinarily, long-term locums employed on the middle grade rota have evidence of clinical competencies and are assigned a Consultant for Clinical and Educational Supervision. After a period of supernumerary induction role, they are supervised directly on site by resident consultants in the daytime, before progression to indirect supervision out of hours.

4. Neonatal nurse staffing

York is a Level 2 Local Neonatal Unit (LNU) and Scarborough is a Level 1 Special Care Unit (SCU) which provides the following cot capacity/neonatal care. Nursing establishment, calculated using BAPM standard recommended care ratios, is as follows:

*includes required 25% uplift	BAPM safe staffing ratio	York LNU	Required safe staffing	SGH SCU	Required safe staffing
Gestation		≥27 weeks	1 QIS B7 NiC - S/N (6.07 WTE)	≥32 weeks	1 QIS B7 NiC - S/N (6.07 WTE)
Intensive Care (IC) cots (HRG 1) for a limited number of babies requiring neonatal intensive care stabilisation.	1:1 Ratio QIS qualified	2 cots – these are flexed between HDU/ICU as needed	2 QIS RNs (12.14 WTE*)	0 cots	Whilst there are no IC cots, there is a need to stabilise babies born onsite prior to transfer
High Dependency (HDU) cots (HRG 2) for babies needing close monitoring and treatments	1:2 Ratio QIS qualified				
Special Care (SC) cots (HRG 3-5) for babies requiring ongoing support, treatment or monitoring.	1:4 Ratio (non-registered/ registered under direct supervision of QIS qualified)	11 cots	2 RNs (6.07 WTE) and 1 Non-Reg (6.07 WTE)	8 cots	1 QIS RN (6.07 WTE) 1 RN/non-registered (6.07 WTE)

Nurse staffing requirements specified account for:

- A minimum of 2 registered nurses required per shift to meet National Toolkit standards.
- A shift coordinator for every shift (B7) who has no clinical commitment but may support other nurses during periods when additional workload impacts direct care. The calculator does not reflect multi-site services where care is delivered across separate sites and this has been added at individual service level.

- At least 70% of RN/Midwifery staff should be QIS trained. Those in training are not included in this percentage and where IC/HDU care is a high proportion of critical care activity, the percentage will be greater than the minimum 70%.
- 30% of registered nurse staffing can be support staff (1:3 ratio support staff to RNs).

York LNU is currently decanted due to refurbishment, so cot capacity has been temporarily reduced with agreement of Specialised Commissioning to 11 cots, which includes 2 ICU/HDU and 9 SC cots.

4.1 Neonatal workforce establishment (nursing & medical): Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020)

Neonatal nursing workforce in York and Scarborough are non-compliant with minimum safe staffing levels as outlined by BAPM.

The contracted neonatal nurse staffing requirements split by site/quarter is summarised below in line with neonatal nursing workforce calculator output (2020). The calculator gives the actual WTE requirements based on an average of 80% occupancy of cots and includes 25% uplift.

York Q3

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 37.94, of which 26.56 (70%) should be QI					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	20.81	23.82	27.88	-7.07	-4.06
Total reg nurses	20.81	16.71	24.51	-3.70	-7.80
Total QIS	13.31	13.31	17.15	-3.84	-3.84
Total non-QIS	7.50	3.40	7.35	0.15	-3.95
Total non-reg	0.00	7.11	3.38	-3.38	3.73
Reg nurses as % nursing staff	100.0%	70.2%	87.9%		
QIS as % reg nurses	64.0%	79.7%	70.0%		

York Q4

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 37.94, of which 26.56 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	20.81	23.82	27.88	-7.07	-4.06
Total reg nurses	20.81	16.71	24.51	-3.70	-7.80
Total QIS	13.31	13.31	17.15	-3.84	-3.84
Total non-QIS	7.50	3.40	7.35	0.15	-3.95
Total non-reg	0.00	7.11	3.38	-3.38	3.73
Reg nurses as % nursing staff	100.0%	70.2%	87.9%		
QIS as % reg nurses	64.0%	79.7%	70.0%		

SGH Q3

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	16.60	14.99	12.14	4.46	2.85
Total reg nurses	12.16	11.55	12.14	0.02	-0.59
Total QIS	9.94	9.33	8.50	1.44	0.83
Total non-QIS	2.22	2.22	3.64	-1.42	-1.42
Total non-reg	4.44	3.44	0.00	4.44	3.44
Reg nurses as % nursing staff	73.3%	77.1%	100.0%		
QIS as % reg nurses	81.7%	80.8%	70.0%		

SGH Q4

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 18.21, of which 12.75 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	14.98	13.98	12.58	2.40	1.40
Total reg nurses	11.82	10.82	12.14	-0.32	-1.32
Total QIS	9.60	8.60	8.50	1.10	0.10
Total non-QIS	2.22	2.22	3.64	-1.42	-1.42
Total non-reg	3.16	3.16	1.62	1.54	1.54
Reg nurses as % nursing staff	78.9%	77.4%	96.5%		
QIS as % reg nurses	81.2%	79.5%	70.0%		

The table below compares BAPM safe staffing requirements as per current cot configuration against the current funded position which includes a 20% headroom uplift:

	York		**Scarborough**	
	BAPM Standards (per shift)	**Current Funded (per shift)**	**BAPM Standards (per shift)**	**Current Funded (per shift)**
Supernumerary shift coordinator / NiC (B7) - QIS	1 RN (6.07 WTE)	-	1 RN (6.07 WTE)	-
Registered Nurses - QIS (**Some B5s are QIS trained/all B6 are QIS trained)	2 RNs (12.14 WTE)	2 RN (5.71 WTE**)	1 RN (6.07 WTE)	1 RN (4.54 WTE)
Registered Nurses – Non-QIS (B5)	2 RNs (12.14 WTE)	2 RNs (15.11 WTE**)		1 RN (6.25 WTE)
Support Worker (Non-Reg)	1 N/R (6.07 WTE)	1 N/R (9.62 WTE)*	1 N/R (6.07 WTE)	1 N/R (3.77 WTE)

*Includes staffing for transitional care

It is also worth noting that Scarborough is not commissioned for any ICU/HDU cots to provide stabilisation to babies that are born outside of the unit's care level. This happens frequently due to geography as women will present in labour and it is, in some cases, unsafe to transfer. Last year there were 15 off pathway babies born across the trust and 11 of these were born in Scarborough. The length of time these babies remain

on site is also impacted by the length of time it takes for EMBRACE to attend and transfer (EMBRACE will not attend until the baby has been born). A further QIS registered nurse is required to meet this additional activity. However, current BAPM requirements noted above are based on the cot numbers and do not take this additional activity into account.

A full review of the frontline neonatal nurse staffing establishment has been conducted, and a business case has been developed that addresses the identified frontline neonatal nurse workforce gaps. This is currently with the senior leadership team for review and sign off and will then be taken through the care group governance and shared with the Operational Delivery Network (ODN). The workforce non-compliance with BAPM standards is on the care group risk register and has been escalated to the Trust Board.

Due to the current workforce gaps, cross site Neonatal Nursing workforce relies heavily on bank staff which are predominately staff with substantive contracts on the units, breaching work time directives, increasing the risk of burnout/sickness, reduced morale and patient safety incidents. Training compliance has also been impacted. At Scarborough, the staffing shortfalls for registered nurses and the impact of not meeting the required standards for a minimum of two QIS nurses/B7 supernumerary increases patient safety risks of safely covering the ward activity when attending deliveries or stabilising babies prior to transfer.

4.2 Neonatal Nurse Staffing Quality and Safety Indicators

A. QIS compliance

At the end of Q4, QIS compliance against registered nurses in post is:

- York - 79.7% (BAPM requirement 70%)
- Scarborough - 79% (BAPM requirement 70%)

Two Band 5 neonatal nurses in York are undertaking QIS training in 2027. A Band 5 Neonatal Nurse in Scarborough will commence their QIS training in September 2026. There is currently no funding to renumerate any neonatal nurse who has completed QIS to move from Band 5 to Band 6. We are currently an outlier for this and there is ambition to address this through the funding requirements outlined in the neonatal and transitional care workforce business case to support retaining QIS trained staff.

B. Sickness metrics

The target sickness rate for Neonatal Nurse staffing is 3.1%, as per the local Sickness and Absence Policy. Neonatal Nurse sickness rates cross-site in 2025/2026 were as follows:

	Q1	Q2	Q3	Q4
York	6.58%	8.45%	8.7%	2.8%
SGH	8.9%	10.3%	6.2%	6.0%

As can be seen above, sickness rates are consistently above the Trust's local target. This is attributed to insufficient headroom and investment into the staffing establishment cross-site and the additional impact of staff working under pressure.

There is a monthly Check and Challenge roster review meeting attended by the Neonatal Senior Leadership Team whereby an in-depth review of historical rosters takes place to provide oversight and assurance on both previous and future roster compliance.

The main sickness themes include long-term sickness, pregnancy, surgical related illnesses, and chronic health conditions.

C. Training compliance

Neonatal Nurse training compliance cross-site in 2025/2026 is as follows:

	York Q1 & Q2	SGH Q1 & Q2	York Q3 & Q4	SGH Q3 & Q4
NLS	83%	73%	80%	66%
NBLS/PROMT	93%	69%	83%	64%
BFI	93%	57%	80%	33%

Compliance for external NLS is set via BAPM (2022) and requires “All healthcare staff attending deliveries and/or involved in direct clinical care of the neonate should have undertaken a Newborn Life Support course appropriate to their role as recommended by the Resuscitation Council UK and receive regular training updates.”

All nurses who attend deliveries at York are compliant with this. Scarborough is not compliant with 5 members of staff awaiting NLS places. NLS places are limited throughout the region, and a national shortage of courses has been recognised. It is also difficult to release staff from Scarborough due to limited staff numbers and current workforce deficits. Mitigations in place include consultant/medical team presence at any required births alongside the midwifery team and labour ward coordinator.

Compliance with in-house NBLS in Scarborough SCU is 64%. Scarborough SCU staff have been rostered to attend but have been pulled to work clinically due to sickness and staffing shortfalls due to the workforce deficits. All staff have been rebooked to attend the next training sessions in September and November 2026.

BFI training is booked for all outstanding staff in York LNU. Scarborough SCU have been unable to release staff to attend due to staffing sickness and shortages. All staff in Scarborough SCU are booked onto training in September and November 2026.

D. Number of times the unit has closed due to staffing

Cross-site Neonatal unit closures during 2025/2026 are as follows:

	Q1	Q2	Q3	Q4
York	0	2	1	2
SGH	0	0	0	0

In Scarborough, the figures don't show a true reflection as staffing shortages are frequently covered by moving staff from York LNU or moving the ward manager and non-clinical staff to keep Scarborough SCU open. Both units have also been

supported by staff being moved from the Children's wards to maintain safe staffing levels.

It is also worth noting that when neonatal unit closures are in place, maternity remains open which means that some babies who require neonatal unit admission at birth are then required to be stabilised and transferred to another unit which impacts on neonatal staffing capacity.

E. Refused admissions due to staffing levels/capacity

Cross-site refused admissions instances 2025/2026 are as follows:

	Q1	Q2	Q3	Q4
York	2	5	2	4
SGH	5	7	4	8

York LNU and Scarborough SCU have not refused admissions because of reduced staffing levels. Any refused admissions are the result of the unit having high acuity due to required babies needing stabilisation prior to transfer which the current cot configuration does not account for. These episodes of care can be extended due to long waiting times for EMBRACE to attend to transfer a baby out to a regional centre. As a result, admissions are required to be refused for a short time until acuity on the unit stabilises.

5. Midwifery Workforce

5.1 Registered Midwives

Current NHS maternity workforce planning is based on the **Birthrate Plus®** methodology, which is endorsed by NICE for assessing safe midwifery staffing. It calculates staffing requirements using local factors such as birth numbers, case mix, acuity, community workload, geography, continuity models, and service configuration, rather than applying one national ratio.

Registered maternity workforce overview (Data source: Finance) is as follows for Q3 and Q4 2025/26:

Registered Workforce	Sum of WTE Budget	Sum of WTE SIP	Maternity Leave / Secondment WTE	Sickness/ Supernumerary WTE	WTE Available to Roster	Birth rate plus recommended WTE	Variance WTE (Budget to BR+)	Variance WTE (Actual Roster v BR+)
Registered Midwives	158.88	172.88	17.01	17.12	**151.74**	**205.58**	**-33.00**	**-53.84**
Clinical Specialist Midwives	13.70	15.69	2.7					
Non Clinical Specialist Midwives	12.11	13.96	-0.2		**29.56**	**32.89**	**-5.98**	**-3.33**
Midwifery Management	14.8	15.60						
	199.49	**218.13**	**19.51**	**17.12**	**181.30**	**238.47**	**-38.98**	**-57.17**

Headroom remains 20%, with 0% headroom for all specialist midwifery teams and the Community midwifery team covering Scarborough and the East coast. There has

been agreement from the trust board to increase the headroom across all maternity services to 24%, reflecting the national position and the increasing mandatory training requirements. This will be included in all clinical budgets from April 2026 with an increase to 24% followed by specialist midwives in March 2027 due to the phased approach to financial investment into maternity workforce.

5.2 Midwifery workforce establishment Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.

A formal Birthrate Plus assessment was completed in March 2024 (received June 2024), which reviewed the acuity of women who use maternity services at York and Scarborough Teaching Hospitals Foundation Trust. It highlighted a deficit in the funded establishment of 43.64 WTE midwives. Funding has been approved for this deficit over three years with year one being 2025/26 through to 2027/28.

As at Q4, the funded midwifery staffing deficit to Birthrate Plus is 38.98 WTE which is set to reduce in the next quarter. Details of the focused areas of investment for 2026/27 can be found in Appendix 4 - increasing clinical frontline establishments, headroom and essential specialist roles. Considering this new investment coming into budget in Q1 2026/27, the variance of funded establishment to Birthrate Plus will reduce the deficit to 10.2 WTE. This underfunded gap is increasing the pressure within the service to provide safe care.

As at the end of Q4, the current midwifery vacancy position against the funded establishment is +16.86 WTE. The service is recruited to all posts and almost all maternity leave cover (19.52 WTE), hence the vacancy over establishment. Supernumerary status for newly qualified Band 5s and long-term sickness creates an additional -17.12 WTE of roster unavailability, which combined with the funding gap gives a variance (actual roster to Birthrate Plus) of -58.76. Following the investment in April 2026, this will reduce to –29.98 WTE (assuming maternity leave and LTS/SN remain the same).

Underfunded gap to BR+	-38.98	
Maternity leave	-19.52	
LTS/SN	-17.12	-75.62
Over recruitment		16.86
Roster to BR+ gap		-58.76
Investment April 2026		28.78
		-29.98

Recruitment has commenced in view of the additional funding agreed and we have had significant interest in roles advertised. Offers are being made to 5 WTE B6 midwives to support gaps across triage on both sites and 6 WTE B5 midwives to fill vacancy gaps across the Scarborough site. The Band 5's recruited will not be appointable until around November 2026 when their pins are in place and will join the preceptorship programme which allows supernumerary time in each area before incorporation into the roster fully, anticipated in 12 months' time.

