York and Scarborough Teaching Hospitals
NHS Foundation Trust

Quality Account 2025/26

Contents

What is a Quality Account

In healthcare, delivering ‘quality’ means delivering care that:

- Is safe (patient safety).
- Works well and gives the best result (clinical effectiveness).
- Ensures patients feel well cared for (patient experience).

A Quality Account is an annual report about the quality of services delivered by the Trust. It is an opportunity to share some of the work and changes made during the year to improve the quality of care given to patients.

When Quality Accounts were first introduced in 2010 its aim was to drive quality improvement. Sixteen years on, driving quality improvement is now normal practice. This Quality Account aligns with the intentions described in the Trust’s Quality Strategy and its associated annual plan. As such, the Quality Account is not a stand-alone document but is integrated into the routine business of the organisation.

The publication of the report is required in law. A lot of the content, and the way it is written, is mandated. At times, explanations in yellow boxes are given to assist with understanding.

Who we are

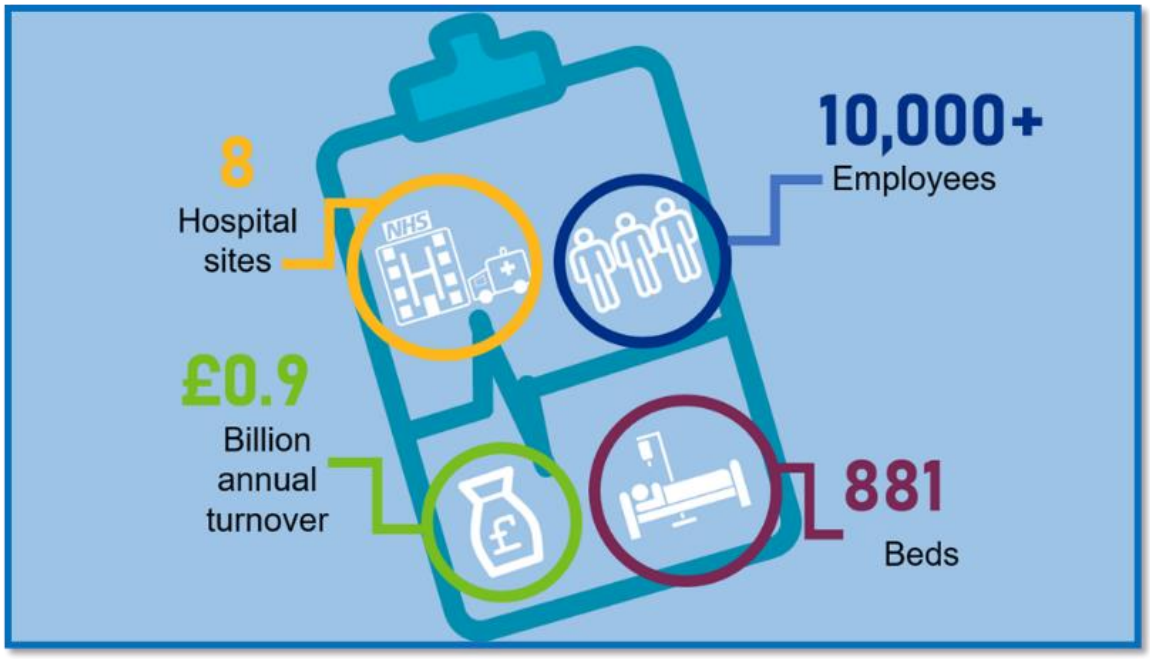
York and Scarborough Teaching Hospitals (YSTH) NHS Foundation Trust provides services to a population of 800,000 people living across North Yorkshire and East Riding. The Trust has 10,000 members of staff and an annual budget of almost £1 billion. The Trust runs acute and community services across eight hospitals.

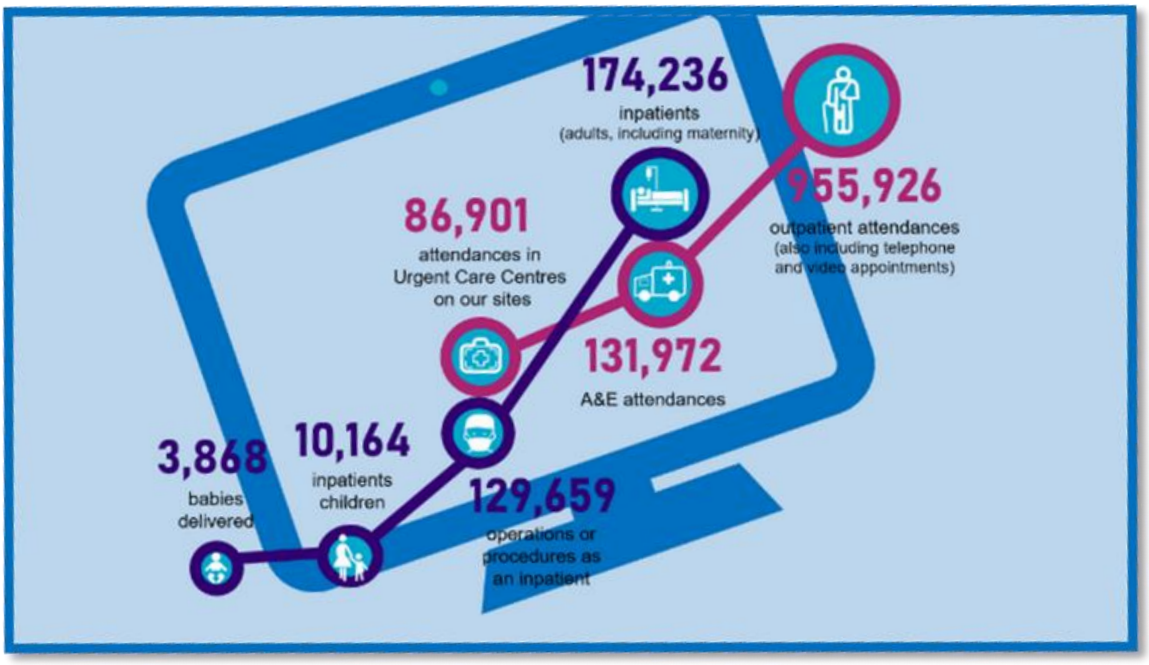
Our website https://www.yorkhospitals.nhs.uk/ provides information on our hospitals and services.

The Trust is managed by a Board of Directors, led by the Chief Executive Officer. Accountability for quality sits with the Medical Director and Chief Nurse.

Clinical services are provided by four Care Groups - Surgery, Medicine, Family Health and Cancer, Specialist & Clinical Sciences. Support is provided from many services including education, catering, finance, estates and IT. Together we all have a responsibility for delivering high quality services and we aim to deliver those services according to our values.

Our year in numbers





PART 1

This part of the report provides a summary of quality from the Chief Executive Officer and confirmation from the Directors that the information given is accurate.

1.1 Statement from the Chief Executive Officer

I am pleased to introduce this year's Quality Account for York and Scarborough Teaching Hospitals NHS Foundation Trust. As Chief Executive, I recognise both the privilege and the responsibility of leading an organisation that provides essential services to the communities we serve.

Having joined the Trust halfway through the year, I would like to acknowledge the contribution of my predecessor, Simon Morritt, who retired in September 2025, and Deputy Chief Executive Andrew Bertram for his leadership during the transition.

A key priority in my first 100 days has been to listen to colleagues, understand our services in detail, and identify the factors that support or hinder the delivery of high-quality care.

This has included time spent in clinical areas, support services and corporate teams, as well as engagement with partners, patients and local communities. Throughout this period, I have been consistently impressed by the professionalism, compassion and determination demonstrated by colleagues across the organisation. This has reinforced my view that our greatest strength is our people.

This is my first Quality Account as Chief Executive, and it comes at a significant time for both the Trust and the NHS. Demand for services continues to increase, workforce pressures remain substantial, and the financial context remains challenging. Against this backdrop, it is important that this report provides a balanced account of both the progress made and the challenges that remain. Throughout the year, the Trust has maintained a clear focus on quality of care and patient experience.

During the year, the Care Quality Commission published two reports following inspections of Trust services. In July, the report relating to urgent and emergency care and medical care services at York Hospital confirmed that urgent and emergency care had improved overall from 'inadequate' to 'requires improvement', with improvements also identified in the safe, responsive and well-led domains. A further report, published in March following assessment activity at Scarborough Hospital, recorded medical care services as 'good' overall and urgent and emergency care as 'requires improvement'. The reports also recognised the

kindness, compassion and respect shown by colleagues to patients and those close to them.

By the end of the year, no patients were waiting longer than 65 weeks for treatment, and there was a further reduction in the number of patients waiting more than 52 weeks. Our cancer performance also improved during the year, although we still have significant work ahead to consistently achieve the national 28-day Faster Diagnosis Standard and the 62-day treatment standard, and we are focusing on the full pathway.

In urgent and emergency care, the Trust made further progress in reducing ambulance handover delays and ended the year in a stronger position against the Emergency Care Standard than at its outset. Demand remains high, and sustained improvement will depend on effective patient flow across hospital and community pathways.

The Trust has also continued to invest in service improvement and future capability. This has included the opening of the new Urgent and Emergency Care Centre at Scarborough Hospital and preparation for the rollout of the first phase of Nervecentre, the Trust's new Electronic Patient Record. Alongside these developments, the Trust remains focused on strengthening leadership, supporting continuous quality improvement, and creating the conditions necessary to deliver excellent care and an improved experience for patients and colleagues.

While progress has been made, further improvement is required. The Trust's priority is to sustain the progress achieved, embed improvements in day-to-day practice, and accelerate action in areas where patients continue to experience delay, overcrowding or inconsistency. I would like to thank colleagues for their commitment to patients and to one another throughout the year. My commitment is that we will continue to address these challenges openly, make decisions that prioritise quality and safety, and deliver the improvements our communities need.

To the best of my knowledge the information in this document is accurate.

Clare Smith
Chief Executive

1.2 Statement of Directors Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, as amended, to prepare a Quality Account for each financial year.

The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Quality Accounts Regulations 2010, as amended).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account are robust and reliable, conform to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance and the Quality Accounts Regulations 2010, as amended.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

Clare Smith
Chief Executive

Martin Barkley
Chair

PART 2:

This part of the report describes:

- The progress that has been made on the improvement priorities for 2025/26 that were listed in the 2024/25 Quality Account.
- The intended priorities for improvement which we will focus on in the coming year, 2026/27.
- A set of statements about the quality of services.
- Our performance against several mandated indicators, giving comparisons with other organisations.

2.1 Progress of our priorities for 2025/26

2.1.1 Patient Safety Priorities

Priority 1: Continued development and review of Patient Safety Incident Response Framework (PSIRF) supporting an enhanced patient safety culture.

Aims for 2025/26

- We will refresh the Patient Safety Incident Response Framework (PSIRF) priorities for 2025/26.
- We will evaluate the quality governance structure, including the Care Group governance meetings and sub-committees, which support the patient safety agenda to ensure this is fit for purpose.
- We will maximise the functionality of Datix within the organisation, utilising elements which are currently unused and train staff to extract data. This will be reported throughout the year to the Patient Safety and Clinical Effectiveness sub-committee.
- We will review the data available and how it is used to support the patient safety agenda within the organisation including the patient safety elements of the Trust Priorities Report in conjunction with the Digital and Information System (DIS) to ensure we have appropriate quality and safety metrics performance. This will be included in patient safety reporting to the Care Groups and for assurance through quality governance.
- We will undertake an analysis of what a good patient safety learning system is and have this in place by the year end.
- We will roll out the Foundations in Patient Safety course to the wider workforce to help promote and increase the understanding of patient safety.

End of Year Position

- The Patient Safety Incident Response Framework (PSIRF) priorities for 2026/27 are currently progressing through the internal approval process, ensuring alignment with the organisation's strategic direction and regulatory requirements.
- A comprehensive review of the quality governance structure, including Care Group governance meetings and sub-committees, has taken place and the process remains ongoing to guarantee the structure is robust and fit for purpose.
- Significant assurance was received from the recent internal audit focusing on the implementation and effectiveness of PSIRF, reflecting well on the organisation's commitment to patient safety.
- The current review of the patient safety learning system is underway, with recommendations being developed to further strengthen organisational learning and improvement processes.
- The Foundations in Patient Safety course is now open for booking to the wider workforce, supporting broader engagement and understanding of patient safety principles. In addition, plans are in place to deliver nationally recognised PSIRF training to ensure staff are equipped with the latest knowledge and best practices.

