York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

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



York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:30
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 29 July 2026 and the extraordinary meeting on 19 August** To be agreed as an accurate record.	Chair	Report	06	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	24	
6.	**Patient's Story** To consider.	Martin Hammond, Chaplain	Verbal	-	9:35
7.	**True North Report** To review the report.	Chief Executive	Report	25	9:45
8.	**Chair's Report** To review the report.	Chair	Report	43	9:55

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	45	10:00
10.	**Quality Committee Report** To receive the August and September meeting summary reports.	Chair of the Quality Committee	Report	89	10:15
11.	**Resources Committee Report** To receive the August and September meeting summary reports.	Chair of the Resources Committee	Report	100	10:25
12.	**Group Audit Committee** To receive the September meeting summary report.	Chair of the Group Audit Committee	Report	108	10:35
13.	**Trust Priorities Report (TPR)** September 2026 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance • NHS Patient Standards	 Chief Operating Officer Medical Director & Chief Nurse Deputy Director of Workforce Chief Digital & Information Officer Finance Director Chief Operating Officer	Report	111 116 163 182 193 201 224	10:45
Break 11:35					
14.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	236	11:45

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Maternity and Neonatal Reports**	Chief Nurse - Executive Maternity Safety Champion	Report	243	11:50
15.1	Maternity and Neonatal 10 Point Plan Baseline Assessment			257	
15.2	Maternity and Neonatal 10 Point Plan: Board-Level Baseline Assessment Against the NHS England National Maternity Triage Specification			259	
15.3	Saving Babies' Lives Care Bundle			266	
15.4	Maternal Care Bundle Implementation Update and Action Plan			274	
15.5	Homebirth Action Plan in response to National PFD - Progress Update			280	
15.6	Maternity In-House Tobacco Dependency Service			291	
15.7	One-year post implementation review of the Community Midwife for Equitable Health role To consider the reports.			295	
16.	**Safeguarding Annual Report** To consider the report.	Chief Nurse	Report	303	12:00
17.	**Winter Plan** To consider the report.	Chief Operating Officer	Report	324	12:10
18.	**Mortality Review (Learning from Deaths) Report** To consider the report.	Medical Director	Report	370	12:25
19.	**Responsible Officer Annual Report** To consider the report.	Medical Director	Report	386	12:30

Item	Subject	Lead	Report/ Verbal	Page No	Time
Governance					
20.	**Emergency Preparedness Resilience and Response (EPRR) Action Plan Update** To consider the report.	Chief Operating Officer	Report	406	12:35
21.	**Culture & People and Digital & Transformation Committees – Terms of Reference** To approve the terms of reference	Associate Director of Corporate Governance	Report	413	12:40
22.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
23.	**Time and Date of next meeting** The next meeting held in public will be on 28 October 2026 at 9am at York Hospital.				
24.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
25.	**Close**				12:45

Minutes
Board of Directors Meeting (Public)
29 July 2026

Minutes of the Public Board of Directors meeting held on Wednesday 29 July 2026 in the Trust Headquarters Boardroom, York Hospital. The meeting commenced at 9.00am and concluded at 12.35pm.

Members present:

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

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

Corporate Directors
- Mr Chris Norman, Managing Director, YTHFM
- Mrs Lucy Brown, Director of Communications
- Mr Mike Taylor, Associate Director of Corporate Governance

In Attendance:
- Ms Kim Hinton, Deputy Chief Operating Officer *deputising for* Ms Claire Hansen, Chief Operating Officer
- Ms Fliss Durrant, Apprenticeship Facilitator, Apprenticeship Team (For Item 6)
- Mr James Pickup, Learning Administrator, Apprenticeship Team (For Item 6)
- Ms Stefanie Greenwood, Freedom to Speak Up Guardian (For Item 15)
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 17)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Linda Wild, Elected Governor and Lead Governor – Public
- Ms Jean Flanagan, Elected Governor – Public
- Ms Julie Southwell, Elected Governor - Staff
- One member of the public

DRAFT

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

2 Apologies for absence

Apologies for absence were received from:
Ms Rukmal Abeysekera, Non-Executive Director
Ms Claire Hansen, Chief Operating Officer
Mr James Hawkins, Chief Digital and Information Officer

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 24 June 2026

The Board approved the minutes of the meeting held on 24 June 2026 as an accurate record of the meeting.

5 Matters arising/Action Log

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

BoD Pub 70(25/26) *Bring a recommendation for the True North metrics for 2026/27 to the next meeting.*
A revised set of True North metrics had been discussed at the recent Board Development Seminar and was presented under Item 7. The action was closed.

BoD Pub 10 *Investigate why the number of zero day length of stay non-elective admitted patients is high.*
Ms Hinton explained that the number had in fact reduced from around 2500 to 1000 which was in part due to a new category of patient recorded as Type 5. It was agreed that the action would be left open while further analysis of the data was undertaken.

BoD Pub 11 *Investigate the reasons for the increase in Whole Time Equivalent staff in the NHS staff infrastructure group*.
Ms Larcum explained that the increase in this group was due to the recent re-classification of some staff roles and was offset by a reduction in the administration and clerical staff group. There were different groups recorded on the Electronic Staff Record compared to the reporting requirements of NHS England.
Ms Larcum was asked to provide a summary paper for further clarification to the Resources Committee.