Birthrate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. The current percentage for York and Scarborough is calculated to be 6.25% of non-clinical specialist midwives with a total of 13.78% employed in clinical and non-clinical specialist midwifery roles to support the workforce and progression of all specialist services. The establishment for Specialist midwives is spread across a range of band 6 and 7 midwives, 3 and 5 admin, clerical and support staff, and 7 and 8a senior managers. The specialist midwives support a range of both non-clinical and clinical work.

Senior Leadership team has experienced significant turnover in Q1 & Q2, resulting in commencement of 4 new matrons. This continues to impact the workload of the Leadership team, including the operational delivery of services, the extensive maternity quality and safety agenda, and the timelines within the single improvement plan. To mitigate, fixed term posts have been extended until a Head of Midwifery is appointed, which is reflected in the workforce review above. The newly appointed Deputy Director of Midwifery commenced in post on 01/06/2026.

5.3 Unregistered Workforce

An overview of the unregistered midwifery workforce (Data source: Finance) is below:

Site	Budget WTE	In Post WTE	Substantive Vacancy WTE	Maternity Leave WTE	Sickness WTE	Roster Vacancy WTE
York	29.1	23.4	5.7	1.6	2.26	9.56
Scarborough	17.59	20.13	-2.54	1	1.26	-0.28
Total	**46.69**	**43.53**	**3.16**	**2.6**	**3.52**	**9.28**

In line with BR+, the recommended registered to unregistered ratio is 90% registered and 10% unregistered. With consideration of the large geographical distance across York and Scarborough, and the smaller size of the Scarborough site, the skill mix ratios, when recruited, will be higher than the recommended BR+ ratios to further support safety in the service.

Recruitment to the vacancy in York site is ongoing, Scarborough have onboarded new MSW and MA's who are now in the roster following all training. The impact of this vacancy is noted daily operationally, resulting in inconsistency of delivery of key services such as maternity triage. This is reflected in the ongoing sickness rates, the staff survey results and feedback from the culture survey engagement day feedback.

5.4 Midwifery Staffing Quality and Safety Indicators

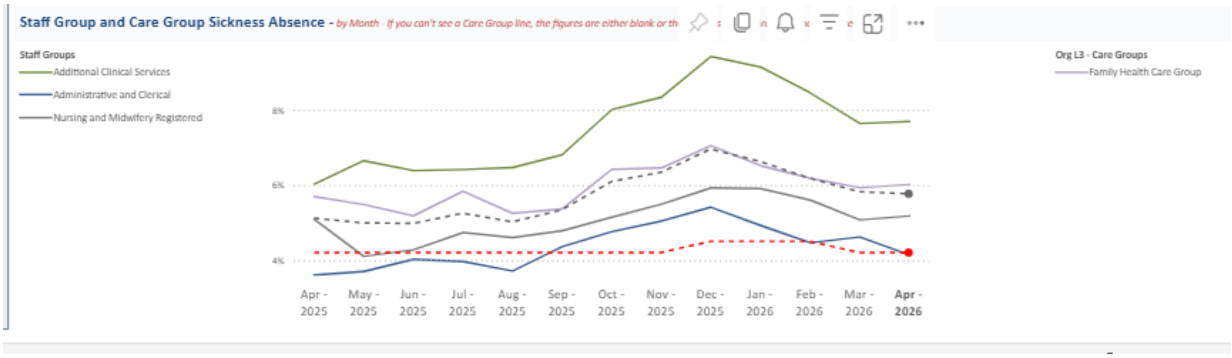
A. Sickness metrics

The trust target for sickness levels remains at 4.3%, with a view to adopt the proposed National reduction to 4.1% by 2035. To achieve this, regular workforce meetings will be established with the engagement of HR, finance, PMA and union where required. A workforce panel for review and agreement of flexible working requests has been established in Q2 and evolved through Q3 and Q4, providing staff with equity in decision making to support their work life balance, thus, reducing potential carers leave or sickness absence.

Overall, sickness has reduced following a peak in December 25 with the highest sickness noted in the non-registered workforce. This is reducing following recruitment into the vacancy rate across both sites.

Date	Oct - 2025	Nov - 2025	Dec - 2025	Jan - 2026	Feb - 2026	Mar - 2026	Q3 / Q4 Average	Q1 / Q2 Average (Previous Report Data)
Nursing and Midwifery Registered	6.85%	6.67%	6.84%	5.20%	5.38%	5.07%	**6.00%**	5.19%
Additional Clinical Services	12.60%	15.34%	17.40%	12.48%	14.59%	10.95%	**13.89%**	11.21%
Administrative and Clerical	7.07%	4.71%	3.78%	5.11%	7.01%	8.53%	**6.03%**	7.11%
Monthly Average	**8.84%**	**8.91%**	**9.34%**	**7.60%**	**8.99%**	**8.18%**	**8.64%**	

York and Scarborough Maternity workforce sickness and absence (Data Source: Signal BI [BI&IREF 10003 - NEW Workforce Performance - Power BI]):



Data shows 1.46% of all absences were related to Anxiety, which is a reduction from Q1 & Q2 and remains in line with the trust performance. Engagement is ongoing with the Psychological Wellbeing team, and the line management team are gaining consent early for referral to Occupational Health alongside early information provided for trust resources available. PMA presence on site has increased over the last 3 months for staff to access and recruitment will commence in the coming months for a Lead PMA Midwife.

B. Maternity Leave

Parenting leave remains high on Scarborough site particularly. Recruitment has been agreed to replace at 100% of working time. This is included in the vacancy rate with a rolling advert to capture any applications. This is outlined in the workforce overall review.

York and Scarborough Maternity Leave overview (Data Source: Healthroster):

	Maternity	Registered	Unregistered
WTE	13.48wte	11.82wte	1.66wte
%	5.4%	6.59%	3.55%

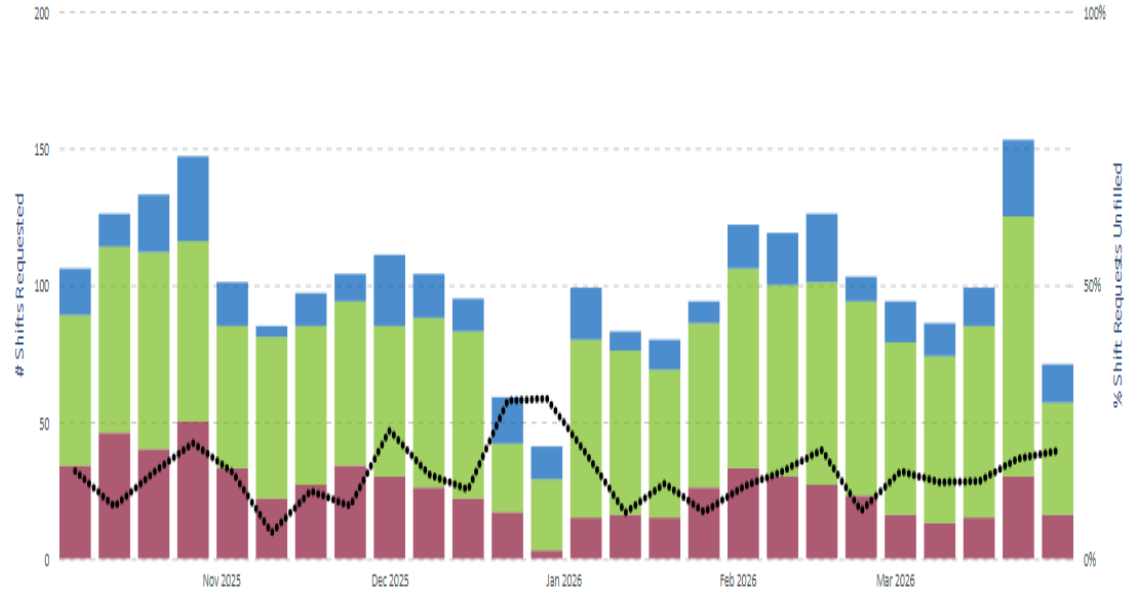
C. Bank and Agency Staffing Overview

Recruitment challenges persist, with ongoing vacancies, increased sickness rates, and a rise in maternity leave levels. The implementation of a comprehensive 12–18-month preceptorship programme further impacts workforce availability. As a result, the use of Bank and Agency staff continues across both sites to maintain safe staffing levels.

To address these staffing needs, unfilled shifts are promptly sent to both agency and bank, ensuring that staffing levels are optimised as early as possible.

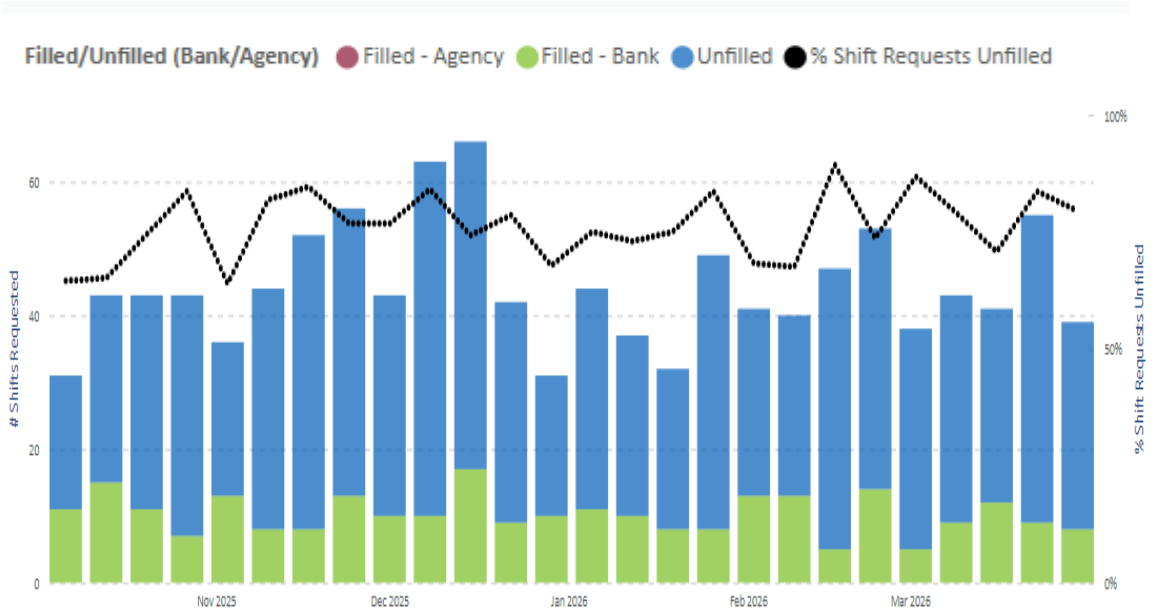
Registered unfilled shifts

Open in Power BI



Non-Registered Unfilled Shifts

Open in Power BI



Data analysis indicates a consistently higher need for registered agency staff at Scarborough over the past 18 months; however, this has reduced over Q3 & Q4 due to the NQM preceptorship programme completion of several midwives. All agency midwives have worked in the service for over 18 months and are well integrated into the team. At York, there is a greater reliance on bank staff, with shifts covered by midwives already employed within the department. The department reviews the skills mix daily and redeploys staff as needed each shift to maintain safety.

Regular monthly Roster and Temporary staffing oversight Group meetings are in place to assess rostering metrics and use of temporary staff. Although broader

improvements are underway across the trust, this project specifically aims to enhance roster management, workforce oversight, and ultimately, staff retention.

Daily safety huddles are firmly established, promoting early recognition of service pressures and facilitating cross-site discussions. These meetings help support patient flow and alleviate pressure at one site when challenges arise. During these huddles, an OPEL score is determined, and escalation policy actions are followed in response to service or staffing issues. The escalation plan has recently been launched in line with best available practice and tailored to the trust local modelling. It is anticipated that a regional guideline will be launched in July 26.

Band 7 managers continue their role as the manager of the day at both sites. Recruitment will commence in Q3 for flow midwives as planned with the trust investment due in April 26.

D. Birth to Midwife Ratio

The birth-to-midwife ratio is calculated monthly using the Birthrate Plus methodology in conjunction with the actual delivery rate. As a benchmark, the Royal College of Midwives and Birthrate Plus have historically referred to a national average of around 1 clinical midwife per 28 births. This metric has now been incorporated into the maternity dashboard, enabling ongoing monitoring alongside clinical data. The table presents the real-time monthly birth-to-midwife ratio across York and Scarborough (Source: Finance report and BadgerNet):

This ratio includes WTE employed by the trust in a clinical role, with the exclusion of labour ward coordinators to enable supernumerary status. Sickness and supernumerary WTE have been removed to give an accurate reflection of the Birth: Midwife ratio.

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Births	**326**	**314**	**310**	**311**	**297**	**358**
Clinical RM (WTE)	139.66	141.96	142.16	149.04	156.34	155.20
Clinical Specialists (WTE)	14.49	14.49	14.69	15.29	15.29	15.29
Sickness & Supernumerary Deductions (WTE)	11.55	16.30	15.99	13.95	13.75	17.13
Substantive total (WTE)	**142.60**	**140.15**	**140.86**	**150.38**	**157.88**	**153.36**
Bank / Agency (WTE)	26.6	22.2	18.15	18.2	22.21	22.15
Including Bank / Agency (WTE)	**169.20**	**162.35**	**159.01**	**168.58**	**180.09**	**175.51**

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Substantive Ratio	**1:27**	**1:27**	**1:26**	**1:25**	**1:23**	**1:28**
Including Bank / Agency	**1:23**	**1:23**	**1:23**	**1:22**	**1:20**	**1:25**

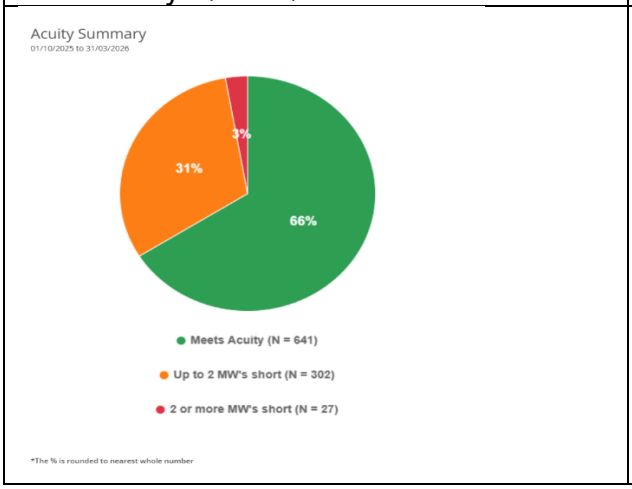
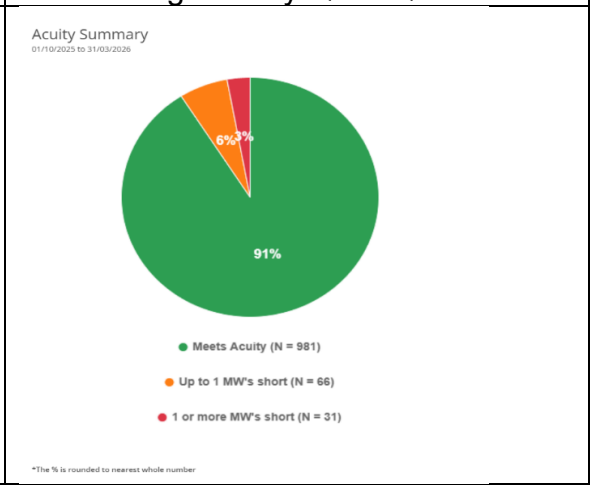
Birth to substantive midwife ratio in Q1 and Q2 averaged 1:29 and 1:25 including bank and agency. In Q3 & Q4 a reduction to an average of 1:26 for substantive and 1:23 including bank and agency was seen.