In summary, the organisation has made strong progress against its stated aims for 2025/26, with ongoing work to embed a culture of safety, robust governance, and continuous learning. These efforts lay a solid foundation for the delivery of revised PSIRF priorities aimed to be implemented in 2026/27 and the ongoing enhancement of patient safety across all services.

Priority 2: Falls *'Reducing the incidence and harm from inpatient falls'*

Aims for 2025/26

- Standardise slipper socks to ensure consistent product quality and appropriate use, with the added benefit of potential cost savings.
- Develop the Multifactorial Assessment for Optimising Safe Activity, incorporating elements such as vision, delirium, medication, lying and standing blood pressure, continence, and walking aids.
- Shift from a deficit model—which discourages movement due to fear of falls—to a constructive model that supports safe mobilisation. This approach promotes care planning focused on optimising safety while encouraging physical activity, reinforcing a culture where falls are understood rather than feared.
- Further develop learning from deconditioning and falls through Patient Safety Incident Investigation (PSII) and cluster reviews.
- Progress to the next phase of the 'Activities Volunteer' programme, with a focus on recruitment, education, and the implementation of volunteer roles within wards. This initiative is designed to enhance person-centred care, reduce patient

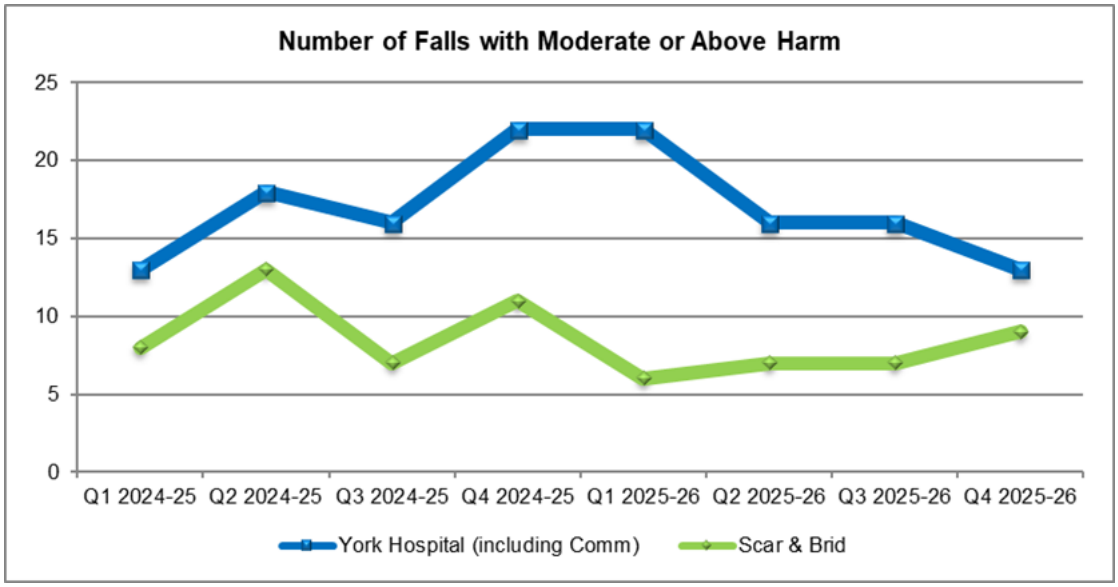
boredom, and prevent deconditioning through meaningful engagement and therapeutic activities.

End of Year Position

The Trust remains committed to reducing the incidence and impact of inpatient falls, with a continued focus on preventing avoidable harm. Falls resulting in moderate or greater harm, including fractures and head injuries, are reported to the National Audit of Inpatient Falls and represent a key patient safety priority.

Building on the 11% reduction in moderate or above harm falls achieved between 2024/25 and 2025/26, the Trust is setting a target reduction of 15% for 2026/27. This ambition reflects both the progress already made and the ongoing commitment to drive further improvements in falls prevention, early risk identification, and mitigation of serious injury.

This approach recognises the importance of sustaining momentum while embedding consistent, high-quality falls management practices across all inpatient areas to reduce variation and improve patient safety outcomes.



In alignment with the National Institute for Health and Care Excellence (NICE) Clinical Guideline NG249 (2025), which recommends lying and standing blood pressure (LSBP) assessment for all patients aged over 65, a three-year improvement trajectory was established within the Falls Quality Account (2023–2026) to strengthen compliance with this critical assessment.

The agreed incremental targets were:

- Year 1 (2023/24): 50% compliance.
- Year 2 (2024/25): 75% compliance.
- Year 3 (2025/26): 90% compliance.

Since implementation, sustained improvement has been demonstrated across the Trust, with an average quarterly compliance rate of 72% achieved by the end of 2025/26. In recognition of ongoing improvement requirements and system transformation opportunities, this target will be extended into 2026/27. The introduction of the new Electronic Patient Record (EPR) system, alongside planned ward-level dashboards, is expected to further enhance real-time data visibility, support local learning, and improve compliance rates.

Priority 3: Deteriorating Patient *'Responding to a deteriorating patient'*

Aims for 2025/26

- Opening of the Urgent and Emergency Care Centre which includes an Enhanced Care Unit. This provides specialist medical and nursing support to meet the needs of higher acuity patients throughout Scarborough Hospital.
- The introduction of a new Electronic Patient Record system called Nervecentre which will help provide automatic escalation of patients with deteriorating vital signs to the Critical Care Outreach Team and senior medical colleagues. We also aim to further develop our Hospital Out of Hours team with the launch of Nervecentre.
- We will continue to develop our deteriorating patient education programmes to strengthen early recognition and response, while ensuring these are accessible, inclusive, and tailored to address health inequalities within our patient population. This includes adapting materials to meet diverse cultural, language, and health literacy needs, and using data to identify and mitigate disparities in outcomes. We continue to review and strengthen our deteriorating patient teaching with focus on our healthcare assistants, registered nurses, midwives and foundation doctors.
- We remain committed to working with NHS England to implement Martha's Rule across our Trust, raising awareness and understanding among patients, visitors and staff to support timely escalation of patient deterioration. We are working towards full implementation of Martha's Rule, including the integration of Patient Wellness Questions into Nervecentre. This will be underpinned by structured staff training and support, with ongoing audit to monitor compliance and inform targeted quality improvement initiatives.

End of year position

- The Urgent and Emergency Care Centre, including the Enhanced Care Unit, has successfully opened at Scarborough Hospital. This facility is now fully operational, delivering specialist medical and nursing support for higher acuity patients across the hospital. The Enhanced Care Unit has improved the hospital's capability to provide timely and appropriate care for complex cases, resulting in better patient outcomes and a more streamlined approach to urgent medical

needs. Staff feedback has been positive, highlighting improved patient flow and enhanced multidisciplinary collaboration.

- The new Electronic Patient Record system started to go live in May 2026. Once fully implemented, we will be able to accurately assess the impact of automatic escalation for patients with deteriorating vital signs to the Critical Care Outreach Team and senior medical colleagues.
- We are fully engaged in Phase 2 of the NHS England rollout of Martha's Rule. This includes adopting nationally developed patient information materials such as leaflets and posters, and making eLearning accessible to all staff. We are piloting Patient Wellness Questions (PWQ) across both York and Scarborough hospital sites and have expanded our Martha's Rule Steering Group to include a Critical Care Consultant and resident doctors, strengthening clinical leadership for audit, evaluation, and continuous quality improvement.

Priority 4: Sepsis *'Improve our delivery and monitoring of Sepsis'*

Aims for 2025/26

- Work with the digital team to ensure a robust and user-friendly Sepsis assessment tool is created within the new Electronic Patient Record System (EPR).
- Staff Training: Expanding education programs to ensure healthcare professionals are equipped with the latest knowledge and skills.
- Public Awareness: Increasing community outreach to help individuals recognise sepsis symptoms early.

End of Year Position

Digital Development

Work with the Digital Team to develop a robust and user-friendly sepsis assessment and monitoring tool within the new EPR system has not progressed as planned.

The Digital Team has prioritised the redevelopment of existing dashboards as part of the Nervecentre rollout. As sepsis monitoring was not previously supported by an established dashboard, it has not been included within the current programme of work.

Despite ongoing efforts, a suitable sepsis dashboard has yet to be developed. Until the dashboard is in place, sepsis monitoring across the Trust will remain limited.

Staff Training

Significant progress has been made in strengthening staff training and education:

- Additional sepsis training has been delivered across the organisation.

- The Trust has adopted NHS England's free sepsis training modules via the Learning Hub, improving accessibility and consistency of education.
- An application is underway to incorporate newly developed paediatric sepsis modules, led by the Paediatric Clinical Educator.

This has enhanced staff knowledge and supports improved recognition and management of sepsis.

Public Awareness

Progress has also been made in increasing public awareness:

- The Trust participated as a pilot site for Martha's Rule, led by the Surgery Care Group. (The patient safety team applied to be the pilot site).
- This initiative has strengthened patient and family awareness, empowering individuals to escalate concerns regarding deterioration, including potential sepsis.

Priority 5: Pressure Related Skin Damage

Aims for 2025/26

- The prevention of pressure-related skin damage remains a key organisational priority. Improvement projects outlined within the Pressure Ulcer Improvement Plan are informed by findings from incident investigations and thematic reviews.
- Looking ahead to 2025/26, the strategic focus will shift toward reducing the incidence of low harm Category 2 pressure ulcers. This proactive approach is based on the recognition that effective early intervention at this level can significantly contribute to a reduction in moderate harm Category 3 and 4 pressure ulcers.
- As referenced in our Quality Objectives, the organisation has set an ambitious target to reduce newly developed Category 2 pressure ulcers by 15% across all care groups by March 2026.

End of Year Position

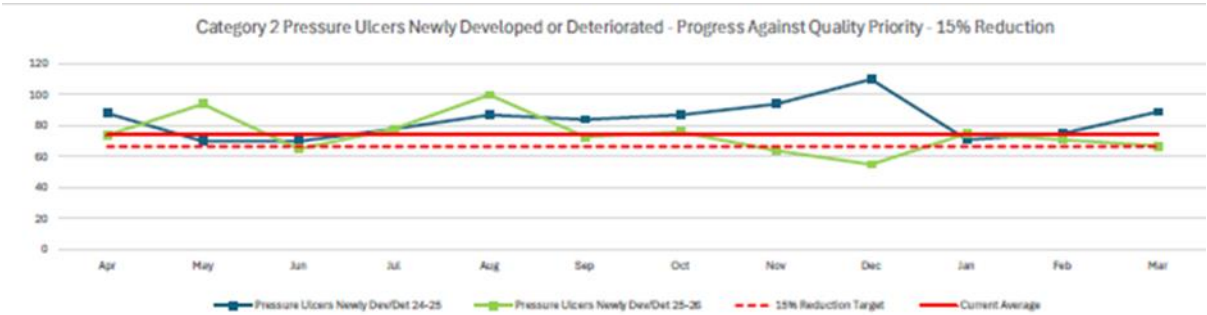
During 2025/26, the former Pressure Ulcer Improvement Group and associated Improvement Plan were replaced by the Patient Quality & Safety Group (PQSG). The PQSG provides a focused, data-driven forum to oversee nursing professional standards and key quality priorities. The group supports the alignment of existing workstreams, reduces duplication, and enables ward-level improvement by responding to areas of identified risk or deterioration. Pressure ulcer data remains a standing agenda item, supporting the identification of actionable hotspots and targeted improvement activity.

Performance during 2025/26 indicates that the focus on reducing low harm Category 2 pressure ulcers, including those tracked as a True North metric, did not result in a

corresponding reduction in moderate and severe harm pressure ulcers. The figures below demonstrate an increase in total numbers compared with 2024/25:

- **Category 3 pressure ulcers:** 304 (2024/25) → 347 (2025/26).
- **Category 4 pressure ulcers:** 24 (2024/25) → 30 (2025/26).

All newly developed or deteriorated Category 3 and Category 4 pressure ulcers continue to be reviewed through the weekly HARM meeting, where multidisciplinary actions are agreed, allocated, and closely monitored. Ongoing improvement work continues at care group level to strengthen root cause analysis, identify contributory factors, and reduce further lapses in care.