BoD Pub 12 *Include in the next report, an indication of where the £2.75m from the investment fund is applied in the income and expenditure table and a table showing expenditure against budget for each Care Group, directorate and the LLP.*
Mr Bertram advised that this had been clarified in the report. The action was closed.

BoD Pub 15 *Invite the Resident Doctor Peer leads alongside the Trust's Senior Lead for Resident Doctor Experience to present at a Private Board meeting.*

Dr Stone advised that she would invite the leads when they began in post. The due date was deferred.

6 Colleague's Story

Fliss Durrant and James Pickup from the Apprenticeship team joined the meeting to present the item. Ms Durrant began by providing an overview of the Trust's apprenticeship programme, highlighting the growth since 2017 when the apprenticeship levy was introduced. The programme now supported around 100 apprenticeship starts each year, covering both clinical and non-clinical roles.

Ms Durrant outlined recent government reforms to the apprenticeship programme which included a greater focus on apprenticeship for young people, changes to the funding system and the withdrawal of funding for leadership and management apprenticeships. These changes would have a significant impact, and the Trust would need to plan ahead to maximise usage of apprenticeship funding.

Mr Pickup shared his personal apprenticeship journey as a learning administrator, describing the skills he had gained and his progression within the Apprenticeship team, and details of his current role.

Miss Smith emphasised the opportunities for both apprentices and for the organisation offered by the programme but highlighted the complexities involved in accessing and spending the funding. It was disappointing however that the funding for leadership and management schemes was being lost and the Trust would need to consider how to harness and develop this experience in the future.

In response to Ms Grantham's question, Ms Durrant explained that the apprenticeships were usually awarded to existing staff, in consultation with departments, to fill skills gaps. There were few roles which were externally advertised and the change of the national focus to school leavers might lead to an increase in external recruitment to apprenticeships. Ms Durrant noted that the apprenticeship route was also used by individuals seeking a career change.

Mr Bertram agreed with Ms Durrant that it was disappointing that Level 7 apprenticeships had been withdrawn as these had been valuable for staff in his team. He asked Mr Pickup about the feedback from the apprenticeship survey. Mr Pickup responded that the responses were still being collated but first indications were that they were positive overall. Miss Smith asked that the feedback be shared with the Board in due course.

Action: Ms Larcum

Ms Durrant advised that the Trust's apprenticeship levy was £2m and would expire in 12 months if not used. Mr Bertram reminded the Board that apprentices spent time training and the cost of this time away also needed to be factored in.

Ms Durrant and Mr Pickup were thanked for their informative presentation and they left the meeting.

7 True North Report

Miss Smith presented the new True North report which contained a revised set of priorities. She referenced the metrics linked to Urgent and Emergency Care and the treatment of patients in non-designated areas and advised that work to eliminate corridor

care had begun in the form of workshops and engagement events, in preparation for significant changes to be implemented from September onwards. Miss Smith reported that there had been significant operational challenges at both York and Scarborough Hospitals in recent weeks, with very high levels of attendances at Emergency Departments (ED) at Scarborough in particular.

Mr Taylor noted that there were four issues facing the Trust: demand at the front door, patient flow, discharge and the quality of care experienced by patients, particularly in terms of communication. He asked which of these was the principal focus. Miss Smith noted that the focus was on all of the first three issues and observed that failure to communicate effectively with patients was often the result of workload and operational pressures. She agreed that there needed to be a greater focus on patient experience, to ensure that patients were more active participants in choices about their care. There were certainly opportunities for more timely discharge of patients. Mr Taylor commented that it would be useful for the Board to understand in more detail the reasons for attendances to ED.

Miss Smith drew attention to the metric relating to patient waiting times for their first outpatient appointment and highlighted its significance as a theme of complaints to the Trust. She also advised that work continued to reduce the monthly staff sickness absence rate. Mr Hague outlined plans to refresh actions to reduce the incidence of Health Care Acquired Infections.

Miss Smith referred to the priority to achieve sustainable finance and observed that the level of oversight and rigour in terms of the Trust's financial position had not diminished.

Mr Floyd asked about the metric relating to the reduction of Type 1 attendances which had an inpatient admission with a length of stay above zero and questioned if the significant decrease in May was only due to admissions to Same Day Emergency Care (SDEC) areas no longer being included in the data. Miss Smith responded that the information on the slide was not sufficiently clear and would be reviewed before the next meeting. However, she confirmed that the main reason was due to the implementation of the new Electronic Patient Record which had introduced a change in coding.

Mr Floyd also asked if the target of 90% for timely responses to complaints and concerns was realistic. Mr Hague confirmed that this was realistic for non-complex complaints. The focus however would be equally on reducing the number of complaints.

8 Chair's Report

The Board received the report.

Mr Barkley advised that he had agreed to host a person for 12 months starting in September who was part of NHS England's Aspiring NED programme. He would therefore be attending all Board meetings and talk with existing NED colleagues to more fully understand the role etc.

9 Chief Executive's Report

Miss Smith presented her report. She began by referencing the recent fire in the Springwood Unit, operated by the Tees, Esk and Wear Valleys NHS Foundation Trust, on the Malton Hospital site. The hospital had been evacuated as a precautionary measure. Miss Smith paid tribute to the attitude and commitment demonstrated by Trust staff in evacuating patients from the inpatient ward which was also operated by another Trust.