E. Birth Rate Plus Live Acuity Tool

The Birth Rate Plus (BR+) Live Acuity Tool is used by midwives to assess real-time workload and staffing requirements based on the number of women requiring care and their level of clinical need throughout labour, birth and the postnatal period. The tool is completed every four hours by the Labour Ward Coordinator and supports safe staffing decisions by identifying the number of midwives required to meet women's needs, including the minimum standard of one-to-one care in labour and additional staffing for women with higher acuity needs.

The tool is based on the nationally recognised Birth Rate Plus workforce planning methodology and is endorsed by NICE as part of its safe midwifery staffing guidance. It provides assurance that staffing requirements are continuously monitored, supports escalation processes during periods of increased acuity, and evidence actions taken to maintain safe care.

For data reliability and interpretability, the BR+ Live Acuity Tool should be completed in at least 85% of assessment periods. Compliance has exceeded this threshold at both Trust sites during the reporting period, with York achieving 88.83% and Scarborough 98.72%, demonstrating strong utilisation of the tool and continued improvement in workforce monitoring and safe staffing oversight.

York Acuity Q3 & Q4	Scarborough Acuity Q3 & Q4
	

These findings indicate that Scarborough consistently maintains staffing levels aligned with acuity demand, while York continues to experience periods where acuity requirements exceed available staffing, highlighting the importance of ongoing workforce planning, escalation processes and recruitment initiatives to support safe maternity care delivery.

F. Supernumerary Labour Ward Co-ordinator

The presence of a supernumerary labour ward co-ordinator is recognised as a fundamental aspect of safe maternity care. This role is filled by an experienced

midwife who provides advice, support, and guidance to clinical staff while effectively managing activity and workload across the labour ward.

Compliance with having a Supernumerary Labour Ward Co-ordinator in place at the beginning of each shift was 100% for both Q3 and Q4. The BR+ system offers a comprehensive overview of shift developments, enabling accurate documentation of any periods where the co-ordinator is unable to maintain supernumerary status.

The table below details monthly compliance, specifically highlighting instances when the co-ordinator was not supernumerary. With the recent approval of additional funding to fully implement the recommendations of BR+, it is expected that these occurrences will decrease, ensuring the co-ordinator can consistently remain supernumerary during times of high acuity.

Labour ward coordinator supernumerary compliance (Data source: BR+ Acuity):

	No of episodes (shifts)	No of shifts per month	Compliance (%)	No of episodes (shifts)	No of shifts per month	Compliance (%)
Month	York			Scarborough		
October 25	1	62	98.4%	3	62	95.2%
November 25	1	60	98.3%	1	60	98.3%
December 25	0	62	100%	2	62	96.77%
January 26	0	62	100%	4	62	93.55%
February 26	0	56	100%	1	56	98.21%
March 26	0	62	100%	0	62	100%

G. One to One Care in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour. York and Scarborough One to One care in established labour (Data Source: Badgernet) shows that all women in the last 6 months received 1:1 care:

Month	% one to one care provided
October 25	100%
November 25	100%
December 25	100%
January 26	100%
February 26	100%
March 26	100%

H. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the

service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed.

Red flags are collected through the live Birthrate Plus acuity tool and via the Datix system. There are differences noted between the number of red flags reported via Birthrate plus and Datix because Birthrate Plus data only collects red flags within Labour Ward, whereas Datix captures red flags reported in any location across maternity.

The table in Appendix 1 outlines the red flag events captured. Delay between presentation and triage of 30 minutes or more is the area where the most red flags occur in York Triage services. Supernumerary coordinator status is the most reported red flag in Scarborough. These areas are monitored closely and included in the quality and safety metrics through the directorate and care group.

6. Anaesthetic staffing

The anaesthetic staffing establishment at York and Scarborough as at March 2026 is as follows:

	York	SGH
General Anaesthetists	36	6
Obstetric Anaesthetists	11	4
SAS	10	3
TG	10	8
Trainees	29	8

All York Consultants are dual site, whereas Scarborough Consultants are site specific. The Obstetric Anaesthetists also come within the total general counts; however, they are analysed separately above as it is important to monitor the number of Obstetric Anaesthetists across the trust to ensure sustainability within the service. The trainee count is only involving those that may have to cover Labour Ward on call.

6.1 Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.

It is always standard practice for anaesthetic procedures in all areas (including out of hours and emergencies) for a dedicated and appropriately trained anaesthetic assistant to be present throughout the entire anaesthetic procedure, including sedation given by an anaesthetist. A written policy is in place as evidence that this should be provided.

6.2 Where the Duty Anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1.

A Duty Anaesthetist is immediately available for the obstetric unit 24 hours a day to ensure clear lines of communication to the supervising Anaesthetic Consultant at all times. The rota is included in Appendix 3 for February and March 2026 demonstrating 100% obstetric 24/7 compliance at York and Scarborough.

7. Neonatal medical staffing

This section summarises the latest comparison between York & Scarborough's neonatal medical staffing and the most recent BAPM workforce standards (2025).

7.1 BAPM Requirements for Local Neonatal Units (LNUs)

- Minimum 8 WTE Tier 1 and 8 WTE Tier 2 resident doctors.
- Dedicated Tier 1 practitioner 24/7.
- Tier 2 practitioner with intermediate airway skills for day & evenings; immediate availability overnight.
- Minimum 7 WTE Tier 3 consultants.

Current Trust Position (York)

Tier 1: Non-compliant
8 WTE (meets number requirement).
Dedicated 09:00–17:00 only - No dedicated overnight or weekend Tier 1

Tier 2: Non-compliant
9 WTE
Does not meet recommendations in view of requirement for intermediate airways skills

Tier 3: Compliant
8 WTE consultants.
Non-resident but available within 30 minutes.

Action plan to achieve full compliance

1. Recruit a minimum of 2x additional WTE Tier 1 doctors.
2. Develop a business case.
3. Ensure dedicated Tier 1 cover overnight and at weekends by adjusting rota to provide 24/7 neonatal-only Tier 1 coverage.
4. Early identification of the gaps in the next 6 months rota to be covered by locums to allow time to recruit to these vacant posts till they are permanently filled.
5. Rota master will be reporting to the management every week if the rota has been compliant with the BAPM recommendation and if was not will be escalated as a safety risk.
6. Any staff shortages will be datixed.
7. Need to review tier 2 rota to determine if additional numbers required and also agree training plan for ongoing assessment of airway skills**.**

Current Trust Position Scarborough

SCARBOROUGH WORKFORCE – TIERS 1, 2 & 3 – STANDARD							
	DAY SHIFT		EVENING SHIFT		NIGHT SHIFT		
TIER	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**COMPLIANT?**
1 minimum 8 WTE on rota	At Least one dedicated Tier 1 with basic airway capability	8 WTE on the rota cover the SCU during the day (week days from 9am - 5pm) and experienced QIS nurses carry the resuscitation bleep for immediate response	At least one immediately available tier 1 The sharing of the tier 1 should not reduce quality of care delivery and safety to the neonatal unit	Tier 1 covers both sites Paediatrics/ neonates and experienced QIS nurses carry the resuscitation bleep for immediate response	At least one immediately available tier 1 The sharing of the tier 1 should not reduce quality of care delivery and safety to the neonatal unit	Tier 1 covers both sites Paediatrics/ neonates and experienced QIS nurses carry the resuscitation bleep for immediate response	YES
2 minimum 8 WTE on rota	8.30am - 1.00pm at least one dedicated Tier 1 with standard airway capability 1pm – 5pm	8 WTE and one immediately available with standard airway capabilities					YES

	At least one immediately available tier 2 The sharing of the tier 2 should not reduce quality of care delivery and safety to the neonatal unit						

	DAY SHIFT		EVENING SHIFT		NIGHT SHIFT		
TIER	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**COMPLIANT?**
3 minimum 7 WTE on rota, 1:7 on call including weekends	Mon-Fri 8.30am – 5pm Sat/Sun 8.30am – 1pm (onsite hours) At least one immediately available with intermediate airway capability	10 tier 3 doctors (consultants) on the rota and a consultant is onsite from 9am – 9pm and when on call from home is available within 30 minutes			On call from home and available within 30 minutes		YES

Summary for Scarborough Workforce:

- Tier 1 compliant
- Tier 2 compliant

- Tier 3 compliant

8. Recommendations

The Board is asked to note the contents of the report and formally record to the Trust Board minutes areas of non-compliance as follows:

- Neonatal nursing in York and Scarborough is non-compliant with minimum safe staffing levels as outlined by BAPM. A business case has been developed and is under review in the care group.
- Scarborough is not compliant with training for Resuscitation Council NLS with 5 members of staff awaiting course places. Mitigations are in place with appropriately trained medical and midwifery staff in attendance at neonatal resuscitations. The neonatal staffing position is impacting this.
- As at the end of Q4, the current substantive midwifery vacancy position against the funded establishment is +18.64 WTE due to backfill of almost all maternity leave cover (19.1 WTE). Whilst the vacancy is over established, an additional -17.12 WTE of roster unavailability (sickness and supernumerary) combined with the funding gap gives a variance (actual roster to Birthrate Plus) of -57.17 WTE.
- Tier 1 and Tier 2 neonatal medical staffing is non-compliant at York with BAPM standards.

Date: **16/06/2026**

Appendix 1: Red Flags (Data Source: Datix & BR+ Acuity Tool)

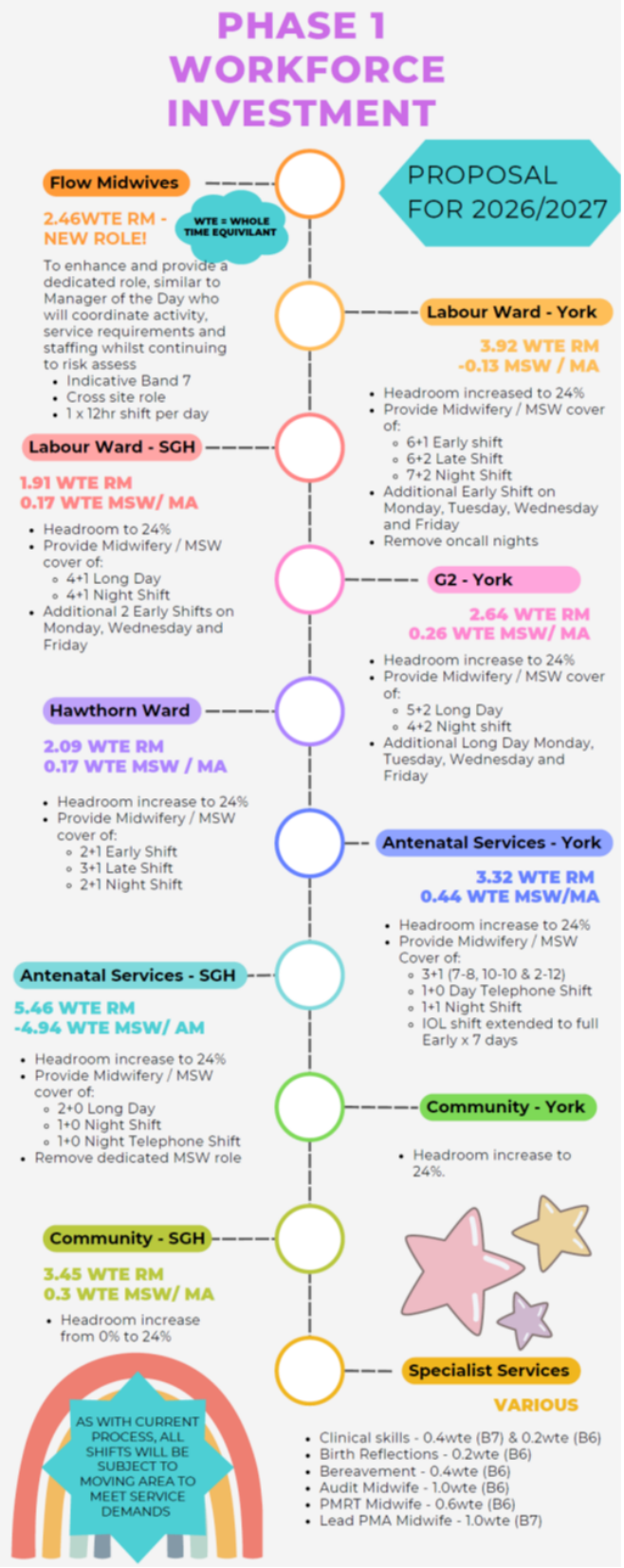
Site 1: York Q3 and Q4

	Red Flag Incidents York Q3 and Q4 2024/25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
1	Delayed or cancelled time critical activity	2	0	0	2	3	0
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	4	3	7	0	0
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	1	1	0	2	0	2
4	Delay in providing pain relief of more than 30 minutes	1	1	0	1	0	2
5	Delay between presentation and triage of 30 minutes or more	10	20	7	9	4	26
6	Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
7	Delay between admission for induction and beginning of process of 2 hours or more	0	0	0	0	0	0
8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0
9	Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0	0	0	0	0
10	Coordinator not able to maintain supernumerary/supervisory status	0	0	0	1	1	0
Subtotal		15	26	10	22	8	30

Site 2: Scarborough Q3 & Q4

	Red Flag Incidents Scarborough Q3 and Q4 2024/25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
1	Delayed or cancelled time critical activity	1	1	1	1	0	0
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0	0	0	1	0
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0	0	0	0	0
4	Delay in providing pain relief of more than 30 minutes	0	0	0	0	0	0
5	Delay between presentation and triage of 30 minutes or more	0	1	0	1	0	0
6	Full clinical examination not carried out when presenting in labour	1	2	2	0	0	0
7	Delay between admission for induction and beginning of process of 2 hours or more	0	2	2	0	1	0
8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0
9	Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	1	0	0	0	0
10	Coordinator not able to maintain supernumerary/supervisory status	1	2	3	2	0	4
Subtotal		3	9	8	4	2	4

Appendix 4: Phasing of investment communication



1. Consultant attendance (obstetric workforce)
Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations.

2. Short-term locum certification (obstetric workforce)
Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.

3. Neonatal workforce establishment (nursing & medical)
Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020). MIS acknowledges the updated medical staffing standards for LNU and SCU (Recommended Medical Workforce Standards for Local and Special Care Safety Action A 17 Advise / Resolve / Learn Neonatal Units in the UK | British Association of Perinatal Medicine). As this is new and includes significant changes, for year 8 the previous staffing standards (BAPM_Service_Quality_Standards_FINAL.pdf) or the updated version will be accepted as meeting the requirements.

4. Midwifery workforce establishment
Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.

5. Anaesthetic workforce
Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2. Capacity to deliver planned and emergency care Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. Trusts do not need to prove that delays never occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated.