The Trust largely achieved the 15% reduction target for newly developed or deteriorated Category 2 pressure ulcers, although performance was variable across quarters and care groups. Overall, performance demonstrates improvement compared with 2024/25, with SPC analysis showing no sustained special cause variation across the reporting period, as indicated by the green baseline trend line.

Priority 6: Discharge and Onward Referral

Aims for 2025/26

- To continue working to improve the quality and timeliness of discharges.
- To continue in the journey to improve effectiveness of board rounds in all wards.
- To progress towards a criteria led discharge methodology.

- To progress with Discharge to Assess transformational programme on pathways 1, 2 and 3 in conjunction with community health and social partners.
- We, as a system, are aiming to achieve an ambitious no criteria to reside ratio of 10%, super stranded ratio of occupancy of 12% and stranded ratio of occupancy of 40% by end of March 2027.

End of year position

A Trust-wide thematic review of discharge processes has been completed, with the final report submitted. The findings have been presented at both the Patient Experience and Safety Committee (PESCE) and the Patient Safety and Improvement (PSI) Group. In addition, the review has been shared with the ICB-led Quality of Discharge Group.

A total of 88 discharge-related incidents were analysed across the Trust.

Key Risk Themes

The review identified three principal areas of risk:

- Medication management and Electronic Discharge Notifications (EDNs).
- Communication failures across teams and organisations.
- Patient transport coordination and delays.

Recommended Actions

The following actions have been recommended to address the identified risks:

- Standardisation of communication processes across services and partner organisations.
- Strengthening of medication governance and control measures.
- Improvement of patient transport coordination and oversight.
- Establishment of a single, system-wide governance forum to provide enhanced oversight, shared metrics, and clear accountability across the system.

Improvement Plan

To support delivery of these recommendations, the following actions will be implemented:

- Establish a system-wide Quality of Discharge Working Group, involving system partners. Consideration will be given to appointing an independent Chair. This group will replace the current Discharge to Assess meeting.
- Develop an internal Trust assurance meeting focused on driving discharge improvements. Key outputs and themes will be escalated to the system-wide group for wider system alignment.

- Review and refine Datix reporting categories to ensure comprehensive capture and analysis of all discharge-related incidents.
- Develop and implement a more robust discharge checklist to reduce the risk of errors and improve consistency in discharge processes.
- Embed ongoing performance monitoring through the monthly Site Quality Report, while strengthening links into wider Trust governance structures to ensure sustained oversight and accountability.

Priority 7: Food, Nutrition and Hydration

Aims for 2025/26

- Publish a Food, Nutrition and Hydration Strategy and associated improvement plan for 2025/26, supported by the recruitment to a new specialist Food Service Dietitian role.
- Work collaboratively with the Trust's digital teams to build effective food, nutrition and hydration-related screening tools, assessments, and documentation into the new electronic patient record.
- Continue quality improvement work in relation to provision of safe and effective care for patients with swallowing difficulties within our hospitals, underpinned by a robust Patient Safety Incident Investigation framework.
- Gain documented assurance on the competency, through sign-off against Observed Structured Clinical Examination (OSCE), of all clinical staff who insert and provide ongoing management of nasogastric feeding tubes for adults, children, and neonates. We will publish a new Trust policy for nasogastric and Naso jejunal feeding tubes.

End of year position

- At the end of Quarter 4, we published our new Food and Drink Strategy for 2026 – 2028: https://www.yorkhospitals.nhs.uk/seecmsfile/?id=8648; the associated improvement plan has yet to be published.
- In September 2025, we recruited a Food Service Dietitian into a 12-month, fixed term post.
- Nutrition- and hydration-related assessments, screening tools and recording templates were developed with the Trust's digital team and tested in readiness for the new electronic patient record going live; this includes the "MUST" (Malnutrition Universal Screening Tool) for adults and "STAMP" (Screening Tool for the Assessment of Malnutrition in Paediatrics) for children, comprehensive nutrition and hydration assessments for adults and children, digital fluid balance chart, digital fluid risk assessment and digital food and drink chart.
- Improvement actions from the Patient Safety Incident Investigation (PSII) were undertaken and signed off via the Patient Safety Incident group in February 2026,

in relation to improving the provision of the correct food and fluid textures for patients in hospital who have swallowing difficulties.
- Our first standalone Trust Enteral Feeding via Nasogastric (NG) and Nasojejunal (NJ) Tube policy has been published on the Trust's intranet.
- We have established partial records of all staff who have completed NG tube insertion and ongoing management training and who have been signed off as competent on insertion and ongoing management of NG feeding tubes (adults, children and neonates) using the "OSCE" (Objective Structured Clinical Examination) approach; this will be an ongoing priority for 2026/27.

Priority 8: Infection, Prevention and Control

Aims for 2025/26

- Refresh the IPC Board Assurance Framework.
- Develop and deliver a Trust IPC Improvement Plan which supports the delivery of the national Health Care Associated Infection thresholds.
- Deliver a 5% reduction of Meticillin sensitive Staphylococcus aureus bacteraemia.
- Embed the 5 agreed high impact IPC actions: bare below the elbow and effective hand hygiene, appropriate use of Personal Protective Equipment, when to take stool samples, decluttering the clinical areas and effective aseptic non-touch technique.

End of year position:

This section summarises Trust performance against the national Healthcare Associated Infection (HCAI) thresholds and the action being taken to reduce infection. The 2025/26 HCAI thresholds run from 1 April to 31 March and focus on reducing CDI and gram-negative bloodstream infections.

Although Meticillin-sensitive *Staphylococcus aureus* bacteraemia is not included in the NHS contract thresholds, the Trust set a local quality objective to achieve a 5% annual reduction.

Over the last 12 months we have strengthened the Infection Prevention and Control (IPC) governance arrangements across the Trust. Internal Audit have reviewed the governance and effectiveness of IPC meetings and returned an opinion of significant assurance. Care Group Infection Prevention and Antimicrobial Stewardship (AMS) groups are now established and running monthly and formally report to the Infection Prevention and Control Strategic Assurance Group. The care group meetings are a formal sub-group of the Care Group Governance and Management Board and their focus is to understand their IPC/AMS performance and deliver a Care Group specific HCAI/AMS improvement plan.

The IPC Board Assurance has been repeated in February 2026 and demonstrated that the Trust is partially compliant with 14 elements and fully compliant with 40

elements. A Trust IPC improvement plan, which focuses on 4 key improvement categories of: education and professional standards, clean and appropriate Healthcare environment, device related HCAI and surveillance of HCAI is in place, which is reported to the Infection Prevention Group (IPSAG) and the Quality Committee, a sub-committee of Trust Board.

The strengthened IPC governance has increased the ownership of IPC compliance within the Care Groups which has had a direct impact on the reduction of infection rates as the care groups discuss cases, learning and impact of improvement actions which are shared across the Trust via IPSAG.

Clostridioides difficile infection (CDI):

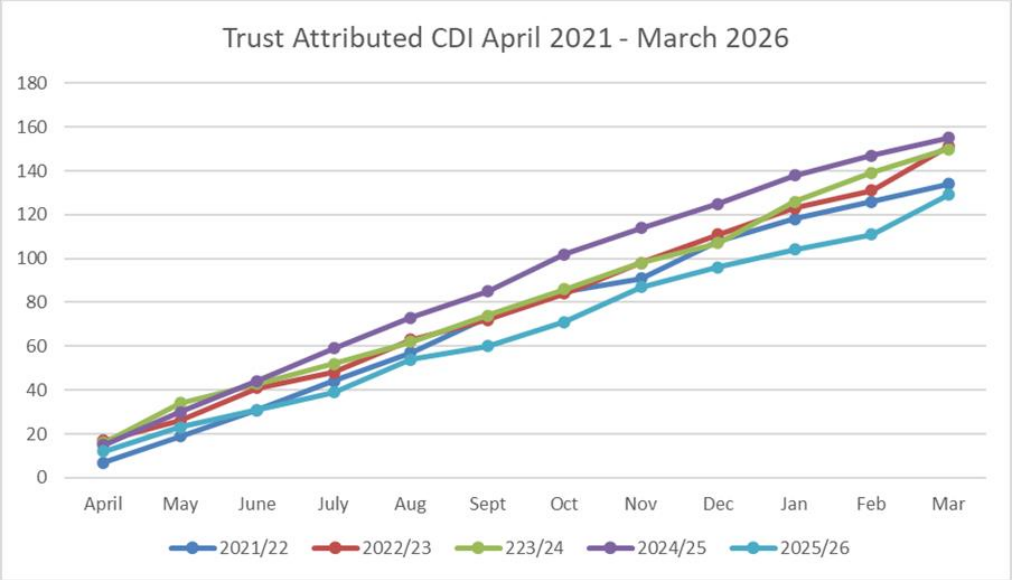
We have seen a significant reduction of Trust attributed *Clostridioides difficile* infection (CDI) in 2025/26 with the Trust recording 129 trust attributed cases; community onset (COHA) =46; hospital onset (HOHA) = 83, 15 cases under the threshold and 26 cases less than the previous year. This is the lowest number of Trust attributable cases in 5 years, with the highest number of cases being recorded in 2024/25, see Figure 1. 60% of the cases are attributable to York Hospital, 35% of the cases are attributable to Scarborough and Bridlington Hospital and 5% are attributable to the community units.

The Trust has been ranked at 1 in the NHS Oversight Framework (quarter 3 2025/26 data) due to the improvement in case numbers. The Trust does acknowledge that there are still improvements to make as despite reducing our number of cases we still remain above the national rate per 100,000 bed days.

Specific action taken to reduce CDI cases has included:

- Refreshing the CDI review process and having a weekly infection review meeting with all care groups present.
- Audit of each case to review compliance with clinical guideline with face to face training to areas where there are gaps in compliance.
- Clinical summit approach with any areas that have a period of increased incidence, with a written improvement plan which is owned by the ward/department manager.
- Recognising and celebrating successes such as the "Golden Commode" award and the soon to be launched "Sparkling Sluice" award.

Figure 1 Trust attributed Clostridioides difficile cases 1st April 2021 to 31st March 2026.



Blood stream infections (Bacteraemia):

Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia:

The Trust attributed annual objective for 2025/26 was set at zero cases. The Trust ended the year with 7 cases, with 4 (57%) attributed to York Hospital, 3 (43%) attributed to Scarborough Hospital.

Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia:

The Trust is under the internal objective for MSSA bacteraemia, recording 81 cases, with 57% attributed to York, 41% attributed to Scarborough and Bridlington Hospitals and 2% to the community sites. The output for 2024/25 was 92 cases. The Trust set an internal target of a 5% reduction but achieved 12% reduction, however we remain over the national rate per 100 000 bed days.

E.coli bacteraemia:

The Trust has exceeded its annual objective by 17 cases, reporting 187 Trust attributed cases with 61% attributed to York, 34% attributed to Scarborough and Bridlington and 5% attributed to the community sites.

Klebsiella Bacteraemia:

The Trust has exceeded its annual objective by 17 cases, reporting 187 Trust attributed cases with 61% attributed to York, 34% attributed to Scarborough and Bridlington and 5% attributed to the community sites.

Pseudomonas Bacteraemia:

The Trust has exceeded its annual objective by 16 cases, reporting 32 Trust attributed cases with 69% attributed to York and 31% attributed to Scarborough and Bridlington hospitals.

The Trust has commenced a programme of reducing Trust attributed E.coli, Pseudomonas and Klebsiella Bacteraemia in January 2026 and since then we have seen a significant reduction in the number of Trust attributed cases.

Specific action taken to reduce the bacteraemia cases has included:

- Audit of peripheral cannula management and improvement actions built into the Trust IPC improvement plan.
- Ongoing compliance checks of Visual Infusion Phlebitis (VIP) scores which is the responsibility of the Ward/Department manager.
- Point Prevalence audit of urinary catheters.
- A task and finish group supported by the QI team has been established following the point prevalence audit of catheterised in-patients. The key areas identified for improvement are the introduction of the “HOUDINI” catheter protocol, consistent use of fixation devices and refreshing the urinary catheter care plans.
- A Trust IPC study day was delivered in October 2025 at Malton Rugby Club with the theme of IPC ownership at ward and department level and delivered sessions on CDI, Urinary Catheter Management, Antimicrobial Stewardship, Gram negative Blood Stream Infections and the review process of infections. The event was attended by circa 90 delegates and was well evaluated.