Miss Smith advised that lessons would be learnt from the incident and the wellbeing of staff involved continued to be supported. Miss Smith also recorded thanks on behalf of the Trust to the North Yorkshire Fire and Rescue Service for its rapid action to prevent the fire from spreading and also to staff at Malton School who went above and beyond in offering immediate assistance and in caring for evacuated patients. With local business also stepping up to provide food and drink, the entire response to the incident reflected a strong sense of partnership and community. Mr Barkley advised that he had written letters of thanks to the Chief Fire Officer of the North Yorkshire Fire and Rescue Service and the headteacher of Malton School.

Miss Smith also highlighted the following:

- the Trust had signed the contract with its commissioners, the Humber and North Yorkshire ICB, but the financial plan had still not been formally approved by NHS England;
- Tranche 2 of the new Nervecentre Electronic Patient Record (EPR) was due to go live commencing on 24 August;
- the number of letters and directives issued by NHS England over the course of the last month; these would be worked through and reports brought to the Board as appropriate; a report on patient experience would be presented to the Board in September;
- a Chief Culture and People Officer had been appointed who would begin in post in the autumn; Miss Smith recorded her thanks to Ms Larcum for her ongoing commitment to the interim Director of Workforce and Organisational Development role.

10 Quality Committee Report

Dr Boyd summarised the key escalation points from the meeting of the Quality Committee on 21 July 2026:

- the Committee was pleased to hear the report that paediatric surgery sessions had commenced at Bridlington Hospital, supporting patient care closer to home;
- the Committee had received the Annual Chaplaincy report which had been very positive; the team had achieved its goals for the year and had made an impressive contribution to patient and staff experience and wellbeing; a copy of the report would be circulated to members of the Board;
- pathways for sepsis diagnosis and treatment for hip fractures remained challenging, due to operational pressures; the Committee would monitor the position through escalations from the Patient Safety and Clinical Effectiveness Sub-Committee and the quarterly sepsis updates.

Ms Hazelgrave observed that the Board needed more high level information on key challenged areas such as sepsis, hip fractures and stroke. Miss Smith responded that discussions on the most effective way to report this type of information to the Board would be held with the Trust's Continuous Quality Improvement partner.

11 Resources Committee Report

Ms Grantham reported that the meeting held on 21 July had focussed on three key areas: the Waste Reduction and Productivity (WRAP) programme, performance of cancer services, and workforce. In terms of the WRAP programme, Ms Grantham reported that delivery remained behind plan. The discussion around the challenges facing different areas of cancer services had been valuable. The Committee had expressed its support for

the Big Conversation initiative which was aimed at reshaping the culture and values of the organisation.
Ms Grantham advised that the Committee had also received a progress report on diagnostic performance which was very positive, albeit that the improvement remained fragile given the workforce and equipment challenges. Improvement in Urgent and Emergency Care metrics had been impacted by the implementation of the Nervecentre EPR, and reviews were being undertaken to ensure that the systems and processes associated with the first phase of the Acute Model of Care were as effective as possible.

12 Well-Led Action Plan Q1 Progress Report

Miss Smith presented the report, noting that actions scheduled for Quarter 1 linked to the Continuous Quality Improvement model, the Integrated Accountability Framework and the Big Conversation had not been fully completed but were all on track.

A request was made for the action plan to be re-formatted to make it easier to read and determine which actions were progressing according to plan. Miss Smith would discuss this with Mr Taylor, Associate Director of Corporate Governance.

Action: Miss Smith

Mr Barkley asked about the timeline for Action 14.4 *To further embed the Managing Violence and Aggression policy launched in 2025 to manage patients who are racist or discriminatory to colleagues.* Mr Hague advised that the policy would be reviewed by September but there was a wider piece of work to understand the impact of violence and aggression across the organisation which would take 6 to 12 months but the scope of this should also be determined by September. It was agreed that the wording of the action would be amended to describe this work and the due date moved to Quarter 4, subject to recording that the original action had been completed.

Action: Mr Taylor/Mr Hague

Mr Barkley noted that the progress update for Action 35 *The Trust should consider ways in which it can strengthen the dissemination of learning within and across Care Groups. This should also include consideration of the formal mechanisms and processes for triangulating learning across multiple data points* described what was already in place, not how it was being strengthened. Mr Hague would progress this for the next report.

Action: Mr Hague

13 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hinton presented the summary of operational activity and performance, beginning with Urgent and Emergency Care:

- the Emergency Care Standard was off trajectory in June by 0.4%; Miss Smith described the ongoing improvement work which included a review of rotas;
- Type 1 12-hour waits remained ahead of trajectory;
- community and social care capacity was impacting on the ability to discharge patients in a timely manner;
- ED teams were working through Nervecentre optimisation with Digital colleagues and set of priority actions had been agreed;
- an audit of “missed opportunities” was being undertaken with a review of the process for ambulance handovers and discussions with the Yorkshire Ambulance

Service on alternative pathways, and the reinforcement of pathways to the Extended Emergency Medicine Ambulatory Care (EEMAC) unit;
- there was also dedicated work on improving Urgent and Emergency Care paediatric metrics.