6. Planned Caesarean birth capacity mapping
Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (preoperative assessment → theatre → recovery → postnatal ward). Trusts should use existing NHS England regional maternity SitRep data wherever possible to avoid duplication. Governance, escalation, and improvement

7. Board and governance oversight (as detailed in Safety Action F)
Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly

integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.

Appendix 6: Safe staffing maternity indicators

Indicators are events that should be considered when reviewing the midwifery staffing establishment and should be agreed locally.

Outcome measures reported by women in maternity services (as suggested by CQC Maternity Services Survey)

- Adequacy of communication with the midwifery team.
- Adequacy of meeting the mother's needs during labour and birth.
- Adequacy of meeting the mother's needs for breastfeeding support.
- Adequacy of meeting the mother's postnatal needs (postnatal depression and post-traumatic stress disorder) and being seen during the postnatal period by the midwifery team.

Outcome measures

- Booking appointment within 13 weeks of pregnancy (or sooner): record whether booking appointments take place within 13 weeks of pregnancy (or sooner). If the appointment is after 13 weeks of pregnancy the reason should also be recorded, in accordance with NHS Digital's Maternity Services Data Set.
- Breastfeeding: local rates of breastfeeding initiation can be collected using NHS England's Maternity and Breastfeeding data return.
- Antenatal and postnatal admissions, and readmissions within 28 days: record antenatal and postnatal admission and readmission details including discharge date. Data can be collected from NHS Digital's Maternity Services Data Set.
- Incidence of genital tract trauma during the labour and delivery episode, including tears and episiotomy. Data can be collected from the NHS Digital's Maternity Services Data Set.
- Birth place of choice: record of birth setting on site code of intended place of delivery, planned versus actual. Data can be collected from the NHS Digital's Maternity Services Data Set.

Staff-reported measures (as indicated in NHS staff survey)

- Missed breaks: record the proportion of expected breaks that were unable to be taken by midwifery staff.
- Midwife overtime work: record the proportion of midwifery staff working extra hours (both paid and unpaid).
- Midwifery sickness: record the proportion of midwifery staff's unplanned absence.
- Staff morale: record the proportion of midwifery staff's job satisfaction.

Midwifery staff establishment measures

Data can be collected for some of the following indicators from the NHS England and Care Quality Commission joint guidance to NHS trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England.

- Planned, required and available midwifery staff for each shift: record the total midwife hours for each shift that were planned in advance, were deemed to be required on the day of the shift, and that were actually available.

Report to:	Trust Board of Directors
Date of Meeting:	29 July 2026
Subject:	Complaints Annual Report FY 2025-26
Director Sponsor:	Joe Hague, Chief Nurse
Author:	Justine Harle, Complaints and Concerns Lead

Status of the Report (please click on the appropriate box)
Approve ☐ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes
☐ No
☐ Not Applicable

Executive Summary:

This report provides an overview of complaints received by the Trust between 1 April 2025 and 31 March 2026. It sets out complaint activity, performance in responding, involvement of the Parliamentary and Health Service Ombudsman (PHSO), and the actions taken in response to the concerns raised.

The Trust continues to meet its statutory duties for complaints handling, supported by clear governance, executive oversight and formal sign-off of all final responses.

A total of 1,455 complaints were received in 2025/26, reflecting increased demand, with improved performance against response times compared to the previous year.

There is strong alignment between complaints data, PHSO findings, national survey and Healthwatch feedback. Key themes remain delays, communication, discharge, and staff behaviours, all of which are being addressed through targeted Care Group improvement plans.
Focused improvement work is in place across Care Groups, alongside training, a zero-tolerance approach to response times, and a stronger emphasis on early resolution. Together, this supports a more responsive, patient-centred complaints process and demonstrates a clear commitment to continuous improvement in patient experience.

Recommendation:
The Board is asked to note the contents of the report and continue to support the work being undertaken to improve patient and carer experience.

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
Patient Experience Subcommittee	10 June 2026	Supported the paper to be shared at Executive Committee
Quality Committee	21 July 2026	

Annual Complaints Report 2025-26

1. Introduction

York and Scarborough Teaching Hospitals NHS Foundation Trust provides acute and community services to a population of around 800,000 people across York, North Yorkshire, North East Yorkshire and Ryedale. Delivering safe, effective and compassionate care remains central to the Trust's strategy, and the effective management of complaints and concerns is a key part of this approach.

This Annual Complaints Report covers the period 1 April 2025 to 31 March 2026. It supports transparency and accountability by outlining the number of complaints received, key themes, performance against response times, and the outcomes of Parliamentary and Health Service Ombudsman (PHSO) investigations. It also demonstrates how feedback from patients, families and carers is used to drive learning and improve the quality and safety of care.

Complaints are managed within a statutory framework, primarily the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including Regulation 16: Receiving and Acting on Complaints. The Trust's approach is further guided by the PHSO's principles of good complaints handling, which emphasise openness, clear communication, responsiveness and a focus on learning.

Within the Trust, complaints and concerns are embedded within the clinical governance framework. Performance, themes and learning are reported through Care Group management teams, the Patient Experience Subcommittee and the Quality and Safety Committee, ensuring appropriate oversight and action in response to feedback. Complaint handling is also monitored through Care Group Performance, Risk and Improvement Meetings (PRIM), with a strengthened focus on improving timeliness and overall performance.

The Board retains corporate responsibility for the management and oversight of complaints, with day-to-day responsibility delegated by the Chief Executive to the Chief Nurse. Monthly and quarterly reporting arrangements support ongoing monitoring, accountability and continuous improvement.

2. The number of complaints which the body responsible received and the number of complaints which the body responsible decided were well-founded

2.1 New complaints

In 2025/26, the Trust received 1,455 formal complaints, compared with 1,221 in 2024/25. This is an increase of 234 complaints (19%), equating to an average of 121 complaints per month.

Of the total received in 2025/26, 1,178 were recorded as standard complaints and 277 as complex complaints. This was the first full financial year in which complex complaints were formally reported.

New Complaints 2025/26	Q1	Q2	Q3	Q4	Total
York Hospital	186	204	205	237	**832**
Scarborough Hospital	73	92	84	75	**324**
Bridlington Hospital	3	4	8	7	**22**
Total	**262**	**300**	**297**	**319**	**1178**

New Complaints by Care Group	Q1	Q2	Q3	Q4	Total
Medicine	113	127	122	111	**473**
Surgery	73	85	84	96	**338**
Family Health	34	46	47	46	**173**
CSCS	35	33	31	53	**152**
Corporate Services	7	9	13	13	**42**
Total	**262**	**300**	**297**	**319**	**1178**

New Complex Complaints 2024/25	Q1	Q2	Q3	Q4	Total
York Hospital	23	35	73	72	**203**
Scarborough Hospital	12	19	12	29	**72**
Bridlington Hospital	0	2	0	0	**2**
Total	**35**	**56**	**85**	**101**	**277**

New Complex Complaints by Care Group	Q1	Q2	Q3	Q4	Total
Medicine	20	34	35	65	**154**
Surgery	8	9	25	19	**61**
CSCS	0	8	9	8	**25**
Family Health	7	4	15	6	**32**
Corporate Service	0	1	1	3	**5**
Total	**35**	**56**	**85**	**81**	**277**

2.2 Reopened Complaints

The Trust is committed to being open and honest when care falls short. We apologise where things have not gone as they should and apply duty of candour principles throughout the complaints process. Each final response is carefully reviewed through a robust approval process and is formally signed by the Chief Nurse on behalf of the Executive.

In 2025/26 1215 complaint investigations were concluded, of which 6% (72) were reopened at the request of the complainant and further investigations undertaken. These figures are comparable to previous years. Complainants are encouraged to contact us if they have any further questions and almost half of complainants took the opportunity to raise additional questions.

2.3 Outcome data

The Trust is required, under complaints legislation, to record whether the issues were found to be substantiated following investigation.

A complaint is recorded as upheld where the investigation finds that the concerns raised are fully justified. This means that failings in care, communication, or process have been identified and accepted by the Trust.
A complaint is recorded as partly upheld where some elements of the concerns raised are upheld, while others are not supported by the evidence. This outcome recognises that aspects of the complainant's experience were valid, even if not all concerns could be substantiated.

Of the 1397 complaints closed this financial year 1382 had an outcome code provided by the investigating officer.

Of the complaint cases, 19% were upheld, 43% were partially upheld and 38% were not upheld. These figures are broadly consistent with previous years.

Complaint Outcomes 2025-26	Not upheld	Partially Upheld	Upheld	Total
CSCS	56	60	34	**150**
Corporate Services	0	1	1	**2**
Family Health	42	87	44	**173**
Medicine	161	229	76	**466**
Surgery	169	116	63	**348**
Total	**428**	**493**	**218**	**1139**

Of the complex complaint cases, 11% were upheld, 64% were partially upheld and 25% were not upheld.

Complex Complaint Outcomes 2025-26	Not upheld	Partially Upheld	Upheld	Total
CSCS	5	14	2	**21**
Corporate Services	4	10	17	**31**
Family Health	9	16	3	**28**
Medicine	30	78	3	**111**
Surgery	13	38	1	**52**
Total	**61**	**156**	**26**	**243**

2.4 Parliamentary and Health Service Ombudsman (PHSO)

While the Trust aims to resolve complaints at a local level wherever possible, we recognise this is not always achievable. Patients retain the right to request an independent review by the PHSO.

During 2025/26, the PHSO completed initial assessments of seventeen complaints relating to the Trust. Eleven were closed with no further investigation required. A further six cases progressed to full investigation during the year. Two of these have now been concluded, and we await outcomes for the remaining four cases.

Of the two cases concluded in 2025/26, both were partially upheld. In addition, the PHSO concluded one case opened in 2024/25 and one from 2022/23, both were also partially upheld.

Case 22849: The PHSO investigation found that the IBD team did not adequately assess the patient during two key contacts in March and April 2022. While this may have delayed his diagnosis of bowel cancer, it would not have changed the eventual outcome. Additionally, there was a delay in monitoring the patient's condition in September 2022, which, although not medically harmful, understandably caused distress to the patient and

his family. To prevent similar issues in future, the Medicine Care Group has strengthened monitoring procedures in line with NEWS2 guidance, delivered targeted staff training to improve clinical assessment and documentation, and reviewed IBD assessment protocols to ensure symptoms like unexplained weight loss are promptly recognised and acted upon.

Case 20654: The PHSO identified missed opportunities in investigating the patient's condition including a failure to carry out a pre- or post-operative CT scan during the patient's hysterectomy. While the report concludes her death was likely due to an undetectable, aggressive cancer, the Trust recognised the painful uncertainty this has left her family. An action plan has been implemented by the Family Health Care Group to enhance investigative processes and care quality. Updated guidance now mandates contrast-enhanced CT scans of the chest, abdomen, and pelvis for patients with suspected ovarian cancer or borderline disease, based on ultrasound, MRI, or histopathological findings. Additionally, a working group led by the Gynaecology Cancer Unit Lead is exploring improved imaging selection tools, including the IOTA-ADNEX model, to better assess adnexal masses and guide diagnostic decisions.

Case: 23976: The PHSO found the Trust did not provide timely follow-up after complications following rectal prolapse surgery, as the patient's appointment was not brought forward despite concerns from both GP and hospital teams. Although this delay did not affect the clinical outcome, it caused avoidable distress due to a lack of timely reassurance and support. Key learning included strengthening escalation processes, improving timely access to care, and ensuring compassionate, patient-centred communication. The Trust accepted the findings in full, issued an unreserved apology, and offered £250 in recognition of the distress caused in accordance with the PHSO recommendations. The case was reviewed through the Surgery Care group internal governance processes, including the Surgery Quality and Safety Meeting where the need for timely advice, appropriate escalation, and earlier clinical review when a patient's condition changes has been reinforced. It was also acknowledged that outpatient capacity pressures may contribute to delays and this has been escalated to the Senior Leadership Team.

Case 463: The Trust accepted lapses in care in the Emergency Department and the distress caused. The PHSO recognised that the Trust's internal investigation had already identified what went wrong and that appropriate learning had been taken. Additional actions were required to reinforce this learning. In response, the Trust issued a full apology and implemented further improvements. Learning from the case has been shared directly with the clinician involved, with a clear focus on ensuring examinations take place in an appropriate clinical setting. Wider actions include improvements to the Emergency Department environment through a new building design and better access to take-home medications to support timely and safe discharge. The Trust paid £1,200 to acknowledge the avoidable distress experienced and confirmed our ongoing commitment to improving patient safety, clinical standards and communication with families.

The findings from these PHSO investigations are consistent with the Trust's own complaint analysis, with no new or unexpected themes identified. Issues relating to delays in assessment, diagnosis and follow-up, alongside gaps in communication, reassurance and escalation, mirror the Trust's most frequent complaint themes. This alignment provides assurance that the Trust is accurately identifying the key drivers of poor patient experience, particularly at known pressure points such as access to care and periods of uncertainty. The PHSO cases further reinforce that avoidable distress is often linked to how care is communicated and coordinated, even where clinical outcomes are unchanged.

The challenge for the Trust is to ensure consistent delivery of improvement actions to address these known themes and demonstrate measurable impact.

3. The subject matter of complaints that the body responsible received

In 2025/26, the most common complaint themes were delays or failures in treatment or procedures, communication with patients, and concerns about the attitude of both medical and nursing or midwifery staff. Delays or failures in diagnosis also featured prominently.

For complex complaints, the profile differed slightly. While delays or failures in treatment and diagnosis remained the most frequent issues, there was a greater focus on higher-risk concerns, including medication issues and unsafe discharges. Communication concerns in these cases were more often related to relatives and carers rather than patients themselves.

Healthwatch provides monthly reports summarising anonymous patient feedback relating to the Trust. The themes identified through this feedback closely align with those seen in formal complaints data, reinforcing the consistency of patient experience issues across multiple channels. Recurring concerns highlighted included: Communication challenges between staff and patients, delays in care and waiting times, discharge planning and coordination, staffing pressures and gaps in basic care and accessibility and equality issues (including repeated concerns relating to BSL interpretation, support for patients with disabilities, and dementia care).

Alongside these concerns, it should be noted that the Healthwatch feedback also contains consistent praise for the compassion, professionalism, and dedication of individual staff, specialist services (including oncology, cardiology, and audiology) and the overall quality of clinical treatment and outcomes.

Complaint Top 5 Themes	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	Total
Delay or failure in treatment or procedure	22	30	28	32	112
Communication with Patient	13	15	28	22	78
Attitude of medical staff	15	13	6	25	59
Attitude of nursing staff/midwives	13	16	19	9	57
Delay or failure to diagnose	13	16	9	17	55

Complex Complaint Top 5 Themes	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	Total
Delay or failure in treatment or procedure	7	4	11	8	30
Delay or failure to diagnose	2	4	7	6	19
Medication Issues	2	3	5	4	14
Discharge – Unsafe discharge	0	2	2	8	12
Communication with relatives/carers	2	2	3	5	12

NB: There are often multiple subjects within a single complaint, reflecting the complexity of many complaints.