The overall HCAI performance for the organisation is showing signs of improvement and the IPC team are committed to change their working practice and improve the delivery of the IPC service. The governance, ownership and accountability for IPC has been strengthened within the care groups, as demonstrated by the internal audit results. The monitoring metrics are currently being reviewed to increase the assurance that the IPC team can provide to the organisation for 2026/2027.

Priority 9: Medication Safety

Aims for 2025/26

- Complete a Patient Safety Incident Investigation (PSII) into missed doses of insulin and support the development of an insulin safety group.
- Complete a thematic review of incidents relating to use of Lorazepam and Haloperidol in sedation.
- Complete the gap analysis and action plan in response to the HSIB report into missed doses of anticoagulants.
- Produce guidelines to support staff to challenge others if they are concerned about prescribing issues and commence medication safety walk rounds.
- Explore barriers to medication incident reporting to try and increase our reporting rates.
- Provide updated guidance on second checks for medicines administration.
- Support the annual yellow card week in November.

End of year position

- A Patient Safety Incident Investigation (PSII) into missed doses of insulin has been conducted and all identified safety actions completed. A Quality Improvement project on improving insulin administration has also been undertaken, with an associated reduction in missed doses of insulin and in hypoglycaemic events and an improvement in the timely administration of insulin. Further improvement cycles are planned and a Diabetes Safety Group is in the process of being established.
- A thematic review of anticoagulation incidents is currently being undertaken and a thematic review of benzodiazepines in sedation will be conducted later in the year.
- Developing a medication safety culture remains a priority within the Medication Safety Strategy, achieved through embedding medication safety in Care Groups and Ward Teams and sharing learning from medication incidents and alerts. Medication Safety walk rounds are due to be implemented later in the year.
- Medication incident reporting rates are monitored through the Medication Safety Group. Over the last year, there has been a consistent reduction in the number of medication related incidents reported associated with harm and improving incident report rates remains a priority within the Medication Safety Strategy and associated work plans.
- There is a clear guidance in the Trust Medicines Code about when second checks for medicines are required by nurses. A project to further reduce second checking in paediatrics has also been undertaken successfully.
- A campaign to promote yellow card reporting has been undertaken and reporting for the Trust has increased by 97% from the previous year placing us as the 6th highest reporter in the Northern and Yorkshire regions.

In summary, the organisation has made strong progress against its stated aims for 2025/26, with ongoing work to embed a culture of medication safety, robust governance, and continuous learning.

Priority 10: Quality Improvement

Priorities for 2025/26

- We will develop and establish a QI Community/Network to promote shared learning. The network will have had its first meeting by September 2025.
- We will review and develop the QI training across the Trust by April 2026 to ensure we understand the benefit realisation from the investment into training.
- We will continue to support the organisation to create a continuous improvement culture through 2025/26 to deliver against the strategy. Our first simple step will be to conduct a spring clean across the Trust using 5S+safety method. This will introduce a simple tool to staff which they can apply to other aspects of their work.

End of year position

The QI Community/Network was successfully established, with the first meeting held in September 2025, as planned. Since then, the network has continued to grow through regular coaching circles and drop-in sessions across the year. This has created a space for shared learning and practical support. Senior representation from the operations team has also strengthened the network, helping to shape and deliver focused workshops on key topics that directly support improvements in quality of care for our patients.

The review of QI training across the Trust has been completed and is continuing into 2026/27. This work is helping us better understand the benefits of our investment in training. Benefit realisation is being seen in both measurable outputs from projects and in the wider impact of building a culture of improvement across the organisation. This includes increased engagement, shared learning, and the development of staff capability in quality improvement. QI training improves staff engagement by helping people understand how their day-to-day work links to the wider goals of the Trust. When staff are trained, they feel more confident to spot problems and suggest improvements. It also gives them simple tools to act on their ideas rather than just raising concerns. Over time, this builds ownership, where staff see improvement as part of their role rather than something done to them. Training also creates a shared language and approach, which helps teams work together and learn from each other. The result is more motivated staff, more involvement in change, and a stronger culture where improvement becomes “everyone’s responsibility.”

The Trust has continued to support the development of a continuous improvement culture throughout 2025/26, including the rollout of the 5S + safety approach across wards and teams. This simple and practical method has helped staff organise their environments more effectively. The benefits have been seen in a range of areas, including cash-releasing schemes, more efficient and tidy working environments, and improved patient care through having the right equipment available in the right place at the right time.

2.1.2 Clinical Effectiveness Priorities

Priority 1: We will review and rationalise our clinical policies, Standard Operating Procedures (SOPs) and guidelines to ensure they are current, accessible and support safe care.

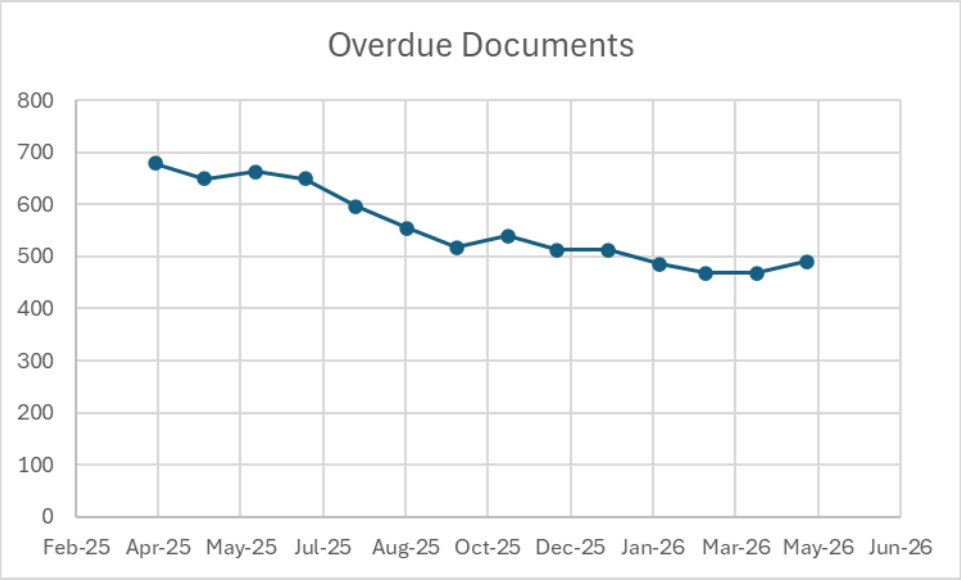
Clear and up-to-date documentation supports staff to deliver safe, consistent and effective care.

Oversight of overdue and soon-to-be overdue documents is maintained through the Clinical Outcomes and Effectiveness Group, with a monthly position report produced to provide visibility of performance across Care Groups. A formalised tracking process is in place, supported by the Q-Pulse system, although variation remains due to documents held in local systems or specialty-specific modules.

A structured process has been established, including advance notifications at six months and three months prior to review dates, enabling authors to plan updates and reduce the number of expired documents. This has contributed to a reduction in the number of overdue documents and improved governance oversight.

End of year position

- The number of overdue documents has continued to reduce over time, alongside an increase in documents formally “under review,” demonstrating improved engagement and control of the review cycle.



- Governance processes have been strengthened through routine reporting, escalation through committee structures, and clearer allocation of responsibility for document ownership.

Priority 2: We will improve the quality and consistency and accessibility of patient information through the procurement of EIDO (a digital patient information platform).

There is a recognised risk that patient information may be inconsistent, outdated, or not aligned with current clinical pathways, which can impact patient understanding, informed consent, and experience of care. Introducing a standardised, evidence-based digital information system, such as EIDO, supports safer care, improves patient experience, and strengthens clinical effectiveness.

EIDO is a digital system providing standardised, evidence-based patient information and consent materials to support informed decision-making and improve the consistency and quality of patient information.

End of year position

- We have procured all patient information leaflets through the EIDO platform and all accessibility and language options available.
- The EIDO patient information leaflets are accessed through the Trust intranet.
- A reconciliation of Trust produced leaflets and those available through EIDO has been completed. Work is underway to archive Trust documentation and replace this with EIDO information.

2.1.3 Patient Experience Priorities

Our delivery against the patient experience priorities for the 2025/2026 financial year is outlined below.

Priority 1: Improving patient and carer experience of our concerns and complaints processes

Patient, family and carer feedback is central to the Trust's approach to quality and improvement. It provides an important insight into how our services are experienced and highlights what matters most to those who rely on our care. By listening to feedback, the Trust can reflect on the standard of care delivered, recognise good practice, and identify opportunities to improve where expectations have not been met.

End of year position

- During 2025/26 the Trust received 1178 formal complaints compared to 1124 in 2024/25, representing an increase of 5%. This equates to an average of 23 complaints per week. In 34% of cases, investigations concluded that no failings in care were identified. This highlights opportunities to improve communication, manage patient expectations more effectively, and strengthen overall patient experience.
- Overall Care Group performance in responding to complaints within agreed timescales was 57%, an improvement from 49% in the previous year. While this demonstrates progress, the overall position reflects the ongoing challenges associated with increased complaint volumes and wider service pressures.
- We have introduced Parliamentary and Health Service Ombudsman (PHSO) training alongside complaint response letter-writing skills training to support the delivery of clear, compassionate and patient-centred complaint responses.
- In June 2026 we held a rapid process improvement workshop.
- A new concerns and complaints form, co-produced with Healthwatch, has been developed to improve accessibility and ease of use.
- Bedside handovers have been implemented at ward level to strengthen communication and engagement with patients, relatives and carers, enabling concerns to be identified and addressed more promptly.

Priority 2: Supporting the delivery of the Accessible Information standards through the new electronic patient record system

Initiatives were identified to support the delivery of the statutory Accessible Information Standards and the Trust's wider health inequalities agenda.

End of year position

- Launch of an Accessibility Hub on the Trust's website to help ensure they can access the care they need. The hub includes information about accessible parking, accessible toilets, the new animal spending area at York hospital, how to request information in a range of formats e.g. audio, large print and braille, and how to request an interpreter for an appointment.
- Introduction of visual communication tools and picture food menus.
- Improved support for assistance animal access.
- Collaboration with digital inclusion partners to support access to online health information including supporting the public to use platforms such as AccessAble, Reach Deck and Interpreters Live to assist patients in accessing information on our website and online platforms including the NHS app.
- Working with York St John University and people with lived experience, the Trust coproduced an information video to support neurodivergent patients attending urgent and emergency care at York hospital. The resource has been positively

received by parents/carers and is now used as both patient preparation tool and staff training resource.

Priority 3: Procurement of the new supplier for the national patient surveys

The Trust continues to participate in the NHS Patient Survey Programme, commissioned by the Care Quality Commission (CQC) providing nationally comparable insight into patient experience and assurance regarding the quality of care.

Survey results are reviewed through established governance routes, including Care Group forums and Trust-wide committees, ensuring learning informs both local and strategic improvement plans.

Following a full procurement process, IQVIA was appointed as the Trust's new national survey provider from May 2025, ensuring continuity and quality assurance in survey delivery. This is a phased transition due to the timing of the national surveys so that the surveys reported below were supported by the previous provider.

End of year position

National Adult Inpatient Survey 2024

Results published in September 2025 from the Adult Inpatient Survey 2024, showed patient experience to be broadly stable and in line with national averages. Areas of strength included respect and dignity, kindness and compassion, and privacy during care and treatment.

As in previous years, the survey highlighted opportunities for improvement in areas including waiting times, noise at night, food outside of mealtimes, and information provided at discharge, particularly around ongoing support after leaving hospital. These findings are informing our improvement actions within inpatient services.

National Children and Young People's Survey 2024

Published in May 2025, The Children and Young People's Survey (2024), demonstrated performance in line with national benchmarks, with positive feedback regarding staff attitudes, privacy, and parental and carer involvement. Improvements focus on communication, information provision support during hospital stays, particularly for older children and young people.

National Maternity Survey 2025

Published in December 2025, results from the Maternity Survey (2025), highlighted strong performance in mental health discussions, multidisciplinary working and pain management during labour.

Areas requiring improvement included partner involvement post birth, feeding support at nights and weekends, and communication on postnatal wards. These actions are embedded within the Maternity and Neonatal Single Improvement Plan.