Ms Hazelgrave asked about the single of point of access for ambulance conveyances which had been in place. Ms Hinton advised that this had not been funded for this financial year and agreed that this was disappointing as it had helped ambulance crews to navigate the multiple options available for receiving and treating emergency cases.

Ms Hinton reported that the monthly trajectories for both the Cancer Faster Diagnosis Standard (FDS) and the 62 first definitive treatment standard had been exceeded, building on a period of sustained improvement, but meeting year-end trajectories would be challenging. The Trust was sourcing support for work on demand and capacity. Ms Hinton provided an update on work to improve the performance of Cancer Services, which was primarily focussed on the causes of delays in pathways which included capacity challenges in diagnostics and digital pathways in pathology. She highlighted a significant increase in referrals from primary care for skin cancer and the need to agree a position on who would undertake dermoscopy imaging when the Local Enhanced Service agreement ended in November.

Mr Barkley queried why 62 day performance had deteriorated in May. Ms Hinton explained that this was directly related to the previous months' FDS performance, which had been particularly impacted by the increase in skin cancer referrals, but she expected to see improvement in future months. Miss Smith underlined the need to inform patients in timely manner about the results of their diagnostic tests, and this was proving a challenge currently. Ms Hinton advised that work was underway to extend the use of Ambient Voice Technology in Cancer services to address administrative delays.

Ms Hinton reported that there had been a small reduction in the total waiting list although the continued demand was driving an increase in the Referral To Treatment (RTT) position. This had increased by 9% in June driven by referrals to the Pain and Gastro Services. The Trust would be sharing this data with the ICB to discuss demand management action which needed to be taken. Ms Hinton noted that the proportion of appointments assigned as first appointments was not sufficient and she described the action being taken to address this. Miss Smith added that there was a risk that some patients would breach 65 week waiting times for the Pain service. There was some discussion on the use of virtual appointments and the new NHS England requirement for a Single Point of Access. Ms Hinton added that work on pathway changes had identified a number of opportunities for greater efficiency.

In response to Mr Barkley's question, Ms Hinton advised that the proportion of patients waiting more than 52 weeks for a first outpatient appointment rather than for surgery depended on the specialty. Mr Barkley highlighted that there was still a failure to record patients' ethnicity. Ms Hinton would raise this with the Chief of Allied Health Professionals who was the Health Inequalities lead.

Action: Ms Hinton

Ms Hinton advised that the percentage of patients using Patient Initiated Follow Up (PIFU) had increased to 5% which was positive but there were further opportunities to extend this.

Ms Hinton referenced the Single Point of Access project which was a significant area of work. A project board had been established and clinical workshops had commenced. The

work would include determining the temporary impact on performance of transferring time in consultants' job plans to triage. Progress on the project and its impact would be reported to the Resources Committee.

In terms of diagnostic performance, Ms Hinton reported that a positive position had been maintained for the last few months. She noted the reliance on insourcing and bank staff in some diagnostic modalities. She advised that the Community Diagnostic Centre in Scarborough was open and now fully operational. In terms of risks, performance in Echocardiography was the most significant, and Ms Hinton described the actions underway to support improvement. Mr Barkley noted the deterioration in performance in Neurophysiology. Ms Hinton explained that this was covered by a single practitioner whose annual leave it had not been possible to cover with the use of bank staff.

The Board acknowledged the significant improvement in diagnostic performance, particularly in the number of patients waiting more than 13 weeks.

With reference to services for children and young people, Ms Hinton advised that the paediatric pathway in ED was under review. In terms of outpatient appointments, risks remained to performance in Ear, Nose and Throat and oral surgery specialties.

Ms Hinton reported that the 2-hour Urgent Community Response compliance was at 75.6% in June. A Business Case for a new model of community care was due to be presented to the Executive Committee in August for approval. Ms Hinton was asked to provide an explanation of the difference between Community Response Team (CRT) referrals and 2-hour Urgent Community Response referrals.

Action: Ms Hinton

Quality and Safety

Mr Hague reported that the Trust was under trajectory for C.Difficile and klebsiella bacteraemia infections but over trajectory for all other Health Care Acquired Infections. A deep dive review would be undertaken to identify the drivers of poor performance, and this would also link to the work to eliminate corridor care.

Mr Hague advised that the number of Category 2 pressure ulcers was slightly above the monthly trajectory. New patient chairs had been ordered which should contribute to an improved position. Mr Hague reported that the number of patient falls per thousand bed days was below the monthly threshold however, which was positive. In terms of complaints to the Trust, there had been a slight improvement in performance, but long term plans focussed on addressing the themes of complaints to prevent them arising. Mr Hague was asked to investigate the discrepancy between the number of complaints recorded in the narrative as opposed to the graph in the report.

Action: Mr Hague

Maternity

There were no comments or questions on this section.

Workforce

Ms Larcum reported a slight increase to the rate of staff sickness absence in June which was disappointing; work to address this continued at pace. She advised that resident doctors had voted to accept the Government's pay and jobs offer but consultants had now voted in favour of industrial action. The ballot result provided a mandate for industrial action for the next 12 months, although none had currently been announced.

Ms Larcum also reported that the staff turnover rate remained low and workforce numbers were stable, with a small reduction in the number since the same period last year. Eight new medical colleagues had been welcomed to the Trust in June. Ahead of the changeover in August, the Trust was onboarding 207 resident doctors; there had been the usual challenges in obtaining information in a timely manner.