3.1 Main Themes

Delays in clinical treatment, tests or diagnosis

Delays in clinical care are a consistent and prominent theme across complaints. Patients frequently described delays in diagnosis, missed or late investigations, and delays in treatment or procedures. This includes concerns about missed fractures, delayed

identification of serious conditions (such as infections, neurological issues, or cardiac problems), and delays in follow-up action or specialist input.

In emergency and acute settings, people often reported long waits to be assessed or reviewed, sometimes alongside prolonged waits in ambulances or waiting areas. Delays were also evident in outpatient pathways, including long waits for surgery, diagnostics (e.g. MRI scans), and follow-up appointments.

The National Inpatient Survey 2024 identified ongoing concerns in pathway and flow (including waits and delays featuring strongly in negative free-text feedback), alongside some improvement in perceived waits for admission.

Why does this matter: long waits and lack of information leave people feeling anxious and forgotten and lead to a loss of confidence. Where they are unavoidable, the experience depends heavily on expectation setting and regular communication.

Communication (patients and families)

Communication issues remain a central theme across complaints. Patients and families described inconsistent, unclear, or conflicting information, particularly around diagnosis, treatment plans, and discharge arrangements. A recurring theme is fragmentation of care where multiple teams are involved. Patients described a lack of joined-up working, with poor handovers and unclear ownership of care.

There were repeated examples of patients not being told about key clinical events, deterioration, or results, families struggling to get updates or speak to clinicians, conflicting explanations from different staff members and lack of explanation about treatment decisions or delays.

Poor communication at key moments, such as breaking bad news, explaining diagnoses, or outlining plans, was particularly distressing. There were also concerns about communication between clinical teams, leading to fragmented care and inconsistent messaging. The National Inpatient Survey 2024 also highlighted communication gaps as a recurring negative theme, including people not being kept informed and needing clearer explanations.

Why does this matter: communication shapes how safe and cared for people feel. Even when care is clinically appropriate, poor communication can undermine confidence and escalate concerns into formal complaints. Integrated care is essential, particularly for complex patients. When coordination is weak, patients experience confusion and delays, and this is often perceived as unsafe. Consistency, clarity, and timely updates remain critical.

Staff values and behaviours

Feedback about staff behaviour featured strongly in many complaints. While some patients recognised the pressures staff are under, others described interactions as dismissive, abrupt, or lacking compassion. Patients reported feeling unheard, not taken seriously, or treated in a transactional way.

Concerns included perceived rudeness or lack of empathy, patients being labelled or dismissed (e.g. symptoms attributed to anxiety), poor handling of sensitive situations, including end-of-life care and staff not listening to patient concerns or family input.

However, complainants also gave positive feedback, particularly where individual staff showed kindness, sensitivity, or took time to support patients and families.

This theme was also reflected in the National Adult Inpatient Survey 2024, where “staff” was the most frequently commented theme. Positive comments focused on compassion and professionalism, while negative feedback described interactions that felt hurried, transactional, or lacking empathy, often linked to pressures on staffing and workload.

Ward audits have provided additional context, highlighting the impact of challenging patient behaviours, including violence and aggression, that staff are required to manage alongside routine care. This further illustrates the difficult operating environment on some wards and the cumulative pressure placed on staff. These challenges, when combined with high acuity, staffing pressures and workload demands, may contribute to strain on behaviours, communication, and patient experience if not appropriately supported.

Why does this matter: behaviour and tone remain key drivers of patient experience. Small interactions have a large impact, especially when people are anxious or vulnerable. In pressured environments, values-based leadership and support for staff are essential to maintain compassionate care.

Problems with discharge, transfers, and coordination of care

Discharge and patient flow issues were widely reported. Many patients and families described discharge as poorly coordinated, rushed, or unsafe. Concerns included lack of care plans, missing or incorrect medication, and inadequate communication with patients, families, or community services.

There were also frequent issues with: transfers between wards or services without clear communication, multiple ward moves leading to loss of continuity, poor coordination between teams and external services and inadequate follow-up or support after discharge. In some cases, patients deteriorated shortly after discharge, contributing to distress and loss of confidence.

Why does this matter: discharge is a high-risk point in the patient pathway. Failures in coordination or communication can undermine otherwise good care and lead to avoidable harm or readmission. Clear planning, accurate documentation, and partnership with patients and families are essential.
Appointments, access, and administrative processes

Administrative issues were a consistent source of frustration. Patients described cancellations at short notice, long waits for appointments, and difficulty contacting services by telephone. There were also concerns about access to booking systems, responsiveness of administrative teams and confusion around waiting lists or referral processes.

In some cases, administrative failures such as lack of follow-up after appointments or tests, directly delayed clinical care. In the National Inpatient Survey 2024, pathway of care feedback also included negatives around waits and process issues in the patient journey.

Why does this matter: reliable administrative processes underpin patient confidence. When systems are difficult to access or unreliable, people turn to PALS or complaints processes. Improving access and responsiveness can reduce escalation and improve overall patient experience.

Patient care and basic needs

A significant number of complaints relate to fundamental aspects of care. Patients described issues with hygiene, nutrition, hydration, continence care, and timely assistance. Some reported being left in discomfort or distress, including delayed responses to call bells or not receiving help when needed. There were also concerns about medication management, including delays, missed doses, or errors, as well as monitoring and escalation of deteriorating patients.

Why does this matter: basic care needs strongly influence how people experience services. When these are not met, it quickly erodes trust and can make care feel unsafe or neglectful. Strengthening oversight of fundamental care remains essential.

3.2 Thematic summary by Care Group

Medicine Care Group
Concerns largely relate to delays in diagnosis and treatment, communication with families, and basic care needs. Emergency care pathways feature prominently, including long waits, delayed assessments, and concerns about safety netting. Patients want timely clinical decisions, clear communication, and consistent care.

Surgery Care Group
Themes include delays in procedures and diagnostics, post-operative care concerns, and communication issues. Patients often described uncertainty about plans and delays in treatment pathways. Experience is strongly influenced by how well care is coordinated and explained.

Family Health Care Group
Complaints frequently relate to maternity and paediatric care, particularly around communication, consent, and decision-making. Patients often described feeling vulnerable and reliant on staff to explain what was happening clearly and sensitively.

Cancer, Specialist and Clinical Support Services (CSCS)
Key issues include delays in diagnostics and results, communication gaps, and difficulties accessing services. Patients highlighted frustration with waiting times and unclear pathways, particularly where conditions are serious or ongoing.

Corporate Services
Concerns focus on administrative processes, communication, and facilities. Patients described difficulties in accessing services, booking appointments, and interacting with non-clinical staff. These issues often act as triggers for wider dissatisfaction.

3.3 Communication: Accessible Information Standard

All NHS organisations are legally required to comply with the Accessible Information Standard. The Standard sets out a clear and consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

In 2025/26 three complaints related to the Accessible Information Standard.

Case 3633: The complaint highlighted that the Contact Centre relied too heavily on phone access, with no suitable alternatives for patients with communication needs. This created delays, reliance on PALS, and potential inequity. The investigation confirmed these gaps.

In response, the Trust introduced a direct email contact for appointment queries, acknowledged the shortfall, and committed to improving accessible communication options going forward.

Case 3925: A parent raised concerns that no quiet waiting area or alternative provision was available for her child with ADHD. She reported that no reasonable adjustments were offered to support her child's needs, which impacted their experience within the department. Contact was made with the Equality and Diversity Lead to seek advice on potential improvements to both the environment and wider patient experience. This case highlighted an opportunity to strengthen the consistency of reasonable adjustments for neurodiverse children, particularly in relation to the availability of quiet spaces and staff awareness of individual needs.

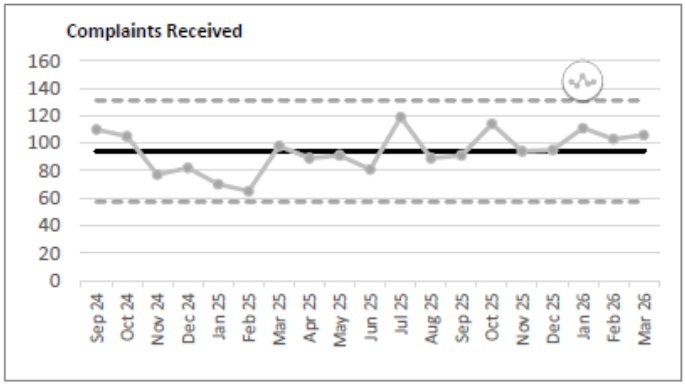
Case 3653: This complaint highlighted how reliance on certain communication methods can create barriers for patients with specific needs. An 87-year-old patient was unable to use email and experienced significant difficulty accessing the Audiology service due to long telephone waits and lack of queue information. The case reflects wider digital exclusion issues, particularly for older patients, and reinforces the requirement to provide accessible, appropriate communication routes. While service pressures (staffing shortages and backlog) contributed to delays, the experience highlighted the importance of offering alternative, non-digital access options. Actions taken included arranging the required appointment, providing a direct contact route for future queries, and feeding back suggestions to improve telephone accessibility (including clearer wait information and increased staffing cover).

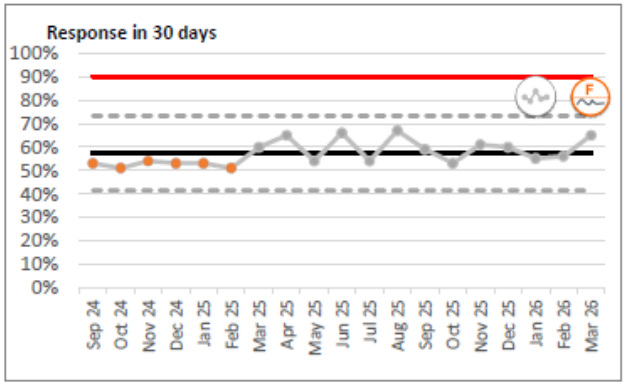
4. Any matters of general importance arising out of those complaints, or the way in which the complaints were handled

National guidance supports a proportionate approach to complaint handling. In practice, this means providing a clear and honest response as quickly as possible, while taking account of the complexity of the issues, the level of investigation required, and whether more than one service or organisation is involved. This helps ensure straightforward concerns are resolved without delay, while more complex cases receive the time and coordination they need.

Under the Trust's current approach, complaints are expected to be responded to within 30 working days. Where a complaint is identified as complex, a response timeframe of 45 working days is applied. This approach aims to set realistic and achievable timescales while maintaining a focus on timely, patient-centred resolution.

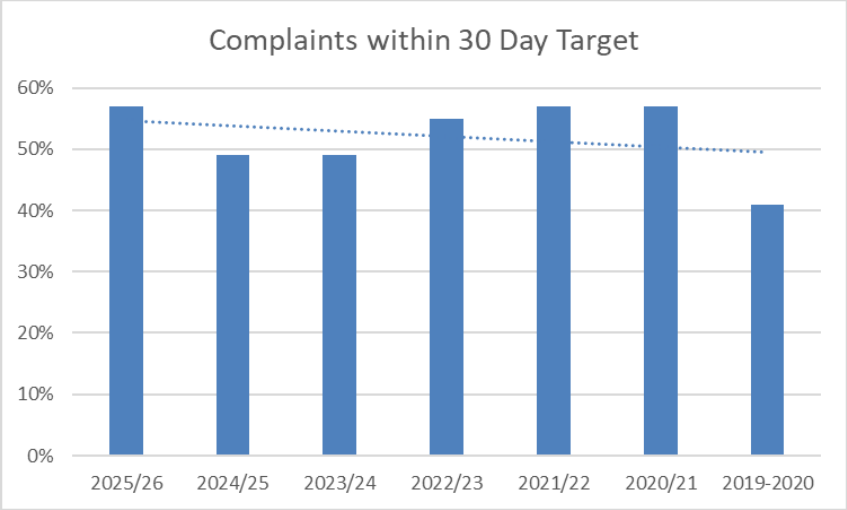
Complaint Performance 2025/26





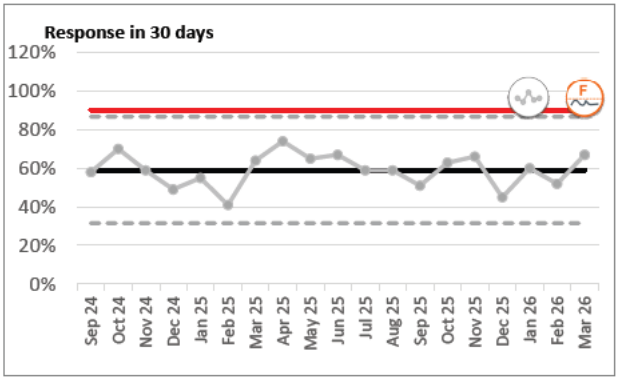
On average, 57% of closed complaints met the Trust's 30-day response target, representing a 16% improvement on the previous year.

2025/26	2024/25	2023/24	2022/23	2021/22	2020/21	2019/20
57%	49%	49%	55%	57%	57%	41%

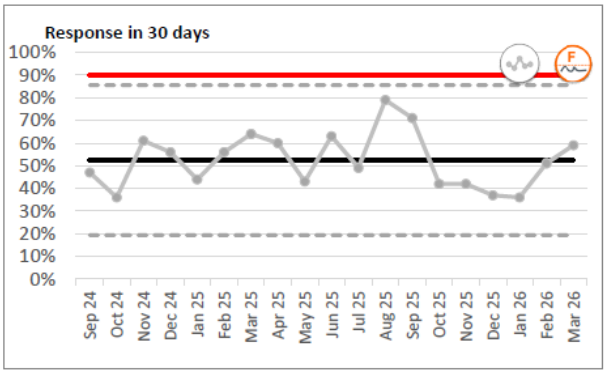


Care Group percentage performance per month (working days)