National Cancer Survey 2024

Published in July 2025 the National Cancer Survey results reflected high levels of confidence in quality, timeliness and staff helpfulness.

Improvement actions are focused on providing holistic patient care including wellbeing and advice for care planning during treatment phase, confidence and trust in staff during stay in hospital, including family access and involvement in decision making, pain management and time to speak with ward staff, access to cancer research opportunities and environmental factors such as car parking, food and treatment rooms.

Priority 4: Procurement of the new supplier for the Friends and Family test

The Friends and Family Test (FFT) provides timely insight into patient experience. During 2025-2026, the Trust transitioned to a new FFT service provider, Gather It Limited, introducing a digital-first approach, while retaining paper options to ensure accessibility.

End of year position

- The new FFT service went live in September 2025 and has delivered significantly higher response rates (11-22%) compared with the national averages (typically 4–10%).
- The FFT delivers core questions to all patients and has provided flexibility for us to adapt questions relevant to specific services. The surveys include standardised demographic questions enabling services to identify disparities in experience and take action to improve their services for everyone.
- Standardised demographic questions support identification of disparities in experience.
- The new service has improved the timeliness for staff at ward and department level being able to access insights from patients completing the survey, therefore enabling us to celebrate good care and the prompt identification of areas requiring improvement.

Priority 5: Procurement of the new translation and interpretation service provider

The tender process for the future provider is being managed by the Humber and North Yorkshire Procurement Collaborative. Trusts taking part in this procurement include Northern Lincolnshire and Goole NHS Foundation Trust, Hull University Teaching Hospitals NHS Trust, York and Scarborough Teaching Hospitals NHS Foundation Trust and Humber Teaching NHS Foundation Trust.

The tender went live in June 2025, with the aim to award the contract in October 2025.

- All assessors were trained on the evaluation process by Hempsons Solicitors, with re-evaluation overseen by the procurement lead. This was completed in March 2026.
- Communications, IT, and Information Governance teams on standby to implement changes once a new provider is confirmed.
- Transition plan in place, with Care Groups aware of potential timescales and impacts.

End of year position

- A legal challenge to the tender for the new interpreting contract has delayed transition from Autumn 2025 to Summer 2026.
- We have agreed a contract extension with our current provider ensuring continuity of translation and interpreting services.

Priority 6: Developing and implementing our Carers Improvement Plan

The Trust recognises the essential role of unpaid carers and identified the need to work with carers and carers organisations to further improve experience for carers who provide essential support to patients. Unpaid carers play a vital role in supporting patients' health, wellbeing, and recovery, yet their needs can often be overlooked.

An improvement group, chaired by the Associate Chief Nurse for Community, was established in September 2024. Since then, we have engaged with a range of carers to understand what's important to them when accessing health services. As a result of this work, the Carers Charter was developed, alongside our improvement plan.

End of year position

- The Carers Forum supported the co-production of the Trust's carers improvement plan and a new Unpaid Carers Charter.
- We co-created the 'Supporting those who support others' icon to help unpaid carers feel seen, understood and supported. This was developed by a group of local health and social care organisations across North Yorkshire. The icon is a simple visual prompt identifying that the service recognises the everyday pressures of unpaid carers.
- A new 'Carers Hub' has been established on the Trust website and provides guidance and resources for carers accessing hospital services.
- We have established new volunteer positions of Carers Champions who will be designated points of contact to assist carers in navigating hospital services. The

role description of Carers Champion was co-created with carers representatives and carers.

- We have developed and piloted a carers workshop for staff to increase their understanding of the role of carers and programme in collaboration with Carers Plus. This training helps colleagues and volunteers recognise carers as partners in care, ensuring we meet our statutory duties and deliver compassionate, inclusive services across the Trust. The programme will be rolled out in the new financial year.

2.2 Our priorities planned for 2026/27

Improving quality is a continuous cycle – one that takes account of where we are now but aiming ahead to where we want to be. Reaching that aim requires change which comes from refinement, implementing new ideas and removing areas of work that are not necessary. Often the greatest difference is made by the first changes and improvements get smaller as time moves on. Some of the priorities in section 2.1 have been retired because the potential for large scale change is limited. Retiring priorities doesn't mean that we stop working to make improvements. That work carries on by subject experts working with staff; collecting data and providing assurances to monitoring groups and committees.

Retiring priorities allows us to focus on new priorities where we can aim to make the biggest difference. These priorities are identified from a range of information such as feedback from patients, data from incidents, changes noted from routine monitoring.

2.2.1 Patient Safety Priorities

Priority	Current position (25/26)	Aim (26/27)
Ongoing development and review of the Patient Safety Incident Response Framework (PSIRF), fostering a stronger patient safety culture and ensuring when approved the effective implementation of the updated PSIRF priorities.	-The revised PSIRF priorities are going through internal approval processes. -Development of an inhouse PSIRF training programme has been progressed to ensure a proportionate approach aligned to NHS England expectations and replaces the previously externally provided programme.	-The Trust will have established core PSIRF priorities, each supported by robust oversight mechanisms to track progress towards enhanced patient safety. -A rise in incident reporting signaling a stronger safety culture. -Improved Patient Safety related staff survey results by increased cross service working such as the Freedom to Speak Up.

Priority	Current position (25/26)	Aim (26/27)
		-To deliver PSIRF training in-house by the Trust through three core modules covering systems-based learning, oversight, and compassionate engagement.
Falls *'Reducing the number of falls with harm'*	- 11% reduction in Falls resulting in moderate or above harm was achieved between 2024/25 and 2025/26	-To achieve a further 15% reduction in falls resulting in harm compared with the data recorded for 2025/26.
Pressure-Related Skin Damage: 'Reducing the incidence of Category 2 pressure ulcers attributed to the Trust'	-The Trust largely achieved the 15% reduction target for newly developed or deteriorated Category 2 pressure ulcers	To achieve a further 20% reduction in Category 2 pressure ulcers, based on 2025/26 data.
A reduction in the number of MSSA (Methicillin-Sensitive Staphylococcus aureus) infections	The Trust set an internal target of a 5% reduction but achieved 12% reduction, however we remain over the national rate per 100 000 bed days.	To achieve a further 5% reduction in MSSA (Methicillin-Sensitive Staphylococcus aureus) infections, based on 2025/26 data.

2.2.2 Clinical Effectiveness Priorities

Priority	Current position (25/26)	Aim (26/27)
We will improve how we review, implement and monitor new and updated NICE guidance to ensure patients receive care aligned with best available evidence.	Updates to guidance are circulated to governance teams to action.	A strengthened assurance framework for NICE implementation Clear reporting through the Clinical Outcomes and Effectiveness Group Evidence that new and revised guidance is consistently embedded into practice.
We will strengthen our clinical audit programme to improve participation, learning and quality improvement across all services.	Local audits plans produced but need further Trust-wide co-ordination.	Delivery of a comprehensive local audit programme. Increased participation in national clinical audits Evidence of learning implemented and

Priority	Current position (25/26)	Aim (26/27)
		improvements made following audit findings.
We will strengthen our approach to responding to external regulatory inspections, ensuring that learning is embedded and sustainable improvements are delivered across the Trust.	Embedded process to respond to regulatory inspection.	Demonstrable improvement against areas identified for action Positive assurance through ongoing internal and external review, including the Trust response to the January 2025 CQC inspection.

2.2.3 Patient Experience Priorities

Priority	Current position (25/26)	Aim (26/27)
Education, to equip staff with the confidence and capability and personal accountability to communicate effectively.	Baseline data currently being established as at the time of writing the report	100% of Investigating Officers to have completed PHSO complaints training.
Timely resolution of complaints, ensuring that those that cannot be resolved immediately are managed within policy timescales.	On average 57% of complaints meet the Trust's 30 day response target. On average 44% of complex complaints meet the Trust's 45 day response target.	90% of complaints to be resolved within 30 working days for complaints and 45 working days for complex complaints.

2.3 Statements of assurance from the Trust Board

The Quality Account regulations require Trusts to comment on specific aspects of their services. These are described below but exclude an update on the 'Commissioning for Quality and Innovation' (CQUIN) scheme as this was discontinued in 2023/24.

Review of services

During 2025/26, the York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTH) provided a wide range of clinical services in over 90 different treatment specialties. During the year the Trust had outsourcing agreements with 22 organisations.

The income generated by the NHS commissioned services reviewed in 2025/26 represents 89% of the total income generated from the provision of services by the YSTH for 2025/26.

Participation in clinical audits

National clinical audits

During 2025/26 68 national clinical audits and 6 national confidential enquiries covered NHS services that YSTH provides. During that period YSTH participated in 96% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The two tables below show:

- The national clinical audits and national confidential enquiries that YSTH was eligible to participate in during 2025/26.
- The national clinical audits and national confidential enquiries that YSTH participated in during 2025/26, and for which data collection was completed during 2025/26, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audit	Eligible	Participated	Numbers submitted (by % or total number)
BAUS - British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Y	At the time of publication awaiting confirmation from clinical lead	TBC
BAUS - Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Y	Y	Data for 2025/26 is not yet available
CMP Case Mix Programme	Y	Y	100%
RCEM Emergency Medicine QIPs - Adolescent Mental Health	Y	Y	Data for 2025/26 is not yet available
RCEM Emergency Medicine QIPs - Care of Older People	Y	Y	Data for 2025/26 is not yet available
RCEM - Emergency Medicine QIPs - Mental Health Self Harm	Y	Y	Data for 2025/26 is not yet available
RCEM Emergency Medicine QIPs - Time Critical Medications	Y	Y	Data for 2025/26 is not yet available
Epilepsy12 National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	Data for 2025/26 is not yet available
FFFAP Falls and Fragility Fracture Audit Programme - NAIF National Audit of Inpatient Falls	Y	Y	Data for 2025/26 is not yet available
FFFAP Falls and Fragility Fracture Audit Programme - NHFD National Hip Fracture Database	Y	Y	Data for 2025/26 is not yet available
LeDeR Learning from lives and deaths of people with a learning disability and autistic people	Y	Y	Only national-level data is available
MBRRACE UK Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Morbidity Confidential Enquiry - annual topic based serious maternal morbidity	Y	Y	Only national-level data is available
MBRRACE UK Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality Confidential Enquiries	Y	Y	Only national-level data is available
MBRRACE UK Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality Surveillance	Y	Y	Only national-level data is available
MBRRACE UK Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality and Serious Morbidity Confidential Enquiry	Y	Y	Only national-level data is available
NDA National Diabetes Audit - Adults - National Core Diabetes Audit	Y	Y	100%

National clinical audit	Eligible	Participated	Numbers submitted (by % or total number)
NDA National Adult Diabetes Audit - NDFA National Diabetes Footcare Audit	Y	Y	100%
NDA National Adult Diabetes Audit - NDISA National Diabetes Inpatient Safety Audit	Y	Y	33.3%
NDA National Adult Diabetes Audit - NPiDA National Pregnancy in Diabetes Audit	Y	Y	Data for 2025/26 is not yet available
NDA National Adult Diabetes Audit - Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Y	Data for 2025/26 is not yet available
NACR National Audit of Cardiac Rehabilitation	Y	Y	100%
NACEL National Audit of Care at the End of Life	Y	Y	74.9%
NAD National Audit of Dementia: Care in General Hospitals	Y	N	Data collection did not take place in 2025/26
NBSR National Bariatric Surgery Registry	Y	Y	100%
NATCAN National Cancer Audit Collaborating Centre - NAoME National Audit of Metastatic Breast Cancer	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - NAoPri National Audit of Primary Breast Cancer	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - NBoCA National Bowel Cancer Audit	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - NKCA National Kidney Cancer Audit	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - NLCA National Lung Cancer Audit	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - NNHLA National Non-Hodgkin Lymphoma Audit	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - GICAP National Gastro-intestinal Cancer Programme - NOGCA National Oesophago-Gastric Cancer Audit	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - NOCA National Ovarian Cancer Audit	Y	Y	Data for 2025/26 is not yet available
NATCAN National Cancer Audit Collaborating Centre - NPaCA National Pancreatic Cancer Audit	Y	Y	Data for 2025/26 is not yet available