Ms Larcum highlighted the continuing reduction in the vacancy rate for Health Care Support Workers and the scheduling of interviews for pre-registered nurses.

Digital and Information Services

There were no questions or comments on this section.

Finance

Mr Bertram reported at Month 3 that the Trust had a £9m deficit against a planned deficit of £6m. He confirmed that no further amounts from the investment fund had been used to offset the deficit.

Mr Bertram advised that contract overperformance had been added to the monthly position, £2m of which related to high costs drugs and devices, and £0.6m to variable activity, the latter being linked to the significant increase in referrals highlighted by Ms Hinton. Mr Bertram reported that, in terms of the Waste Reduction and Productivity (WRAP) programme, the Trust had delivered £23.9m in full year terms against a target of £61.6m of which £17.2m was recurrent savings. The monthly WRAP programme delivery was £3.5m behind plan. The key pressure areas were the cost of cover for the resident doctors' industrial action, high cost drugs and devices, medical bank cover and the cost of funding the Bridlington Care Unit. The report now included the best, most likely and worst case scenario modelling for the overall forecast position.

Mr Bertram expressed disappointment at the run rate position and underlined the need for rapid action. He shared details of external support which had been sourced to provide further capacity and expertise. He drew attention to the forecast cash position in September and advised that the Finance team was preparing an application for emergency cash support. He would share more detailed cash modelling information with the Resources Committee in advance of the application being presented to the Board for approval.

Ms Charge voiced some concern about the £2.6m weighted activity position which was above plan. Mr Bertram advised that, as at Month 3, there was £1.8m with the Humber and North Yorkshire ICB of which £1.5m related to high cost drugs and devices, and the remainder to day case work. He would discuss payment for both areas with the ICB at the Contract Management Board. He assured the Board that the risk of non-payment was not the same as that relating to previous overtrades.

There was some discussion on the impact of medical bank staffing costs on delivery of the WRAP programme particularly where these were at premium rates. Executive directors gave assurances that significant work was underway to recruit to substantive posts and to reduce premia, but this was challenging when the medical staff involved had expertise which was scarce.

Mr Floyd commented that there were significant risks in the projections in the report. He also suggested that the level of information included in the report should be reviewed to include a greater focus on strategy and longer term planning and that it would be useful for

finance to be an agenda item in and of itself. Miss Smith responded that the next version of the TPR would be developed in collaboration with the Board.

With reference to the capital programme, Mr Barkley questioned why the RAAC elimination project at Scarborough Hospital was £4.9m behind plan. Mr Norman explained that this was because the investment had been phased over more than one year, due to the complexity of the project and the link with the de-steaming project.

14 CQC Compliance Update

The Board received and noted the report.

15 Freedom to Speak Up (FTSU) Quarterly Report

Ms Greenwood, Freedom to Speak Up Guardian, joined the meeting to present the report. She reported that FTSU activity had reduced in terms of the number of concerns raised but this should not necessarily be interpreted as an indication of an improvement in organisational culture and workforce experience. Ms Greenwood reinforced the link between organisational culture and patient safety which was demonstrated by the concerns raised. She advised that staff continued to use the FTSU route for escalation when their concerns were not addressed through local routes. Behaviour and culture remained key issues.

Ms Greenwood recommended that the Board remain curious about the increase in medical and dental staff contacts, in the context of the number of overall concerns reducing, and it should be cognisant of continuing concerns relating to equality, diversity and inclusion, racism or race discrimination and sexually inappropriate behaviour. Ms Greenwood referenced recent national reports which had identified failures where colleagues were not listened to and their concerns were not acted upon.

Miss Smith observed that the report reflected the important themes of the Big Conversation initiative around reinforcing standards of behaviour.

Ms Greenwood was asked about the causes of the reduction in concerns raised in Quarter 1. She explained that this could be related to her period of annual leave or to natural variation. Dr Stone noted that the rise in medical and dental staff FTSU concerns might be the result of a national campaign to encourage speaking up. Ms Greenwood observed that the information contained in her report could be interpreted in triangulation with other information which the Board received.

Ms Greenwood agreed to add data from previous quarters to the report as a comparison..

Action: Ms Greenwood

16 Trust response to post death care and key actions following the Fuller enquiry

Dr Stone presented the paper which had been prompted by the Nottingham Maternity Enquiry findings on post-death care, the Human Tissue Authority (HTA) regulatory requirements and the recommendations from the Fuller enquiry relating to mortuaries, related storage areas and wider arrangements for the care of people after death. The Board was asked to confirm executive ownership and oversight arrangements, and to support submission of the required Board Assurance Statement by the national deadline.

A time-limited Mortuary and Post-Death Care Assurance Programme had been established, chaired by Dr Stone, and she referenced the key actions detailed in the report. Dr Stone advised that the Trust was compliant with all of the Board assurance statements and, in line with the requirement, had retrospectively identified incidents which now needed to be reported to the HTA.

Miss Smith queried the second of the Board assurance statements: *The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.* Dr Stone confirmed that the review of progress had taken place in 2025 and she would source the evidence for Miss Smith and Mr Barkley.

Action: Dr Stone

Subject to an appropriate amendment to the identified statement, the Board approved submission of the Board Assurance Statement.