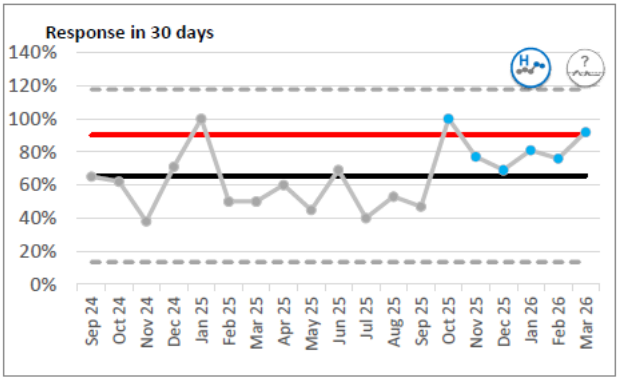
Medicine



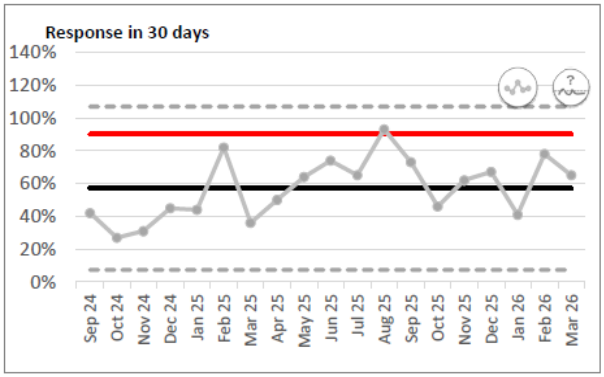
Surgery



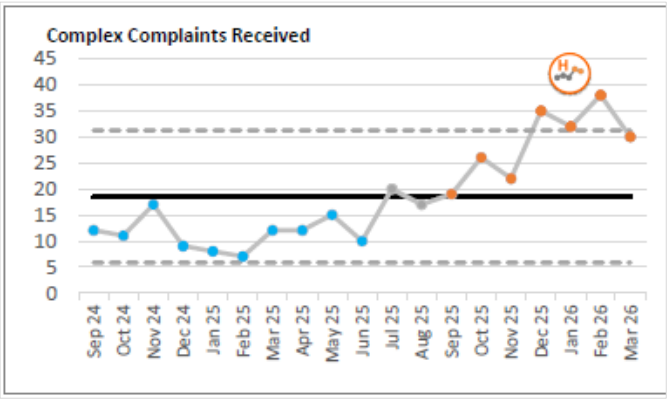
CSCS

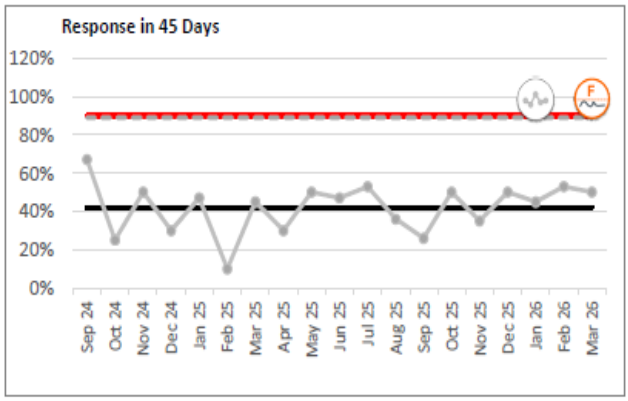


Family Health



Complex Complaint Performance 2025/26

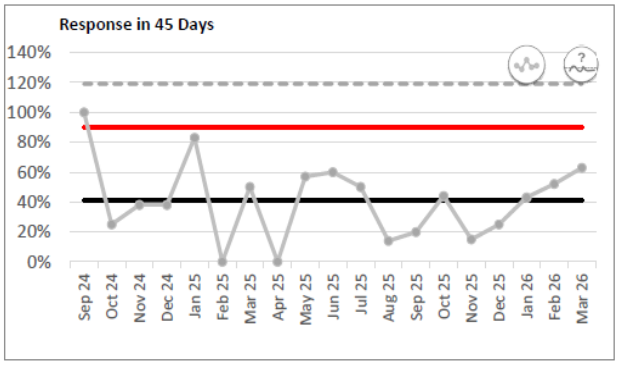




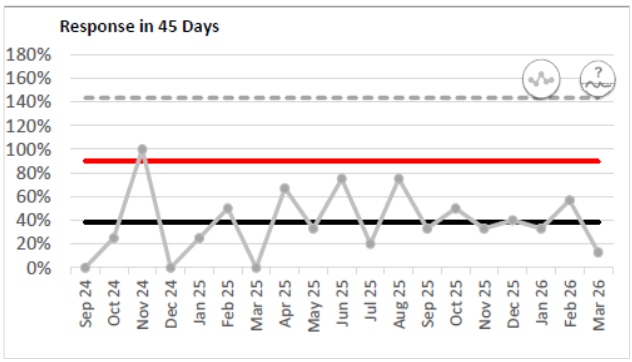
On average, 44% of closed complex complaints met the Trust's 45-day response target.

Care Group percentage performance per month (working days)

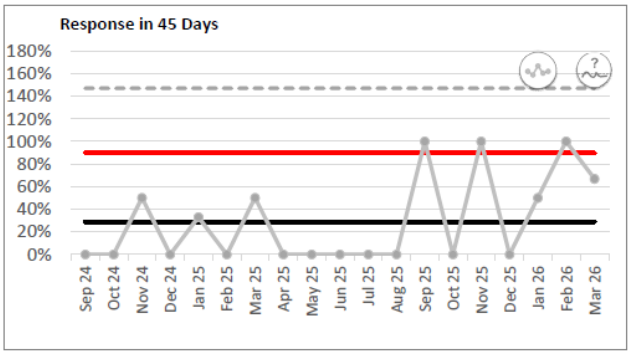
Medicine



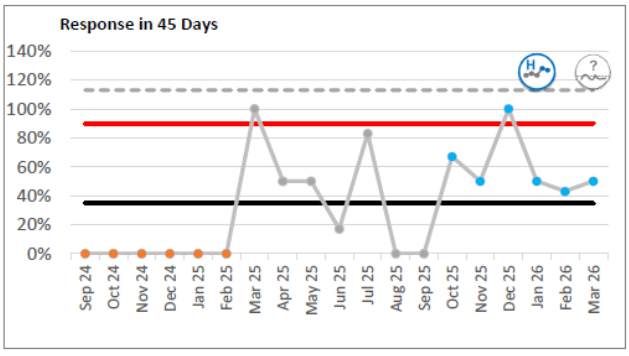
Surgery



CSCS



Family Health



5. Care Group Actions to improve performance

Care groups are expected to improve complaint handling by responding earlier and closer to the point of care, making prompt contact with patients, and improving overall timeliness. This includes stronger oversight of cases, regular review of themes and learning, and ensuring staff have the skills and support to manage complaints effectively.

The introduction of a zero-tolerance approach reinforces these expectations by making clear that missed response timescales are no longer acceptable. Care groups are now

expected to meet agreed deadlines consistently, with increased accountability where this is not achieved, supported by strengthened processes and leadership oversight.

Online training for investigators as well as writing skills training has been delivered. The training seeks to embed effective and engaged investigations, empathetic responses, and appropriate and effective learning within the Trust's handling of complaints.

Assurance is provided through strengthened governance arrangements, including regular care group review of complaints, enhanced oversight by senior leaders, and reporting through the Patient Experience Subcommittee and Trust Board. There is also a clear emphasis on using complaints data to identify themes, implement learning, and evidence service improvement.

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

Care groups will be responsible for ensuring that complaint and concerns key themes, learning and actions are clearly captured within their care group improvement plans. This learning should be routinely triangulated with other sources of patient feedback, incidents, and patient safety data. This approach will support a more comprehensive understanding of risk, help identify recurring and systemic issues, and ensure that improvement activity is evidence-based, aligned, measurable and focused on preventing repeat harm and improving patient experience.

Medicine Care Group

The Medicine Quality Improvement and Patient Experience Group (QIPEG) has been established to provide clear oversight and delivery of improvement actions arising from complaints, concerns, patient feedback, PSIIs, AARs, and audits. The improvement plan focuses on strengthening communication, improving care processes, building staff capability, and providing assurance that learning leads to measurable change for patients.

QIPEG is fully operational, with agreed Terms of Reference approved at Care Group Board, a dedicated Teams channel, and a standard agenda in place. This provides a consistent structure for reviewing themes, monitoring progress, and escalating risks.

The plan prioritises improving communication and staff behaviours across the patient journey, with work underway to develop a standard covering admission, inpatient stay, discharge, and post-discharge. Early activity has focused on improving admission conversations, involving unpaid carers, using care plans effectively, and supporting early, verbal resolution of concerns at ward level.

Actions to improve patient care include staff training in patient experience and communication, reducing deconditioning, improving discharge processes, better use of digital tools such as Nervecentre, and clearer communication of waiting times and appointments. Clinical actions address discharge reliability, nutrition and hydration, clinic utilisation, and use of clinical criteria for discharge.

Governance and assurance have been strengthened through weekly complaints assurance meetings, rapid improvement complaint days, specialty quality meetings, and triangulation of learning from multiple sources. While some workforce challenges remain following management restructuring, mitigation and recruitment plans are in place.

Overall, the majority of actions are on track or complete and demonstrate a coordinated approach to improving patient experience and care within Medicine.

Surgery Care Group

A monthly nursing-led Quality Improvement (QI) meeting has been introduced, chaired by matrons and the Head of Nursing, to address recurring complaint themes. Priority areas align directly with complaints and include communication (including staff attitude), discharge planning, care of patients in side rooms, pain relief, and out-of-hours mobility support. Small multidisciplinary working groups have been set up for each theme. They provide monthly updates, with actions escalated through Care Group Patient Quality Group and Governance meetings to support wider learning and consistency across services.

Communication: Bedside handovers are being rolled out across all surgical wards to improve information sharing and patient involvement.
Daily Ward Manager (or Nurse in Charge) rounds ensure patients and families understand care plans and allow issues to be addressed promptly.
The Surgical “Communication Promise” remains in place at the bedside, including clear routes to escalate concerns to matrons.
Complaints relating to communication in side rooms are being used to target improvements.
Further work is planned to review complaints in more detail to identify specialty-specific or medical communication issues, including ward round communication.

Discharge: A relaunch of the Trust Discharge Checklist is underway, supported by Matron assurance through daily rounds.
Barriers to completion have been reviewed with ward managers.
Compliance and impact are monitored through the QI forum.
Communication improvements are expected to further strengthen discharge planning.

Workforce and care delivery: Development of the HCA workforce to undertake mobility assessments out of hours is underway to improve patient flow and experience.
Leadership development sessions (“Time Out” events) for Ward Managers and Band 6 staff are planned to reinforce expectations and improvement priorities.
Objectives for Bands 7/6/5/2 are being reviewed to explicitly include complaint themes, improvement activity, and training, supporting accountability through appraisal.

Urology: Matron leadership has been reinstated within Urology Outpatients, supported by a focused working group. Work is ongoing to improve clinic efficiency, staffing models, and to expand care delivery outside the hospital setting in partnership with community and independent providers.

Family Health Care Group

Family Health services are taking a targeted and coordinated approach to address themes arising from patient experience feedback, complaints, and concerns, particularly in relation to access, communication, and pathway clarity.

Gynaecology: Ongoing liaison is taking place with clinical and operational teams to review complaint waiting times within Gynaecology and identify issues within referral and treatment pathways. Patient experience feedback is being actively used to highlight the impact of delays on patients and to inform prioritisation, risk discussions, and service planning. Communication with patients has been strengthened to provide clearer information and reassurance while actions are progressed, including signposting to

appropriate services for advice, such as Hysteroscopy and Colposcopy Registered Nurses.

Concerns relating to referral rejections are managed on an individual, case-by-case basis. Each case is reviewed with clinical teams to ensure referral decisions are appropriate, with feedback provided to General Practitioners where required. Patients receive clearer explanations of outcomes and next steps, including signposting back to primary care when appropriate. Learning from individual cases is systematically fed back to services to reduce repeat concerns and improve consistency in decision-making and communication. Work is underway to improve the clarity and consistency of patient-facing correspondence, including a review of letters and responses. Key communication themes and learning are shared with both clinical and administrative teams to support a more standardised approach. Ongoing patient experience feedback is being used to refine, embed, and monitor improvements.

Children's and neonatal services: Feedback mechanisms have been reviewed and confirmed. The Parent and Carer Survey is completed by adults about their child's experience. The Children and Young People (CYP) Survey is completed directly by children or young people using age appropriate, accessible language. Entry routes via QR code and SMS will begin with a clear choice: "I am a parent or carer completing this about my child." "I am a child or young person completing this myself."
A single link will be used for both routes, with the Gather system presenting the appropriate survey version automatically. Implementation is pending rollout.

CSCS Care Group

CSCS is taking a structured and coordinated approach to improving patient experience, with a clear focus on acting on themes from complaints and patient feedback, particularly in relation to access, delays, communication, and diagnostic pathways.
Weekly complaints meetings to monitor timescales and provide support to investigating officers are established within the Care Group alongside monthly Care Group Patient Experience Group meetings to review themes from complaints alongside Gather Friends and Family Test feedback. This provides a consistent forum for identifying priority issues, understanding the patient perspective, and agreeing targeted actions.

Specialty-led improvement: Specialties are responsible for developing and delivering improvement projects in response to identified themes. These projects focus on reducing delays, improving communication with patients, strengthening appointment reliability, and ensuring patients are clear about what to expect from their care. Progress is regularly presented and discussed at the Patient Experience Subcommittee, supporting shared learning and collective oversight.

Ophthalmology: Accounts for one third of complaints and concerns and is reflective of the size of the service. Improvement work is in progress with the Equality, Diversity & Inclusion (EDI) Lead regarding access to interpreters. An improvement plan is in place to address repeated cancellations and the introduction of a failsafe guardian to reduce the risk of delays in treatment and follow-up.

Radiology: Accounts for one third of complaints and concerns and is also reflective of the size of the service. A candour panel is in place in accordance with national guidance for missed radiological diagnosis. Work is planned to understand the communication issues between teams and clinical audits will be utilised to share learning regarding the impact of positive communication on a patient's journey.

Communication & Staff Attitudes: Multiple specialties across the care group are engaging with the Organisation Development Team. Bespoke work is being undertaken on communication between staff, patients and relatives.

Monitoring and escalation: Actions are clearly tracked and routinely reviewed by the Patient Experience Subcommittee. Where progress is limited or risks are identified, these are escalated through Care Group governance processes to ensure timely resolution.

Governance and assurance: Patient experience themes, actions and progress are reported through the Care Group Board, with key risks and escalated issues presented to the Patient Experience Subcommittee. This ensures appropriate oversight and provides assurance that patient feedback is driving measurable improvement.

7. Looking Ahead: Quality Priorities 2026/27

The Trust is shifting towards a more proactive and preventative approach to complaints and concerns, with a stronger emphasis on early communication and resolution to avoid escalation. Over the next year, four corporate priorities will underpin this work, aimed at improving responsiveness, strengthening care group accountability, and embedding a culture of early intervention, learning, and continuous improvement:

Education: Expanding What Matters to You? training, customer care and communication skills, and complaints management training for Investigating Officers. This will build staff confidence and capability to have effective, compassionate conversations and address concerns promptly.

Culture and communication: Promoting a Trust-wide culture that encourages staff to address issues in the moment, listen carefully to patient concerns, and resolve problems early to improve overall patient experience.

Triangulation and prevention: Using intelligence from complaints, PALS, incidents, feedback, and equality data to identify themes, inform patient-centred improvement, reduce avoidable harm, and address health inequalities.

Timely resolution: Ensuring that any concerns or complaints that cannot be resolved immediately are managed within Trust policy timescales, with clear oversight, accountability, and escalation where required.

8. Alignment with the CQC Framework

Safe: Learning from complaints and PHSO cases is used to strengthen clinical processes, escalation, and monitoring. This provides assurance that safety issues are identified, investigated and addressed.

Effective: Complaints are managed within statutory requirements and national guidance, with structured investigation processes and outcome recording. Learning is translated into Care Group improvement plans and tracked through governance, supporting evidence-based improvements in care delivery.

Caring: Training, early resolution approaches, and a focus on compassionate communication demonstrate a commitment to improving how patients and families are treated.

Responsive: There is a strong emphasis on timely, patient-centred responses, with defined response standards and improved performance. Themes such as access, delays,

and communication are being actively addressed, alongside a shift towards earlier resolution and improved accessibility.