National clinical audit	Eligible	Participated	Numbers submitted (by % or total number)
NATCAN National Cancer Audit Collaborating Centre - NPCA National Prostate Cancer Audit	Y	Y	Data for 2025/26 is not yet available
NCAA National Cardiac Arrest Audit	Y	Y	Data for 2025/26 is not yet available
NCAP National Cardiac Audit Programme - NHFA National Heart Failure Audit	Y	Y	Data for 2025/26 is not yet available
NCAP National Cardiac Audit Programme - CRM Cardiac Rhythm Management Audit	Y	Y	Data for 2025/26 is not yet available
NCAP National Cardiac Audit Programme - MINAP Myocardial Ischaemia National Audit Project	Y	Y	Data for 2025/26 is not yet available
NCAP National Cardiac Audit Programme - NAPCI Percutaneous Coronary Interventions	Y	Y	Data for 2025/26 is not yet available
NCMD National Child Mortality Database	Y	Y	100%
NCABT National Comparative Audit of Blood Transfusion - 2025 Major Haemorrhage Audit	Y	Y	100%
NEIAA National Early Inflammatory Arthritis Audit	Y	Y	Data for 2025/26 is not yet available
NELA National Emergency Laparotomy Audit - Laparotomy	Y	Y	Data for 2025/26 is not yet available
NELA National Emergency Laparotomy Audit - No Laparotomy	Y	N	Unable to obtain data for 2025/26
NJR National Joint Registry - Ankles	Y	Y	Data for 2025/26 is not yet available
NJR National Joint Registry - Elbows	Y	Y	Data for 2025/26 is not yet available
NJR National Joint Registry - Hips	Y	Y	Data for 2025/26 is not yet available
NJR National Joint Registry - Knees	Y	Y	Data for 2025/26 is not yet available
NJR National Joint Registry - Shoulders	Y	Y	Data for 2025/26 is not yet available
NMTR National Major Trauma Registry (formerly TARN Major Trauma Audit)	Y	Y	Data for 2025/26 is not yet available
NMPA National Maternity and Perinatal Audit	Y	Y	Data for 2025/26 is not yet available
NNAP National Neonatal Audit Programme	Y	Y	Data for 2025/26 is not yet available
NOD National Ophthalmology Audit Database - Adult Cataract Surgery Audit	Y	N	Trust data has been submitted in the incorrect format
NPDA National Paediatric Diabetes Audit	Y	Y	Data for 2025/26 is not yet available
PMRT Perinatal Mortality Review Tool	Y	Y	Only national-level data is available

National clinical audit	Eligible	Participated	Numbers submitted (by % or total number)
NRAP National Respiratory Audit Programme - COPD Secondary Care	Y	Y	100%
NRAP National Respiratory Audit Programme - Pulmonary Rehabilitation	Y	Y	100%
NRAP National Respiratory Audit Programme - Adult Asthma Secondary Care	Y	Y	100%
NRAP National Respiratory Audit Programme - Children and Young People's Asthma Secondary Care	Y	Y	100%
NVR National Vascular Registry	Y	Y	Data for 2025/26 is not yet available
PQIP Perioperative Quality Improvement Programme	Y	Y	Data for 2025/26 is not yet available
SSNAP Sentinel Stroke National Audit Programme	Y	Y	100%
SHOT Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Y	Y	100%
UK Cystic Fibrosis Registry - Adult	Y	Y	100%
UK Cystic Fibrosis Registry - Paediatric	Y	Y	100%
UK Parkinson's Audit	Y	Y	Only national-level data is available
UK Renal Registry Chronic Kidney Disease Audit	Y	Y	100%
UK Renal Registry National Acute Kidney Injury Audit	Y	Y	100%

National confidential enquiry	Eligible	Participated	% cases submitted
NCEPOD Child Health Clinical Outcome Review Programme - Emergency Paediatric Surgery	Y	Y	100%
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Rehabilitation following Critical Illness	Y	Y	100%
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Blood Sodium Study	Y	Y	100%
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Acute Limb Ischaemia	Y	Y	100%
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Acute Illness in People with a Learning Disability	Y	Y	100%
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Stabilisation of the Critically Ill Child	Y	Y	100%

The reports of 48 national clinical audits were reviewed by the provider in 2025/26 and YSTH intends to take the following actions to improve the quality of healthcare provided.

Local clinical audits

During the period, a comprehensive programme of internal audits has been undertaken to monitor compliance with key clinical and documentation standards.

Within the Medicine Care Group this has included ward-level audits, often initiated in response to complaints, patient safety incidents, and Datix themes, with findings reviewed through Care Group governance structures to inform targeted improvement plans. All actions are recorded on Datix to ensure a transparent audit trail from identification to resolution. Audits are led by Ward Managers and Matrons, supported by multidisciplinary teams, with data triangulated across Datix, Tendable, and Synbiotix environmental dashboards to ensure consistent oversight. Each ward and clinical area maintains a Standard Improvement Plan, reviewed monthly in Ward Manager–Matron 1:1s to monitor delivery, impact, and sustainability. Non-compliance and risks requiring escalation are reviewed at monthly Excellence Meetings, with unresolved issues escalated to senior nursing leadership for assurance and sign-off. Sustained improvement is supported through re-audit, dashboard monitoring, and leadership walk-rounds to ensure learning is embedded and standards maintained.

Audits during the year within Medicine Care Group have also included:

- Patient Identification in the Emergency Department.
- Safeguarding audits.
- Attendances at Same Day Emergency Care (SDEC).

An example of an audit undertaken within our Family Health Care Group regarded the Safe and Secure Handling of Medicines

A 12 month programme of quarterly audits within the Family Health Care Group reviewed the safe and secure handling of medicines in maternity settings throughout 2025–2026, led by pharmacy governance and nursing leadership.

The audit assessed medicines storage and prescribing practices, including to take out (TTO) documentation on the electronic prescribing and medications administration system EPMA, with results showing moderate but variable compliance across York and Scarborough. While inpatient prescribing of Enoxaparin was consistently high, discharge prescribing compliance was lower and variable across sites.

Established controls include a central medicines policy, administration policies are in place on the staff intranet Staffroom, staff training, and regular teaching sessions, with further actions focused on improving medication storage conditions, secure handling of patient-specific medicines, and reducing unattended medications to strengthen safety and compliance.

Research

The number of patients receiving NHS services provided or sub-contracted by YSTH in 2025/26 that were recruited during that period to participate in research approved by the research ethics committee was 5385.

Commissioning for Quality and Innovation (CQUIN)

YSTH income in 2025/26 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the CQUIN scheme was paused by NHS England.

Care Quality Commission

York and Scarborough Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC), and its current registration status is “Registered with Conditions.”

Mental Health Risk Assessment – Section 31 Notice (Emergency Care)

Since January 2020, the Trust has been operating under a Section 31 Notice requiring improvements to the mental health risk assessment process within emergency care. To address this, the Trust initially introduced a paper-based mental health risk assessment proforma, with monthly compliance submissions provided to the CQC.

To further strengthen safety and improve patient outcomes, the Trust developed an integrated Urgent and Emergency Care (UEC) risk assessment screening tool, incorporating mental health, falls and skin integrity assessments. The mental health component of this tool went live in April 2024.

The Trust continues to focus on enhancing staff capability through targeted training and support, alongside introducing a more therapeutic approach to enhanced observation. This work is led by the Mental Health Improvement Group, supported by a strong collaborative relationship with Tees, Esk and Wear Valleys NHS Foundation Trust, who contribute to training and specialist support.

Maternity Services – Section 31 Urgent Conditions Notice

Between October 2022 and March 2023, the CQC inspected Emergency and Urgent Care, Medical Care and Maternity Services. Following this inspection, the Trust received a Section 31 Urgent Conditions Notice relating specifically to maternity services, issued where the CQC identifies concerns requiring immediate action to mitigate risks and protect patient safety.

In response, the Trust delivered a comprehensive improvement programme, including strengthened local leadership, enhanced clinical risk governance, and

increased workforce and safety measures. As a result of sustained improvements, the Trust applied for removal of the Section 31 conditions, and the CQC approved this application in October 2025.

CQC Inspection Activity during 2025–2026

Urgent and Emergency Care and Medical Care Services York Hospital

In July 2025, the CQC published its report following the inspection of medical care services and urgent and emergency care at York Hospital, undertaken in January 2025. The report reflected the significant progress made, particularly within urgent and emergency care, which improved from ‘Inadequate’ to ‘Requires Improvement’. Medical care services were also rated ‘Requires Improvement’, with the ‘Caring’ domain rated ‘Good’, demonstrating the continued compassion, professionalism and commitment of our staff.

Urgent and Emergency Care and Medical Care Services Scarborough Hospital

An unannounced inspection was subsequently carried out at Scarborough Hospital in October 2025. The Trust was assessed across urgent and emergency care and medical care services, with inspectors reviewing whether services were safe, effective, caring, responsive and well-led.

The final report, published in March 2026, confirmed that medical care services had improved to an overall rating of ‘Good’, reflecting strengthened safety, effectiveness and leadership. Inspectors highlighted strong multidisciplinary working and the delivery of positive, patient-centred care. The report also noted areas requiring further improvement, including aspects of governance, ongoing training challenges for medical staff and the management of complaints.

Urgent and emergency care services received an overall rating of ‘Requires Improvement’. Inspectors identified several examples of good practice, including a positive learning culture, effective teamwork and a clear understanding among staff of how to raise concerns.

The report also acknowledges the significant operational pressures facing the service, including sustained high demand that continues to impact patient access, flow through the department, and delays in ambulance handovers. It further identifies areas where improvement is required, including strengthening infection prevention and control practices, improving assurance processes around consent, and ensuring more consistent documentation of ongoing patient assessments. The Trust recognises these challenges and is taking forward a focused programme of work to address them and support continued improvement.

Maternity Services
York and Scarborough Hospital sites

An unannounced onsite inspection of Maternity Services at the York and Scarborough Hospital sites took place between the 14 and 17 April. The inspection was a planned re-assessment following the 2023 inspection, where services were rated inadequate.

The Trust is committed to addressing all regulatory breaches identified in the CQC reports published during 2025/26. A structured improvement programme is in place to ensure that all required actions are delivered in full, supported by strengthened governance, clear accountability and enhanced monitoring through Trust Board and sub-committee oversight.

Secondary Uses Services
YSTH submitted records during 2025/26 to the Secondary Uses Service. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid General Medical Practice Code is given in the table below.

	Included valid NHS number	Included valid General Medical Practice Code
Admitted patient care	99.8%	99.5%
Out-patient care	100.0%	99.9%
Accident & Emergency care	99.2%	98.7%

Information governance / data security

The final submission for the 2026 Data Security and Protection Toolkit will be undertaken on 30th June 2026 and therefore the information cannot be included in this report.

Background

In the NHS, information is essential for the clinical management of individual patients and the efficient provision of services and resources.

Information Governance provides a framework to ensure that patient information is fairly obtained, securely handled, properly maintained, and readily accessible to staff with a legitimate reason to access it, to facilitate the provision of high-quality healthcare services.

Our commitment to the fundamental principles of data protection, confidentiality and privacy means our patients can be assured that their information will be always handled legally and appropriately.

Data Security and Protection Toolkit

The Trust measures its performance against the Data Security and Protection Toolkit, a set of standards established by the National Data Guardian (NDG) and the Department of Health and Social Care (DHSC). The Toolkit was updated this year to reflect the Cyber Assurance Framework, introducing more rigorous and comprehensive requirements.

At the final submission in June 2025, the Trust achieved compliance with 31 of the 47 assessed outcomes (66%), falling short on 16 outcomes (34%). While this reflects partial progress, the Trust remains unlikely to achieve full compliance in the next assessment cycle under current conditions.

In response, an improvement plan has been submitted to NHS England. This plan outlines the actions being taken to address the areas of non-compliance and strengthen the Trust's overall data security and protection measures, with the aim of improving performance against the updated Toolkit standards in the future.

Information Asset Register

The Trust has established a basic Information Asset Register with entries from all Care Groups and Directorates. This allows us to understand how personal data is being processed across the Trust and highlight any risks to the accountable managers.

Data Protection Impact Assessments

Work has continued in relation to Data Protection Impact Assessments; these assessments enable the Trust to review any data protection and privacy risks. The Trust has 400+ assessments in place or open for review.