17 Maternity and Neonatal Reports

Ms Wells-Munro presented the reports beginning with the Maternity and Neonatal Safety report. She highlighted:

- there were no reportable neonatal deaths in May and no cases met the criteria for referral to the Maternity and Newborn Safety Investigation (MNSI) programme;
- workforce growth continued following the additional maternity investment approved by the Board; another cohort of new Band 5 midwives would begin in post in the autumn, and a bid had been submitted for resources to support the over recruitment of newly qualified midwives; a well-qualified of Band 6 midwives had applied for vacation positions; the workforce position overall was improving with these new recruits;
- interviews would take place shortly for a Clinical Standards and Culture lead midwife and a Head of Midwifery; both posts had attracted a strong field of applicants; the new Deputy Director of Midwifery was proving a very valuable appointment;
- training compliance remained on track;
- the rate of Post-Partum Haemorrhages over 1500mls was 1.4% for May.

Ms Wells-Munro summarised the key risks and concerns which included gaps in the workforce despite recent recruitment and the uncertainty caused by the planned disestablishment of the Local Maternity and Neonatal System (LMNS) and the Maternity and Neonatal Voices Partnership (MNVP). Ms Wells-Munro noted that 55 milestone actions in the Single Improvement Plan were currently off track, but she assured the Board that there was no risk to the safety of women and babies.

17.1 The National Maternity Review: Amos Final Report and Recommendations

Ms Wells-Munro explained that the paper summarised the findings of the independent national maternity investigation undertaken by Baroness Amos and included the national 10-Point Plan, with progress to date. Ms Wells-Munro highlighted the increased role of the Board in the scrutiny of real-time patient outcomes, experience and audit data and the dual Board level accountability for maternity and neonatal care outlined in the Plan.

Ms Wells-Munro assured the Board that the Single Improvement Plan was already aligned with the recommendations, and she would continue to provide the Board with progress reports against the 10-Point Plan.

Referring to the 10-Point Plan, Miss Smith highlighted the role of the MNVP in listening to women and families and expressed concern that this would no longer be fulfilled. Ms Wells-Munro advised that there was an indication that the ICB had identified some funding to maintain a similar service.

Dr Stone advised that the Maternity Assurance Group, which she chaired, was a key element in the governance process and escalated through to the Quality Committee and to the Board. She confirmed that the Group had clinical input. Ms Wells-Munro outlined the changes already made to ensure the safety of the Home Birth service pending further national guidance.

Ms Wells-Munro noted that the Board had agreed to support a focus on the 10-Point Plan, the Saving Babies' Lives Care Bundle, the Maternal Care Bundle and the Maternity Incentive Scheme as a priority.

17.2 Nottingham Review Findings, Conclusions and Essential Actions

Ms Wells-Munro advised that the paper provided the Board with a summary of this key report.

A typographical error was noted: the recommended actions were for the Trust, not the Humber Health Partnership.

17.3 Maternity Feedback Survey

Ms Wells-Munro reported that the paper summarised the results from the newly developed in-house maternity survey. The paper had been presented to the Quality Committee and there had been discussion on how to increase the number of responses.

17.4 Perinatal Equity and Anti-Discrimination Programme (PEADP)

Ms Wells-Munro reported that participation in the Perinatal Equity and Anti-Discrimination programme was mandatory for all maternity services and would commence in September. She drew attention to the intensive resource it would require to deliver the programme which would not be nationally funded. The cost pressure resulting from the backfill needed would be £38k.

17.5 Bi-annual Maternity, Obstetric, Anaesthetic and Neonatal Workforce Report Quarters 3 and 4

Ms Wells-Munro summarised the key areas of compliance and non-compliance, noting that the Service was now in a much stronger position.

Mr Barkley referred to the table of red flags and the number relating to the delay between presentation and triage of 30 minutes or more on the York site. Ms Wells-Munro explained that the demand on York services was higher than Scarborough and peaked at certain times of the day, specifically between 4pm and 8pm. A twilight shift had been added to increase capacity.

18 Annual Complaints Report

The Board received the report and acknowledged the work undertaken to improve response times to complaints. Mr Hague underlined the work still to be done, particularly in reducing the number of complaints.

In response to a question, Mr Hague outlined the support and training in place to support complaint investigators. There was also opportunity to introduce more digital solutions.

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Mr Hague would investigate if complaints data relating to delays in treatment could be split into non-elective and elective care.

Action: Mr Hague

19 Public Sector Equality Duty (PSED) Report

Ms Larcum presented the report, summarised the contents and invited questions. It was noted that the links to the report in the paper would function on the public website.

20 Fit and Proper Persons Test (FPPT) Annual Report

The Board received and noted the report.

21 Q1 2026/27 Board Assurance Framework (BAF)

Mr Taylor presented the paper, noting that the new Board Assurance Framework had been developed based on recommendations from the external Well-Led Developmental Review report and internal audit. The framework introduced a formal assurance opinion for each strategic risk, and each risk would be reviewed by the relevant assurance committee of the Board.

The Board of Directors approved the 2026/27 Quarter 1 Board Assurance Framework and note the amendments to the assurance provision process for 2026/27

22 Questions from the public received in advance of the meeting

There were no questions from members of the public.