Well-led: Complaints are overseen through clear structures, including Care Groups, the Patient Experience Subcommittee, and Board reporting. There is robust executive oversight, triangulation of data, and a clear link between feedback, learning, and service improvement.

This report demonstrates alignment across all CQC domains, with clear governance, executive oversight, and a structured approach to learning from complaints. Feedback is triangulated, acted on, and driving measurable improvements in safety, responsiveness, and patient experience.

9. Conclusion and request for the committee

Feedback from patients, families and carers offers important insight into how care is delivered in practice. It highlights both what is working well and where improvement is needed.

This report shows that there are a number of recurring patient experience issues: communication, delays and waiting, discharge quality and medicines information, appointments/access, and values and behaviours.

These themes are strongly consistent with the Trust's National Adult Inpatient Survey 2024 findings and PHSO findings and provide a clear and reliable picture of where experience deteriorates most for patients and families: at points of uncertainty (waiting), at transitions (discharge), and where communication is inconsistent.

The committee is asked to note the contents of the report and continue to support the work being undertaken to improve patient experience. The priority is to ensure Care Groups can evidence practical improvement actions, monitor impact over time, and demonstrate learning through governance reporting, so that patient feedback results in visible, sustained change.

10. Our Data

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

Date: 29 May 2026

Report to:	Board of Directors
Date of Meeting:	29 July 2026
Subject:	EDI Annual Report 2026
Director Sponsor:	Lydia Larcum, Interim Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Diversity and Inclusion (EDI)

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This report is being presented to the Trust's Board of Directors for assurance and approval, as it is a legal requirement to comply with the Public Sector Equality Duty (PSED.) The Trust has an obligation to produce an annual report stating the work that has been conducted to meet its Equality Objectives, which are produced every four years. The Trust's objectives run from 2024-2028.

The Trust has made clear progress in year two of its Equality Objectives, with strengthened governance, improved compliance with national standards, and early

evidence of impact across services, workforce, compliance and the inclusive built environment. While progress is evident, delivery is not yet consistent and further work is required to improve data quality, embed inclusive practices and accelerate outcomes.

To achieve the 2024–2028 ambitions, the Trust must now focus on embedding delivery, improving data quality and strengthening accountability across all directorates.

The full report is available to view here.

Recommendation:

To note the work that has been undertaken to meet the Equality Objectives and compliance with the Public Sector Equality Duty (PSED).

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

Meeting/Engagement	Date	Outcome/Recommendation
Corporate Directors	15 June 2026	
Resources Committee	23 June 2026	

EDI Annual Report, 2026

1. Introduction and Background

This report is being presented to the Trust's Board of Directors for assurance and approval, as it is a legal requirement to comply with the Public Sector Equality Duty (PSED.) The Trust has an obligation to produce an annual report (found here) stating the work that has been conducted to meet its Equality Objectives, which are produced every four years. The Trust's objectives run from 2024-2028.

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions, these are to:

1. Eliminate discrimination, harassment, and victimisation
2. Advance equality of opportunity between people who share a protected characteristic and people who do not
3. Foster good relations between people who share a protected characteristic and those who do not

The Public Sector Equality Duty places additional specific duties on public authorities, including NHS Trusts, this is to 'Publish sufficient information to demonstrate compliance with the general duty by 31 January 2012 and thereafter annually'.

These are published in the report which can be found here.

2. Current Position/Issues

The Trust has made clear progress in year two of its Equality Objectives, with strengthened governance, improved compliance with national standards, and early evidence of impact across services, workforce and the inclusive built environment. While progress is evident, delivery is not yet consistent and further work is required to improve data quality, embed inclusive practices and accelerate outcomes.

To achieve the 2024–2028 ambitions, the Trust must now focus on embedding delivery, improving data quality and strengthening accountability across all directorates.

The report can be viewed here.

Summary of Equality Objectives Progress:

Inclusive Built Environment - Progress to Date

- Access audits have been completed across multiple sites, supported by an active Access Plan.
- Continuous implementation of Disability awareness training.
- The Inclusive Built Environment Strategy has been updated.

Compliance-Progress to Date

- Strengthened health inequalities and patient access work.
- Embedded and progressed EDI frameworks and governance.
- Improved data insight and early signs of positive workforce trends

Services - Progress to Date

- Quality monitoring within patient surveys has improved.
- The use of patient feedback has improved.
- Communication tools have been enhanced.

Workforce - Progress to Date

- The neurodiversity toolkit was implemented; the Trust has an Anti-racism Statement on its website and anti-racism training has commenced.
- Workforce governance has improved, providing greater visibility of inclusion issues and clearer accountability for progression.
- The Trust's approach is increasingly aligned with national NHS priorities, supporting a more consistent and strategic focus on equality, inclusion and workforce experience.

3. Summary

The Trust has established a credible foundation for delivering its Equality Objectives, with clear progress across governance, compliance, services, workforce inclusion and the inclusive built environment. This provides assurance that key structures and initiatives are in place. However momentum must be maintained across the two remaining years of the current Equality Objectives, and beyond, to ensure meaningful and sustained changed is seen.

Sustained leadership focus will be critical to translating this progress into measurable and lasting change, enabling the Trust to deliver meaningful improvements in equality, diversity and inclusion by 2028.

Item 20

Report to:	Board of Directors
Date of Meeting:	29 July 2026
Subject:	Fit and Proper Persons Test (FPPT) Annual Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The purpose of this report is to provide annual assurance to the Board of Directors regarding compliance with the NHS England Fit and Proper Person Test Framework and the Trust's Fit and Proper Persons Test Policy.

The annual review of all Board members, comprising Executive Directors and Non-Executive Directors, has now been completed for the 2025/26 reporting period. The assessment process included the completion of annual self-attestations and verification checks in accordance with the NHS England Fit and Proper Person Test Framework and the Trust's local policy.

The outcome of the review confirms that all serving Board members satisfied the requirements of the Fit and Proper Person Test. No breaches, concerns, restrictions, disqualifications, adverse findings or other matters were identified that would affect any Board member's eligibility to hold office. This includes compliance with relevant employment, professional registration, conduct, insolvency, director disqualification and declaration requirements.

The Trust's annual FPPT return was completed and submitted to NHS England by the required deadline of 30 June 2026. All supporting documentation and evidence have been retained in accordance with NHS England requirements and the Trust's policy framework.

Recommendation:

The Board of Directors is asked to:

1. Note the outcome of the 2025/26 annual Fit and Proper Persons Test review.
2. Receive assurance that all Executive and Non-Executive Directors have met the requirements of the NHS England Fit and Proper Person Test Framework.
3. Note that no breaches or compliance concerns were identified.
4. Note that the Trust's annual FPPT return was submitted to NHS England by the required deadline of 30 June 2026.

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

Meeting/Engagement	Date	Outcome/Recommendation
N/a		

Fit and Proper Persons Test (FPPT)

1. Background

Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, NHS organisations are required to ensure that all Board Directors satisfy the Fit and Proper Persons Test. The NHS England Fit and Proper Person Test Framework further strengthens these requirements by providing a consistent national approach to assessing Board member suitability.

The Framework applies to all Trust Board members, irrespective of voting rights or contractual arrangements.

2. Annual Assurance 2025/26

The annual assessment process has been completed for all Executive and Non-Executive Directors.

The review confirmed that:

- Annual FPPT self-declarations were completed.
- Required verification checks were undertaken and evidenced.
- Professional registrations (where applicable) were verified.
- Director disqualification checks were completed.
- Insolvency and bankruptcy checks were completed.
- Relevant public domain searches were undertaken.
- No matters were identified that would call into question an individual's fitness and propriety to hold office.

Outcome:
All Board members have successfully met the requirements of the Fit and Proper Persons Test for 2025/26.

Breaches Identified:
None.

Regulatory Return:
The Trust's annual FPPT submission was completed and submitted to NHS England by the mandated deadline of 30 June 2026.

3. Conclusion

The Board can be assured that robust arrangements are in place to assess compliance with the Fit and Proper Person Test Framework and that all current Executive and Non-Executive Directors have met the necessary requirements during the 2025/26 annual review process.

No issues requiring escalation, regulatory notification, remedial action or further investigation have been identified.

Report to:	Board of Directors
Date of Meeting:	29 July 2026
Subject:	2026/27 Q1 Board Assurance Framework
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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☒ To be well led with effective governance and sound finance.

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides the revised 2026/27 Q1 Board Assurance Framework (BAF).

The BAF has been reviewed from Q4 2025/26 with all risks in the context of the threats and opportunities to achieving the Trust's Strategy. As a result, the new BAF risks for Q1 2026/27 are defined as follows:

- PR1 - Clinical Pathways & Quality of Care
- PR2 - People, Culture and Capability
- PR3 - Partnerships and System Working

- PR4 - Transformation, Innovation and Service Redesign
- PR5 - Sustainability, Estate and Infrastructure Resilience
- PR6 - Financial Sustainability
- PR7 - Governance, Leadership and Assurance Effectiveness

Following the Well-Led Developmental Review and the Trust's increased focus on strengthening the Board Assurance Framework (BAF), a revised BAF template has been developed which introduces a formal assurance opinion for each strategic risk. The Lead Assurance Committee will be responsible for scrutinising the available evidence, challenging the Executive Director's assessment, agreeing an assurance rating, and escalating concerns where assurance is deteriorating.

The proposed assurance ratings are:

- Substantial Assurance – Strong evidence that controls are effective and objectives are likely to be achieved.
- Moderate Assurance – Controls are largely effective, although some material gaps or uncertainties remain.
- Limited Assurance – Significant weaknesses or assurance gaps exist that may prevent achievement of the objective.
- No Assurance – Insufficient confidence in the effectiveness of controls or the availability of reliable assurance.

Further guidance is provided at Appendix 1. During 2026/27, strategic risks will be subject to periodic Committee review and deep-dive scrutiny as required, with an assurance opinion provided to support Board oversight of the Trust's principal risks.

Recommendation:
The Board of Directors is asked to approve the 2026/27 Q4 Board Assurance Framework and note the amendments to the BAF assurance provision process for 2026/27.

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

Meeting/Engagement	Date	Outcome/Recommendation
Executive Director Updates	Q1 2026/27	Risks reviewed and updated

PR1 – Clinical Pathways and Quality of Care

Principal risk statement

Failure to deliver consistently safe, effective and timely clinical pathways, resulting in avoidable harm, poor patient outcomes and experience, regulatory intervention and failure to achieve the Trust strategy.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 1	Chief Nurse	Quality Committee, with Resources Committee for flow and capacity dependencies	Quality of Care / Operational Performance	Low (1-6)	25 (5x5)	16 (4x4)	12 (4x3)	Out of appetite

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Fragile clinical services and workforce constraints in key specialties. • Sustained urgent and emergency care pressure, poor patient flow and bed capacity constraints, care on corridors. • Inconsistent fundamentals of care, infection prevention and control, documentation and assessment standards. • Variation in response to deteriorating patients and delayed escalation. • Clinical estate and digital dependencies affecting pathway reliability.	• Patient harm, poor experience and deterioration in clinical outcomes. • CQC/NHSE regulatory attention and/or conditions. • Increased complaints, incidents and avoidable variation in standards. • Staff stress, moral injury and reduced confidence in safety systems.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Trust Priorities Report with clinical quality, safety and access metrics. • PRIM process for Care Group performance review across quality, operations, finance and workforce. • Patient Safety Incident Response Framework and Quality & Safety Group oversight. • UEC, elective recovery, maternity, IPC and deteriorating patient improvement programmes. • Clinical governance sub-groups with escalation to Quality Committee and Board.	• Quality Committee escalation reports to Board. • CQC inspection intelligence and action plan monitoring. • Internal audit, clinical audit and patient safety learning reports. • TPR performance trajectories and improvement plan updates. • Patient and staff feedback, complaints, incidents and claims triangulation.	• Sustained pressure in ED and patient flow remains a high-rated operational risk. • Further consistency required in ward-to-Board assurance and evidence of embedded improvement. • Clinical strategy and clinical estate dependencies require continued progression. • Patients cared for on corridors in ED and across the inpatient adult wards (operational risk-ID530)

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Complete clinical strategy and align quality, estates, digital and workforce dependencies.	Chief Nurse / Medical Director	Q2-Q3 2026/27	Completed clinical strategy in place and aligned strategies
Strengthen assurance on deteriorating patient, IPC and documentation through thematic deep dives.	Chief Nurse	Q2 2026/27	Expected evidence from deep dives, including identified learning and improvement actions
Continue focused programme to reduce corridor care and improve flow, with clear escalation thresholds.	Chief Operating Officer / Chief Nurse	Quarterly	Quarterly report as evidence to Executive Committee
Focus on eradication of corridor care across the Trust	Chief Nurse	Q2 2026/27	Delivery Board Terms of Reference approved by July Executive Committee. Implementation of Workstreams.

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	16 (4x4)	To update	To update	To update
Assurance rating	To validate	To update	To update	To update

PR2 – People, Culture and Capability

Principal risk statement

Failure to recruit, retain, develop and support a skilled, engaged and healthy workforce, leading to reduced service resilience, poorer staff experience and compromised delivery of safe, effective care.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 2	Interim Director of Workforce and Organisational Development	Resources Committee	People	**High (10-12)**	**20 (4x5)**	**16 (4x4)**	**12 (4x3)**	**Above appetite / monitor against agreed tolerance**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Recruitment and retention pressures in clinical and specialist roles. • Sickness absence, wellbeing pressures and staff fatigue. • Inconsistent appraisal, mandatory training and leadership development. • Cultural issues resulting in inconsistent experience for colleagues. • Insufficient capacity for transformation and improvement alongside operational demands.	• Reduced service resilience and increased reliance on temporary staffing. • Reduced staff engagement, morale and retention. • Impact on quality, productivity, performance and financial sustainability. • Weaker leadership capability and governance follow-through.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• People Strategy 2025-2030 and workforce plans. • Workforce performance reporting through TPR and Resources Committee • Mandatory training, appraisal and leadership development programmes. • Cultural reform programmes e.g. Big Conversation and Continuous QI • Freedom to Speak Up, staff engagement and staff network arrangements. • Care Group PRIM reviews including workforce metrics.	• Resources Committee workforce reports and Board escalation. • Staff survey, pulse survey, FTSU and people metrics. • Medical staffing, appraisal and training compliance reports. • Internal audit, external review and Well-Led action reporting. • Sickness and Employee Relations metrics	• Leadership development and consistency of line management capability require sustained focus. • Consistent agreement of, and sign up to, organisational values require concentrated effort. • Prioritization of Employee Relations and sickness support processes.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Leadership appraisals including 360 feedback Big Conversation: values and behavioural framework	Interim Director of Workforce and OD	Q2 2026/27	Expected evidence to be added before closure
Refreshed values and behavioural framework	Interim Director of Workforce and OD	Q2-Q3 2026/27	Expected evidence to be added before closure
Integrated Accountability Framework	Chief Executive	Q3-Q4 2026/27	Expected evidence to be added before closure
Revision of leadership programmes and training to complement work to embed CQI Model	Interim Director of Workforce and OD	Q3-Q4 2026/27	Expected evidence to be added before closure