Clinical coding audit

YSTH was subject to the DSPT clinical coding audit during the reporting period by Grant Thornton. Clinical coding accuracy overall was found to be at Data Security and Protection Toolkit (DSPT) standards exceeded. This is the highest accuracy level that can be achieved and are an improvement on the previous external review, where DSPT accuracy standards were met, but not exceeded.

Data quality

Our Trust is continuing its major digital transformation programme with the rollout of the new Nervecentre electronic patient record (EPR) system across the organisation. This brings together a suite of applications that are instantly accessible wherever staff are working, helping to improve patient care, communication, and clinical workflow.

The new, modern, integrated EPR system will be delivered over three separate tranches. The following areas are now live:

- Patient Safety Bundle (PSB).

- Inpatient paperless and medical case notes.
- Urgent and emergency care.
- Bed management and flow.
- Investigation results (read only).
- Electronic prescribing and medicines administration (EPMA).

The full Nervecentre EPR will, over time, replace the current CPD system, allowing greater connectivity, leveraging of data, supporting evidence-based decisions, and improving patient care and experience. The system will allow for:

- Faster access to key patient data and information.
- Improved patient safety and care.
- System standardisation.
- Reduction in administrative burden and paperwork.

Learning from deaths

The NHS (Quality Accounts) Amendment Regulations 2017 published by the Department of Health and Social Care require mandatory disclosure of information relating to 'Learning from Deaths'. These regulations are detailed below, and relate to Regulation 27:

	Requirement	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
27.1	Total number of in-hospital deaths	561	480	548	603
27.2	No. of deaths resulting in a case record review or PSII investigation (requested reviews of patients who died in 24/25 or 25/26)	ME:561	ME:480	ME:548	ME:603
		SJCRS: 15	SJCRS:9	SJCRS:16	SJCRS:13
		PSII:6	PSII:2	PSII:2	PSII:1
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 24/25)	0	0	0	0

	Requirement	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 6	SJCR: 6	SJCR:	SJCR:0
		PSII:5	PSII:0	PSII:3	PSII:0
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0	0	0	0
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	0	0	0	0

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group.

[2] Reviews completed in 2025/26 after the 2024/25 Quality Account was published.

2.4 Reporting against core indicators

In this section a selection of topics is shown, and the results are given on performance for specific time periods. Comparisons with other trusts are given. The data is sourced from NHS Digital.

A) Summary Hospital level Mortality Indicator (SHMI) and Palliative Care Coding

The Summary Hospital-level Mortality Indicator (SHMI) is one method of measuring deaths in hospital. It is the ratio between the actual number of patients who die in our hospitals, or within 30 days of discharge, against the number that would be expected to die (based on England average figures), given the characteristics of the patients treated.

The England average SHMI value is always '1'. A value less than this represents better than average mortality. 'Bandings' show whether the SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'.

SHMI data is not adjusted for palliative (end of life) care because there is variation between trusts in how palliative care is recorded in the data (known as coding). Instead, the percentage of coded palliative care deaths is given.

Indicator	Reporting periods	Trust performance	National average (last reported time period)	Benchmarking (NHS Trusts with the highest and lowest values)
a) SHMI value and banding	Jan 25 to Dec 25	0.88 2 – As expected	1.00 2 – As expected	Highest 1.33 Lowest 0.70
	Jan 24 to Dec 24	0.95 2 – As expected	1.00 2 – As expected	Highest 1.33 Lowest 0.71
b) % deaths with palliative care coded	Jan 25 to Dec 25	26	44	Highest 69 Lowest 17
	Jan 24 to Dec 24	27	44	Highest 66 Lowest 17

B) Patient reported outcome measure (PROM)

Patient Reported Outcome Measures (PROMs) measure the improvements in wellbeing reported by patients after having surgery. It is measured using questionnaires.

Indicator	Reporting periods	Trust performance	National average (last reported time period)	Benchmarking (NHS Trusts with the highest and lowest values)
Hip replacement surgery	April 24 to Mar 25	96.3	89.5	Highest 100 Lowest 50
	April 23 to Mar 24	100	89.3	Highest 100 Lowest 80
Knee replacement surgery	April 24 to Mar 25	81.6	81.7	Highest 100 Lowest 61.4
	April 23 to Mar 24	75	81.1	Highest 100 Lowest 50
Groin hernia Varicose vein surgery	PROMs data collection on groin hernia and varicose vein procedures in England ceased on 1 October 2017. Historical data is unaffected.			

C) 28-day readmissions

This is the percentage of patients readmitted to hospital within 28 days of being discharged from hospital after an emergency admission. NHS Digital has not published an update of this data since 2012.
The data provided is local data reflecting 30-day readmissions

Indicator	Reporting periods	Trust performance	National average (last reported time period)	Benchmarking (NHS Trusts with the highest and lowest values)
a) % readmissions (0-15 years)	April 24 to March 25	16.0	National data not available	
	April 23 to March 24 (Updated)	16.3		
b) % readmissions (16 years and over)	April 24 to March 25	13.1		
	April 23 to March 24 (Updated)	12.7		

D) Responsiveness to personal needs

Prior to 2021/22 this data was obtained by averaging the scores of five questions from the National Inpatient Survey. Since then the data has not been collected or published by NHS Digital.

E) Family and friends test (staff)

Each year staff across England are invited to complete a survey about their experiences working at their trust. One of the questions asks staff their opinion of recommending the trust to others for care.

Indicator	Reporting periods	Trust performance	National average (last reported time period)	Benchmarking (NHS Trusts with the highest and lowest values)
% staff who would recommend the Trust as a provider of care to their family or friends	2025	46.7	60.8	Highest 88.4 Lowest 34.7
	2024	43.1	61.6	Highest 89.6 Lowest 39.7

F) Venous thromboembolism

Venous thromboembolism (VTE) is a blood clot which may occur in the legs or in the lungs. The re are many reasons for developing a clot and the chance increases when mobility is reduced such as when in hospital. All admitted patients aged 16 and over should be assessed for their risk of developing a clot so that preventative treatment can be given.

A national threshold of 95% has been set.

Indicator	Reporting periods	Trust performance	National average (last reported time period)	Benchmarking (NHS Trusts with the highest and lowest values)
% admitted patients who were risk assessed for VTE	Quarter 3 2025/26	14.9	92	Highest 99.2 Lowest 14.9
	Quarter 3 2024/25	13.7	91	Highest 99.5 Lowest 13.7

G) Clostridium difficile

Clostridium difficile (C. diff) is a bacteria that lives normally in the gut of some people. The bacteria produce spores which are passed out in the faeces and may contaminate surfaces or spread in the air. This is why cleaning and hand hygiene is so important in preventing the spread. C. diff infection may cause diarrhoea and bowel inflammation. The infection can spread very easily which, as well as illness, may lead to the closure of bays and wards.

Indicator	Reporting periods	Trust performance	National average (last reported time period)	Benchmarking (NHS Trusts with the highest and lowest values)
Rate per 100,000 bed days of cases of C. difficile infection reported amongst patients aged 2 or over	April 24 to Mar 25	32.4	23.3	Highest – 81.0 Lowest – 1.8
	April 23 to Mar 24 (Updated)	36.3	20.9	Highest – 63.0 Lowest – 0.0

H) Patient safety incidents

Sometimes patients may have a patient safety incident (PSI) whilst in hospital. These are unexpected and unintended events such as falling or being given the wrong dose of medication. Most incidents do not lead to harm, but others do. Incidents are reported by staff onto an electronic system, Datix. This data is uploaded into a national system where incident reporting patterns, types of incidents etc can be analysed.

Indicator	Reporting periods	Trust performance	National average (last reported time period)	Benchmarking (NHS Trusts with the highest and lowest values)
Number & rate of patient safety incidents	Quarter 3 2025/26	58.2	64.3	Highest 201.6 Lowest 13
	Quarter 3 2024/25	48.6	62.8	Highest 262.8 Lowest 1.1

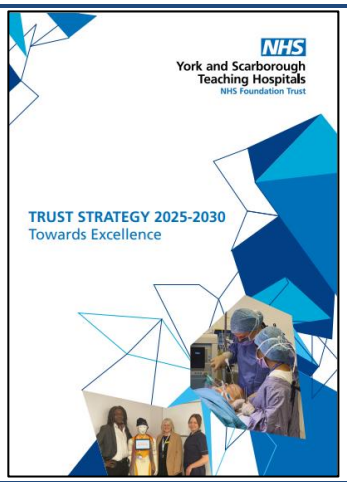
Note: rate is per 1,000 bed days

PART 3

This part of the report provides highlights of some of the other quality improvement initiatives undertaken during the year. The performance against national indicators is also provided.

3.1 Our strategy for quality

2025 saw the approval of the Trust Strategy (2025-30) *'Towards Excellence'* which outlines six objectives. These include people, digital and quality, each supported by their own enabling strategy.



Trust Strategy – *Towards Excellence*

Our purpose:
To deliver excellent healthcare every day

Our ambition:
To provide an excellent patient experience every time

Strategic objective 1:
To provide timely, responsive, safe, accessible and effective services at all times

The strategies set the direction for the next five years which will be delivered through a series of annual plans. Coordinating, measuring and monitoring progress is achieved through:

- A robust governance structure comprising work groups, monitoring groups and assurance committees.
- The use of business intelligence systems to gather and present data.
- The roles and responsibilities of key members of staff for quality management.

3.2 Quality highlights

Our Year in Review 2025-26
Delivering high-quality care through our people and for our patients

April 2025

Bridlington Hospital accredited as elective surgical hub

To start the financial year, Bridlington Hospital achieved NHS England accreditation as an elective surgical hub – a significant milestone in improving planned care. With dedicated theatres, expert teams and ring-fenced beds, the hub delivered faster

access to surgery, fewer cancellations and consistently high standards of patient-centred care.

May 2025

£47 million emergency care centre opened at Scarborough Hospital

Scarborough Hospital opened its £47 million Urgent and Emergency Care Centre – the Trust's largest ever investment. The facility brought together emergency, same-day and acute medical services with advanced diagnostics, transforming urgent care and delivering faster, more coordinated treatment for the region's most seriously ill patients.

Asthma Friendly Schools initiative launched across York

The Trust also launched the 'Asthma Friendly Schools' initiative across York, equipping schools with training and resources to improve support for pupils with asthma. The programme strengthened asthma management and created safer environments for children living with the condition.

June 2025

Lung cancer screening launched in Bridlington

The first patients in Bridlington received invitations for the Lung Cancer Screening Programme, supporting earlier diagnosis of lung cancer and other conditions. Delivered through NHS England's National Cancer Programme, the rollout began in Bridlington, focusing on areas with higher deprivation, smoking rates and later-stage diagnoses. More than 7,000 eligible people were invited, with screening starting via telephone assessment and, where appropriate, a low-dose CT scan on a mobile unit – improving outcomes and tackling health inequalities.

July 2025

Consultant received national award for cancer research

York Hospital's Consultant Oncoplastic Breast Surgeon, Jenny Piper, received a Medipex NHS Innovation Award for developing a pioneering breath test for early breast cancer detection. The award recognised collaborative research advancing diagnosis and screening, with the potential to transform future cancer care.

August 2025

Construction began on York Hospital's new hybrid theatre and MRI facility

This month, work began on York Hospital's £8 million hybrid theatre and MRI facility, combining surgical and imaging technologies to enhance diagnostics, vascular treatment and timely access to high-quality care.

York Hospital opened newly refurbished Women's Unit

Following an eight-month transformation, York Hospital opened its refurbished Women's Unit. The modernised space improved privacy, dignity and comfort – supporting complex treatments, acute gynaecological care and early pregnancy assessment in a purpose-designed environment.

September 2025

Trust joined national trial for groundbreaking cancer vaccine

In September, we joined a national NHS initiative to trial an innovative mRNA cancer vaccine for advanced head and neck cancer. Part of the Cancer Vaccine Launch Pad, the BioNTech-developed vaccine aimed to train the immune system to target and destroy HPV-related cancer cells.

Trust launched new breakthrough service for cancer patients

York Hospital also began delivering a major advance in diagnostics with the launch of its new Endoscopic Ultrasound Service (EUS), supporting patients affected by gastrointestinal cancers and pancreatitis. The 30-minute procedure offers enhanced imaging accuracy and enables biopsies to be taken during the same session.