23 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 30 September 2026 at 9.30am at Scarborough Hospital.

DRAFT

Minutes
Board of Directors Extraordinary Meeting (Public)
19 August 2026

Minutes of the Public Board of Directors meeting held on Wednesday 19 August 2026 in the Trust Headquarters Boardroom, York Hospital. The meeting commenced at 2.15pm and concluded at 2.50pm.

Members present:

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

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

Corporate Directors
- Mr Chris Norman, Managing Director, YTHFM
- Mrs Lucy Brown, Director of Communications
- Mr Mike Taylor, Associate Director of Corporate Governance

In Attendance:
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Linda Wild, Lead Governor – Public
- Ms Jean Flanagan, Governor – Public
- Ms Peter Morley, Governor – Public
- Ms Graham Lake, Governor - Public
- Six members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

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2 Apologies for absence

Apologies for absence were received from:
Ms Julie Charge, Non-Executive Director
Mr Matthew Taylor, Non-Executive Director
Mr Ian Floyd, Associate Non-Executive Director

3 Declaration of Interests

There were no declarations of interest.

4 Future of the Bridlington Care Unit (BCU)

Dr Stone, the Trust's Medical Director, presented the paper which set out a number of recommendations for the future of the Bridlington Care Unit (BCU) which the Board was asked to consider.

Dr Stone provided some details about the BCU. It had been established during the COVID-19 pandemic as a temporary step-down facility to support patient flow from acute hospitals and to provide additional capacity for patients who were medically optimised but unable to return home due to ongoing rehabilitation, recovery or social care needs. The Unit played an important role in a period of exceptional pressure on the health and care system. Similar units established at the same time in Hull and York had been closed a couple of years ago.

Dr Stone explained that the modern model of care had evolved in line with national policy and clinical evidence and the focus across the NHS was now on supporting people in the least restrictive setting appropriate to their needs, promoting independence and reducing unnecessary reliance on hospital-based care and specialist intervention. There was strong evidence demonstrating that this resulted in better outcomes for patients. Dr Stone highlighted the effects of deconditioning: evidence showed that for patients over 80 years of age, a ten day stay in a hospital bed was likely to result in muscle loss equivalent to ten years of ageing.

Dr Stone advised that the commissioning arrangement supporting the BCU had ended in March 2026, requiring the Trust and the wider health and care system to consider the most appropriate long-term model of care for this patient cohort. In May 2026, following consideration of proposals relating to the future of BCU, the East Riding Health, Care and Wellbeing Oversight and Scrutiny Committee recommended a delay to implementation to allow a consultation exercise to take place. The Board had therefore agreed a three month pause for this work to be undertaken.

On behalf of the Board, Dr Stone recorded her thanks to all those who had contributed to the engagement process. Whilst strong opposition to the closure of the BCU had been expressed, this seemed to stem from concerns about what alternative care would be provided if the BCU was to close. The engagement exercises also highlighted concerns around communication with the local community about service provision.

Dr Stone noted that the Humber and North Yorkshire Integrated Care Board (ICB) had provided assurance that a broader system model was being developed to support the patient cohort historically served by the BCU which included continued investment in proactive care and prevention, neighbourhood health programmes, comprehensive geriatric assessment, frailty pathways, Same Day Emergency Care, improved discharge

planning and strengthened integration between acute, community and social care services. The collective aim of these developments was to reduce avoidable hospitalisation, support recovery closer to home and maximise patient independence. Dr Stone advised that the reduction in the number of beds in the BCU had not resulted in delayed discharges from Scarborough General Hospital which was evidence that the revised model of care was working.

Given the evidence supporting contemporary models of rehabilitation and recovery, findings from the engagement, and the assurance provided by system partners, Dr Stone stated that the recommended option was to permanently close the Bridlington Care Unit. This recommendation should not be viewed as the removal of support for this patient group, but as the transition from a historical hospital-based model of care to a modern, integrated and community-focused model that was better aligned to contemporary evidence, national policy and the future direction of health and care services.

Mrs Brown, the Trust's Director of Communications, provided details of the structured community engagement process which had been undertaken on the recommendation of the Oversight and Scrutiny Committee. The purpose of the engagement was principally to reassure residents as to the future of Bridlington Hospital and provide clarity to them that the previous closure proposal related solely to the Bridlington Care Unit and not to wider services at Bridlington Hospital or the hospital as a whole, and to communicate the longer-term strategic vision for the Bridlington Hospital site. Mrs Brown summarised the means by which feedback was collected and referenced the detailed engagement report and appendices included in the paper. The majority of people who engaged were opposed to the closure of the BCU. Trust leaders acknowledged the level of concern from people who sought reassurance that appropriate care would be delivered at home. There was a strong theme emerging from the responses to the engagement that there was a perceived gap in local services. Trust and ICB leaders also needed to recognise the clear lack of trust and focus on rebuilding this with the local community. Mrs Brown summarised that the responses from the engagement process would inform the Trust's clinical strategy in Bridlington and would underpin a programme of continuous engagement with residents.

Mr Hague, the Trust's Chief Nurse, provided further clinical context to the recommendation to close the BCU. He underlined the need to maximise independence and quality of life by providing care closer to home. Patients in their home environment were more engaged in their rehabilitation which led to better outcomes. The evidence clearly supported a transition from hospital-based models which often resulted in deconditioning and poorer outcomes.