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**16 (4x4)**	To update	To update	To update
Assurance rating	To validate	To update	To update	To update

PR3 – Partnerships and System Working

Principal risk statement
Failure to work effectively with partners across place, provider collaborative and system arrangements, resulting in poorer patient care, delayed pathways, fragmented experience and reduced system sustainability.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 3	Chief Operating Officer	Resources Committee, with Quality Committee for quality-related partnership risks	Operational Performance / Quality of Care	Low (1-6)	16 (4x4)	12 (4x3)	8 (4x2)	Out of appetite

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Unclear accountabilities across partnership forums and joint programmes. • Variable effectiveness of joint decision-making and escalation arrangements. • Data-sharing and digital interoperability limitations. • Conflicting organisational priorities and constrained system capacity. • Insufficient leadership capacity to support partnership development and delivery.	• Reduced ability to deliver system productivity, transformation and population health objectives. • Inconsistent patient experience across organisational boundaries. • Financial and operational pressure on the Trust and wider system.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Executive attendance at ICB, place-based and provider collaborative forums. • Collaboration of Acute Providers and joint delivery arrangements. • Information sharing frameworks and partnership agreements where established. • System oversight for UEC, diagnostics, cancer, finance, workforce and place-based priorities. • Clinical Strategy Implementation Lead capacity supporting partnership development.	• ICB, place-based, CAP and Committee in Common meeting outputs. • Resources Committee and Board partnership updates. • Programme reporting on EPR convergence, population health and pathway redesign. • TPR and operational performance data reflecting system-flow impact.	• Need to test effectiveness of partnership forums in delivering agreed outcomes. • Further assurance needed on whether system programmes are improving patient outcomes and sustainability. • Partnership risk ownership and escalation routes require clearer mapping.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Complete review of key partnership forums and map outputs to Trust strategic objectives.	Director of Communications	Q2 2026/27	Executive-approved map of key partnership forums, including purpose, Trust representation, decision rights, strategic objective link, output expectations and escalation route. Evidence of first effectiveness review and agreed priority forums for ongoing oversight.
Develop and implement a documented framework for escalating system risks from partnership forums to Executive Committee, the relevant Board Committee, BAF and CRR.	Chief Operating Officer / Associate Director of Corporate Governance / Clinical Lead for Strategy Implementation / Assoc Director of Quality Improvement	Q3 2026/27	Approved escalation framework; documented route from partnership forums into Executive Committee, Board Committees, CRR and BAF; evidence of at least one system risk escalated and tracked through the route; quarterly Resources Committee report.
Provide annual Board seminar on system partnership priorities, risks, deliverables and unresolved dependencies requiring Board-level visibility or escalation.	Chief Executive / Clinical Strategy Implementation Lead	Q3-Q4 2026/27	Board seminar completed; agreed system priorities and dependencies documented; Board-confirmed areas for further assurance; actions incorporated into BAF, CRR or annual plan governance as appropriate

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	12 (4x3)	To update	To update	To update
Assurance rating	To validate	To update	To update	To update

PR4 – Transformation, Innovation and Service Design

Principal risk statement
Failure to redesign clinical services, pathways, digital transformation and workforce models at sufficient pace and scale, may prevent the Trust achieving its operational plan, elective recovery trajectories, service standards and productivity assumptions, resulting in reduced patient access, deteriorating performance, reduced financial sustainability and inability to deliver long-term strategic objectives.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 4	Chief Operating Officer	Resources Committee and Quality Committee	Operational Performance / Financial / Quality of Care	Low to Moderate depending on scheme	20 (4x5)	16 (4x4)	12 (4x3)	Above appetite / requires sustained Board focus

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Operational capacity limits capacity to transform resulting insufficient pace of pathway redesign and service transformation •Limited alignment between annual planning, BAF risks and transformation portfolios. • Weak programme governance resulting in delayed decision making and escalation. • Benefits from transformation programmes are not consistently quantified, owned or tracked. • Delays in EPR optimisation, interoperability, and digital workforce implementation resulting in delays to fully utilise patient portals, digital communication and automation opportunities • Dependency on system partners, capital, digital and workforce resources.	• Longer waits for diagnosis and treatments for patients, failure to improve patient experience and access and increased risk of harm associated with delayed care. • Failure to delivery elective recovery across RTT, UEC, diagnostic and cancer standards and failure to achieve operational plan trajectories. • Lost income opportunities resulting in increased recurrent cost pressures, • Workforce experiences programme fatigue and disengagement • Reduced ability to deliver commitments within the Trust strategy • Reputational impact with Regulators and system partners, reduced confidence in organisational change capability.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Trust Strategy and associated delivery framework approved by Board. • Board-approved Operational Plan and annual planning cycle. • PMO oversight of major transformation schemes (UEC, Maternity, Culture and leadership, productivity and corridor care) • Quality Impact Assessment for productivity and efficiency schemes. • Continuous Quality Improvement programme for 2026/27. •Elective Recovery Programme with specialty-level trajectories with monthly delivery groups.	• Programme highlight reports and exception reports • TPR, annual plan, operational planning delivery rep. • Resources Committee and Quality Committee focused reviews and Board escalation. • Internal audit, NHSE planning and performance reviews and external benchmarking (GIRFT, model hospital) • Patient, staff and stakeholder feedback on redesigned pathways.	• Benefits realisation arrangements are inconsistent across programmes. • Limited visibility of interdependencies between operational planning, elective recovery and digital programmes. • Transformation reporting focuses on milestones rather than achieved outcomes and benefits. • Assurance regarding delivery of productivity assumptions underpinning the Operational Plan requires strengthening. • Programme capacity and capability risks have not been fully assessed against delivery req

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Implement integrated Transformation Portfolio Dashboard showing schemes, benefits, risks, dependencies and trajectory delivery.	Chief Operating Officer / Clinical Strat Imp Lead	Q3 2026/27	Operational dashboard. Committee Reports
Establish formal benefits realisation framework with agreed baselines and measurable outcomes.	Clinical Strategy Imp Lead/ Finance Director	Q2 2026/27	Approved framework . Quarterly benefits tracking reports
Undertake programme capacity and capability assessment to ensure sufficient delivery resource.	Executive Committee	Q3 2026/27	Workforce assessment completed. Resource gaps addressed
Complete elective recovery transformation review linking pathway redesign programmes to RTT,, UEC, Cancer and Diagnostic trajectories.	Chief Operating Officer	Q2 2026/27	Approved recovery plans. Demonstrable improvement in performance

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	16 (4x4)	To update	To update	To update
Assurance rating	To validate	To update	To update	To update

PR5 – Sustainability, Estates and Infrastructure Resilience

Principal risk statement

Failure to maintain safe, resilient and sustainable estate and infrastructure, and to deliver the Green Plan, resulting in patient safety risk, service disruption, regulatory concern and failure to meet environmental obligations.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 5	YTHFM Managing Director	Resources Committee	Sustainability / Operational Performance / Quality of Care	**High for sustainability innovation; Low where patient safety or service continuity is affected**	**20 (4x5)**	**16 (4x4)**	**12 (4x3)**	**Above appetite for safety-critical estate elements**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Backlog maintenance, ageing infrastructure and constrained capital investment. • RAAC and roof-condition risks at Scarborough Hospital and other estate vulnerabilities. • Inadequate estate provision affecting service delivery in some areas. • Climate change, severe weather and environmental sustainability pressures. • Limited clinical estate strategy maturity and competing investment priorities.	• Patient safety and experience impact from estate failures or service disruption. • Increased cost, inefficiency and operational disruption. • Regulatory, environmental and reputational risk. • Failure to deliver NHS net zero and Green Plan requirements.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Estates risk register, capital planning and emergency preparedness arrangements. • Green Plan and climate change risk assessment processes. • Resources Committee oversight of estates, facilities, finance and sustainability. • EPRR standards, business continuity and incident response arrangements. • Clinical and estates strategy development.	• Estates and facilities reports to Resources Committee. • Capital planning, backlog maintenance and risk updates. • Green Plan works progress through quarterly and annual sustainability reporting and NHSE reporting. • EPRR assurance, climate adaptation and business continuity exercises. • Internal audit, external reviews and statutory compliance reports.	• Backlog maintenance and lifecycle funding remain significant constraints. • Further assurance required on clinical estate strategy, clinical strategy and prioritisation. • Green Plan compliance and Board ownership of sustainability require continued strengthening. • Agreement of clinical sustainability lead

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Develop Board-level estates and infrastructure risk prioritisation plan aligned to clinical strategy.	Finance Director / Director of Estates	Q3 2026/27	Expected evidence to be added before closure
Refresh Green Plan assurance against current NHS expectations and report to Board.	Executive sustainability lead	Q2 2026/27	Expected evidence to be added before closure
Provide quarterly updates on safety-critical estate risks, including RAAC and backlog maintenance.	Director of Estates	Quarterly	Expected evidence to be added before closure

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**16 (4x4)**	To update	To update	To update
Assurance rating	To validate	To update	To update	To update

PR6 – Financial Sustainability

Principal risk statement

Failure to deliver the agreed financial plan and restore long-term financial sustainability, resulting in regulatory intervention, reduced investment capacity and compromised delivery of strategic objectives.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 6	Finance Director / Deputy Chief Executive	Resources Committee	Financial	**Moderate (8-9)**	**25 (5x5)**	**16 (4x4)**	**12 (4x3)**	**Out of appetite / above financial appetite**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Underlying deficit, demand growth, pay and non-pay inflation, and productivity challenge. • High waste reduction and productivity requirement and risk to recurrent delivery. • Operational pressures affecting productivity and elective recovery. • Reliance on system financial arrangements and challenged provider support. • Temporary staffing and workforce deployment pressures.	• Failure to meet annual plan and system control total expectations. • Reduced cash resilience, capital investment and strategic flexibility. • Increased NHSE oversight and reputational risk. • Potential quality, workforce and operational performance trade-offs if savings are not appropriately quality-assessed.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Financial governance, budgetary control and financial improvement arrangements. • Waste reduction and productivity programme with Quality Impact Assessment. • Executive Committee, Financial Improvement Boards and Resources Committee oversight. • System financial planning and engagement with ICB/NHSE. • Board and Committee reporting through TPR and finance reports.	• Monthly finance reports to Resources Committee and Board. • WRAP reporting and QIA approval process. • Internal and external audit reports. • NHSE and system financial review outputs. • Cash, capital and financial recovery plan monitoring.	• Scale of 2026/27 WRAP requirement creates delivery and quality risk. • Need stronger recurrent benefits tracking and triangulation with quality/workforce impact. • Financial recovery remains dependent on operational productivity and system support.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Maintain Board-level financial recovery dashboard showing grip, productivity, cash, CIP and QIA status.	Finance Director	Monthly	Single WRAP tracker in place with full dashboard capability
Report recurrent/non-recurrent split and quality impacts of major schemes to Resources and Quality Committees.	Finance Director / Chief Nurse / Medical Director	Monthly	Single WRAP tracker in place with full dashboard capability including recurrent/non-recurrent split
Agree system and NHSE challenged provider support milestones and track delivery. Including deployment of additional WRAP delivery capacity.	Chief Executive / Finance Director	Q1-Q4 2026/27	Review support commencing week 20 July and full-time delivery support (initially for 6 months) commencing 3 August.

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**16 (4x4)**	To update	To update	To update
Assurance rating	To validate	To update	To update	To update

PR7 – Governance, Leadership and Assurance Effectiveness

Principal risk statement

Failure to maintain effective governance, leadership, assurance and internal control arrangements, resulting in weak oversight, inability to evidence control of strategic risks and failure to meet statutory, regulatory and licence requirements.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 6	Chief Executive / Associate Director of Corporate Governance	Group Audit Committee, with Board Committees for aligned risks	Governance / All risk categories	**Low where statutory compliance or internal control is affected**	**16 (4x4)**	**12 (4x3)**	**8 (4x2)**	**Above appetite / improving**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Complex governance architecture and variable quality of escalation. • Insufficient clarity between controls, assurances and meetings/forums. • Limited assurance grading and evidence of positive/negative assurance. • Action tracking without consistent ownership, milestones and evidence of closure. • Need to embed Well-Led developmental review improvements.	• Board unable to evidence effective oversight of strategic risks. • Weaknesses in Annual Governance Statement evidence base. • Duplicative or inefficient governance meetings and reduced accountability. • Regulatory concern, reputational risk and loss of confidence in governance systems.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Risk Management Strategy and Policy approved by Board. • BAF, CRR and committee work programme cycle. • Board and committee escalation reports and effectiveness reviews. • Well-Led developmental review action plan. • Standing Orders, SFIs, Scheme of Delegation and corporate governance framework.	• Group Audit Committee oversight of governance, risk management and internal control. • Board BAF/CRR reporting and committee escalation reports. • Internal audit overall opinion and audit plan delivery. • External audit, CQC and Well-Led review findings. • Annual Governance Statement and effectiveness review evidence.	• BAF format should more clearly map cause-control-assurance-action. • Need explicit assurance rating and clear distinction between controls and assurance sources. • Further work required to rationalise meetings and improve action evidence.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Implement refreshed BAF template with assurance ratings and cause-control mapping.	Associate Director of Corporate Governance	Q1-Q2 2026/27	Revised BAF template to be approved by the Board of Directors
Align BAF, CRR, committee work programmes and internal audit plan through a single assurance map.	Associate Director of Corporate Governance / Group Audit Committee	Q2-Q3 2026/27	Expected evidence to be added before closure
Report quarterly progress on Well-Led action plan to Board.	Chief Executive / Associate Director of Corporate Governance	Quarterly	Quarterly updates on the implementation plan throughout 2026/27

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**4x3 (12)**	To update	To update	To update
Assurance rating	To validate	To update	To update	To update

Appendix 1
Committee Assurance Definitions

Assurance Rating	Definition	Typical Characteristics
Substantial Assurance	The Committee is satisfied that controls are appropriately designed, operating effectively and supported by sufficient, reliable evidence. Any identified gaps are minor and are unlikely to prevent achievement of the strategic objective.	• Controls embedded and operating consistently • Positive performance trajectory • Strong assurance evidence from multiple sources • Few or no significant gaps • Risk managed within or close to appetite
Moderate Assurance	The Committee is satisfied that key controls are generally operating effectively; however, there are some material gaps, weaknesses or uncertainties that require continued management attention. These do not currently indicate a failure of control but could do so if not addressed.	• Majority of controls effective • Some adverse trends or emerging concerns • Action plans in place to address gaps • Mixed assurance evidence • May remain outside appetite despite controls operating appropriately
Limited Assurance	The Committee has significant concerns regarding the adequacy of controls, the effectiveness of mitigating actions, or the availability of reliable assurance evidence. There is a material risk that the strategic objective may not be achieved without additional intervention.	• Significant control weaknesses • Repeated slippage of actions • Incomplete or weak assurance evidence • Deteriorating performance indicators • Risk materially outside appetite
No Assurance	The Committee is unable to obtain sufficient evidence that effective controls are in place or operating. There are fundamental weaknesses in control, governance or assurance arrangements, creating a serious risk to achievement of the strategic objective	• Major control failures • Absence of credible assurance evidence • Serious regulatory, quality, financial or governance concerns • Immediate Board oversight and intervention required