October 2025

Trust Play Teams marked 50 years of Play in healthcare

The Trust's Play Teams celebrated 50 years of Play in Healthcare, with colleagues and young patients marking the milestone through special ward activities. Hosted by the Society of Health Play Specialists (SoHPS), 'Play in Healthcare Week' highlighted the role of play in supporting children through treatment and hospital stays. The theme, 'Celebrating 50 years of Play', marked the first national week in 1975 – a significant milestone for the profession.

November 2025

Clare Smith, new Chief Executive

In November, we welcomed Clare Smith as Chief Executive, following the retirement of Simon Morritt, who retired from the Trust at the end of September after six years in post. Clare joined from Leeds Teaching Hospitals NHS Trust, where she had been Chief Operating Officer since 2018, and Deputy Chief Executive. Her career has included senior roles in an acute trust in Scotland, alongside experience in the Armed Forces and local authority education services – strengthening our continued focus on quality, improvement and our people.

January 2026

New approach to stroke assessment launched

Colleagues on the Acute Stroke Unit at York introduced Prehospital Video Triage (PVT), enabling stroke specialists to assess patients in real time via live video links with Yorkshire Ambulance Service. Replacing telephone handovers, the approach supported faster, more informed clinical decisions and improved timely access to life-saving treatment when every minute counted.

February 2026

A new era for pathology at Scarborough: the countdown began

In February, the countdown began to the opening of Scarborough's new acute service laboratory, replacing the ageing pathology building following the identification of RAAC in 2023. The three-storey, 2,600m² facility will include a 24/7 acute laboratory supporting urgent care across Scarborough and surrounding communities. The £25 million investment is due to be operational towards the end of 2027 and will also provide future outpatient space and rooftop solar panels to support sustainability.

Supporting every pregnancy journey: new personalised maternity care plan launched

A personalised maternity care plan was introduced across York and Scarborough, developed with the Maternity and Neonatal Voices Partnership (MNVP) and co-produced with women and birthing people. Offered to everyone receiving maternity care, the plan supports informed choices, sets out what to expect at each stage and

provides space to record preferences - strengthening personalised, meaningful conversations throughout pregnancy and birth.

March 2026

Trust and partners won national award for elective care recovery

The Trust, working in partnership with Ramsay Health Care UK, won 'Best Elective Care Recovery Initiative' at the 2026 HSJ Partnership Awards, recognising the impact of a collaborative approach to tackling orthopaedic waiting lists. Through the elective hub at Clifton Park Hospital in York, the partnership expanded capacity, improved patient flow and supported faster access to high-quality NHS care. Since the introduction of a modular theatre in 2022, supported by the NHS England Targeted Investment Fund, around 1,500 patients each year have benefited from treatment through the hub.

3.3 Performance against national requirements

A) National performance indicators (NHS Oversight Framework 2025/26)

Priority	Aim	Actual 24/25	Actual 25/26
< 18-week wait for elective treatment	≥ 65%	55.2%	56.6%
< 18-week wait to first appointment	≥ 72%	57.9%	61.0%
< 52-weeks wait for treatment	< 1% total waiting list	2.3%	1.8%
< 62-day cancer standard	≥ 75%	68.0%	72.4%
< 28-day faster diagnosis standard	≥ 80%	70.6%	77.2%
< 4-hour A&E wait	≥ 78%	65.1%	71.0%
< 12-hour A&E wait	Improvement	-	6.1%

Freedom to speak up

Freedom to Speak Up (FTSU) plays a critical role in protecting patients and staff by enabling concerns to be raised early, acted upon, and learned from. The approach was established nationally following serious failings in care, most notably at Mid Staffordshire NHS Foundation Trust, where the Francis Inquiry highlighted the consequences of a culture of fear, poor leadership, and failure to listen. In response,

the national FTSU review (2015) introduced Freedom to Speak Up Guardians across all NHS organisations to provide an independent, impartial, and confidential route for staff to raise concerns.

The Trust is committed to these principles and has adopted the NHS England national FTSU policy, supporting all workers to speak up about issues affecting safe, high-quality care. The Freedom to Speak Up Guardian reports directly to the Chief Executive, ensuring independence and alignment with best practice, and contributes to national oversight through NHS England. The Trust Board receives an annual report detailing activity, themes, and learning, providing assurance that concerns are listened to, acted upon, and used to drive improvement.

Please find extract from the FTSU Annual Report from Sept 2025:

Freedom to Speak Up cases continue to rise against the backdrop of staff survey results, especially around raising concerns, deteriorating. Most concerns relate to inappropriate behaviours, bullying, worker wellbeing and patient safety. Workers raising concerns about detriment are increasing. Administrative and Nursing staff are the most engaged groups; Medical & Dental contacts are increasing, while Midwifery and Estates contacts have declined.

Information about the Guardian of Safe Working Hours

The 2016 national contract for resident doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training. The Guardian's role is to ensure that issues of compliance with safe working hours are addressed.

The role of Guardian sits independently from the management structure, with a primary aim to represent and resolve issues related to safe working hours for the resident doctors employed by the Trust. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by NHS England Workforce, training and education (formerly Health Education England) who oversee the quality of training.

The resident doctor contract has stipulations on the length and frequency of shifts as well as rest breaks. Rosters and work schedules are designed to these specifications. Doctors have access to an online reporting tool that allows them to highlight variations.

Variations include working extra hours (if essential for patient safety), missed teaching or training sessions, missed breaks and unsafe rest periods between shifts.

Outcomes for each report can be closure with no further action (in terms of compensation), the allocation of payment for extra hours worked or time owing in lieu (TOIL).

Exception reports can also lead to the host department being fined by the Guardian as well as initiating a review of staffing and rostering to tackle any systemic factors that may be contributing to the breaches. Fines are split between the affected doctor and Guardian funds using nationally established criteria. Resident doctors determine how Guardian funds are utilised via the Resident Doctor Forum.

Reports highlighting problems with teaching or training are shared with the Director of Medical Education.

Reporting is affected by factors pertaining to individual doctors, departmental attitudes towards exception reporting, staffing levels and rota design to name a few. Resident doctors are regularly moved between departments and Trusts contributing to fluctuations, as well as making data analysis more complex.

Key metrics for this reporting period are highlighted below.

Exception reports received by site:

Site	No. of reports 2025/2026	No. of reports 2024/2025
Scarborough Hospital	185	111
York Hospital	436	201
Total exception reports received	**621**	**312**

Reason(s) for exception report:

Nature	Type	No. raised 2025/2026	Proportion of reports 2025/2026
Hours & Rest	<11 hours rest between shifts	1	0.16%
	Difference in work pattern	7	1.13%
	Early start	1	0.16%
	Early start, late finish	5	0.81%
	Late finish	419	67.47%
	Late finish, >13-hour shift length	36	5.80%
	Late finish, difference in work pattern	1	0.16%
	Late finish, missed breaks	30	4.83%
	Late finish, missed breaks, >13-hour shift length	1	0.16%
	Missed breaks	51	8.21%
	Missed breaks, difference in work pattern	2	0.32%
Hours & Rest & Education	Late finish, missed breaks, inadequate supervision	1	0.16%
	Late finish, inadequate supervision	0	0
	Missed breaks, inadequate supervision	2	0.32%
	Late finish, missed scheduled teaching	6	0.97%
	Late finish, missed breaks, missed scheduled teaching	0	0
	Missed breaks, missed clinic or theatre session	0	0%
	Difference in work pattern, missed scheduled teaching	1	0.16%
Education	Inadequate supervision	17	2.74%
	Missed clinic or theatre session	4	0.64%
	Missed scheduled teaching	18	2.90%
	Inadequate clinical exposure	3	0.48%
Staffing	Inadequate clinical support	7	1.13%
	Inadequacy of rostered skills mix	4	0.64%
	Raising concerns of suspected non-compliant rota pattern	2	0.32%
Staffing & Hours & Rest	Inadequacy of rostered skills mix & missed breaks	1	0.16%
Other	Detriment or threat of detriment	1	0.16%
	Total	**621**	**100%**

Hours and rest outcomes:

This is the only category of exception report eligible for TOIL or payment. The report must be submitted within 14 days (28 days from 4 February 2026) of the event and demonstrate a clear workplace requirement for the overtime. Resident doctors receive paid breaks, thereby, reports relating solely to missed breaks do not garner TOIL or payment but trigger a period of monitoring.

Outcome type	Number of exception reports	Hours claimed	Value of hours claimed
Payment for additional hours worked	**279** [114]	**327.25** [147.75]	**£7,344.68** [£3,039.38]
Time off in Lieu	**202** [128]	**229.25** [162.25]	N/A (£5,460.89 equivalent)
Other action & pending review	**140** [70]	N/A	N/A

PART 4

The Trust has invited stakeholders to comment on the draft annual report. Statements received from stakeholders are shared, verbatim, below.

4.1 Statement from Integrated Care Board

Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Commissioner Statement from NHS Humber and North Yorkshire Integrated Care Board (HNY ICB) for York & Scarborough Teaching Hospitals NHS Foundation Trust- Quality Account 2025/26

Please insert your statement to be published in the Quality Account verbatim below:
NHS Humber and North Yorkshire Integrated Care Board (ICB) welcome the opportunity to review the 2025/26 Quality Account for York and Scarborough Teaching Hospitals NHS Foundation Trust. As with previous, this year's Quality Account reflects the Trust's values, vision, and ambitions for the future. We would like to take this opportunity to thank all staff for their continued dedication and commitment to improving patient safety, quality and the experience of those who use its services. As with previous years, this Quality Account details clear evidence of your commitment to improving quality and safety, learning from experience, listening to patients and staff, and working with partners to improve and innovate. We recognise the work and improvement plans that were put in place after the CQC visits and it is positive to read that the CQC ratings have improved for both Urgent and Emergency Care and for Scarborough Hospital Medical Services. The ICB commends the Trust on the work relating to the Patient Safety Incident Response Framework (PSIRF) and welcome the progress made during 2025/26. We particularly note the refresh of the Trust's PSIRF priorities for 2026/27, the review of quality governance arrangements, the positive internal audit assurance received on PSIRF implementation, and the continued development of patient safety learning systems. The wider availability of Foundations in Patient Safety training, alongside plans to deliver nationally recognised PSIRF training is a positive step in supporting staff to understand systems-based learning, compassionate engagement and proportionate responses to patient safety events. We also note the improved response rates for the Friends and Family Test, the further development of accessible information and the carers and maternity resources developed in

partnership with patients, carers and local organisations. These achievements show positive momentum and provide a foundation for further improvements across 2026/27.

The ICB further note the reference to other quality improvements made across 2025/26 that demonstrate the breadth of work taking place across the Trust. We particularly note the accreditation of Bridlington Hospital as an elective surgical hub, which is supporting improved planned care; the national Health Service Journal Partnership Award for elective recovery work with Ramsay Health Care UK and an 11% reduction in falls resulting in moderate or greater harm.

We recognise the summary of the Infection Prevention and Control and work completed within year to enhance antimicrobial stewardship improvements, and in embedding practice to reduce and mitigate the impact on Health Care Associated Infections, particularly Clostridium Difficile which is to be commended.

The ICB fully endorse the Trust's quality priorities set for 2026/27, highlighting a focus upon reducing falls with harm, reducing pressure ulcers and improving infection prevention outcomes. All priorities are closely linked to avoidable harm and the day-to-day experience of people receiving care, evidencing the Trust's continued commitment to quality, safety, patient experience and clinical effectiveness. The achievements described in the Quality Account show positive improvement and partnership working, while the priorities for 2026/27 provide a clear opportunity to build on this progress.

Finally, we would like to commend the achievements from 2025/26 as detailed in the Account and including, the new Urgent and Emergency Care Centre at Scarborough Hospital, the rollout of the Nervecentre electronic patient record system and ongoing commitment to reducing long waits and within the Cancer pathways.

The ICB recognises the achievements made across 2025/26 and we look on with interest as the Trust continues to demonstrate the impact of its improvement work.

Humber and North Yorkshire ICB confirm that to the best of our knowledge, the Quality Account is a true and accurate reflection of the quality of care delivered by York and Scarborough Teaching Hospitals NHS Foundation Trust. The Quality Account is a transparent and positive document which demonstrates the organisations continued commitment to co-production and further quality improvement to enhance the quality and safety of patient care and outcomes.

Name:	Deborah Lowe
Job title:	Director of Nursing, Quality Assurance
Date:	7 July 2026