Questions and comments were invited.

Dr Boyd recorded her thanks to all those who had contributed to the work recorded in the papers. She observed that the strategic case for the closure of the BCU was clear, underpinned as it was by the need to get patients home at the earliest opportunity. She noted however that the appropriate levels of support and care in community were key and this was the main concern expressed in the feedback to the engagement process. Dr Boyd questioned whether Trust leaders had seen details of the care about which the ICB had provided assurances. Dr Boyd also queried how the governance around the change in pathways would operate.

Ms Hansen, the Trust's Chief Operating Officer, responded to reassure Dr Boyd. The Humber and North Yorkshire ICB commission a range of services in community to support patients in their own homes, including proactive work to maintain health and

independence, such as Proactive Frailty programmes in both North Yorkshire and the East Riding which had both have seen additional investment in 2026-27 and were aimed at reducing the need for hospitalisation. Linked to initiatives such as Same Day Emergency Care, the programmes also helped to reduce the time patients spent in hospital. Ms Hansen advised that the ICB overall had seen a sustained reduction in delayed discharges from hospital over the last three years but continued to work with its partners, particularly Local Authorities, to improve processes such as Discharge to Assess and pathways to access community care. The ICB had invested additional resource into community services, such as the Bee at Home service, and the East Riding of Yorkshire Council had a well-developed programme on social care improvement, including a comprehensive review of reablement services which were critical to supporting improved discharge and allowing step-up care to avoid admission.

Dr Stone advised that the Trust would be developing transition arrangements with the ICB and had its own arrangements to monitor discharges. Ms Hansen confirmed that the East Riding Place Partnership would provide support and there was also a Bridlington based multi-agency meeting with other providers.

Dr Reece complimented the work undertaken by Dr Stone, Mrs Brown and Mr Hague, but expressed some concern around the timing of the additional services provided by the ICB to ensure that patients were appropriately supported. Miss Smith responded that assurances had been received from the ICB regarding the increased provision, as noted above.

Miss Smith acknowledged residents' concerns around the proposed closure of the BCU and underlined the Trust's commitment to its services in Bridlington.

Mr Barkley summarised what were, in his view, the most pertinent points to consider. Firstly, the BCU was established at the beginning of the COVID-19 pandemic in response to the extraordinary pressure on hospitals. Most actions taken as a result of the pandemic were ceased by the end of 2024 and the conditions under which the Unit was established no longer existed. Secondly, the feedback from the engagement process, specifically the consistent concerns related to access, transport, communication, confidence in community capacity, the coordination of care across organisational boundaries, and the need for a clearer long-term vision for Bridlington Hospital were key to inform the Trust's strategy and future actions, to create a clearer long-term vision for Bridlington. Thirdly, Mr Barkley addressed the recurring area of concern around the closure of the BCU, that patients would be left without suitable alternative care. In fact, patients would remain in hospital until a suitable care package was agreed for them to receive at home in exactly the same way as for patients who were at any of the Trust's hospitals.

Mr Barkley questioned what the next steps would be in terms of a response to the Oversight and Scrutiny Committee. Mrs Brown advised that she had now shared the paper with the Chair of the Committee and had requested guidance on how the response to the Committee should be formulated and what the monitoring framework should look like.

Mr Barkley thanked the Executive Directors for the quality of papers and the time committed to engage with and listen to the public.

The Board of Directors:

- **noted the outcome of engagement exercise;**
- **noted the feedback received from patients, local residents, staff, stakeholders and partner organisations during the engagement process;**

- **noted the assurance provided by Humber and North Yorkshire Integrated Care Board (ICB) regarding the continued development of community, neighbourhood health, rehabilitation and Home First pathways to support the patient cohort currently accessing Bridlington Care Unit services;**
- **agreed that the current Bridlington Care Unit model no longer represents the most appropriate long-term model of care for patients who no longer require acute hospital treatment and are medically optimised for discharge;**
- **approved the permanent closure of Bridlington Care Unit and the cessation of the current inpatient step-down service model;**
- **approved the transition of patients who would previously have accessed Bridlington Care Unit to community, rehabilitation, discharge-to-assess and Home First pathways, delivered in partnership with health and care system partners;**
- **approved the development and implementation of a detailed transition plan;**
- **noted that separate work will continue through the Trust Clinical Strategy and service planning processes to consider future service development opportunities for Bridlington Hospital, informed by the feedback received through the wider engagement process.**

It was noted that the transition of existing patients from the BCU would be managed on an individual basis.

5 Questions from the public received in advance of the meeting

No questions from members of the public had been submitted in advance of the meeting.

6 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 30 September 2026 at 9.30am at Scarborough Hospital.

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Item 5

Action Ref.	Date of Meeting	Item Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	Status
BoD Pub 09	27-May-26	18	Research and Innovation - Annual Report	Ensure that R&I bid success rates are included in the next annual report	Medical Director		May-27	On Track
BoD Pub 10	24-Jun-26	12	Trust Priorties Report	Investigate why the number of zero day length of stay non-elective admitted patients is high	Chief Operating Officer	Update 29.07.26: Ms Hinton explained that the number had in fact reduced from around 2500 to 1000 which was in part due to a new category of patient recorded as Type 5. It was agreed that the action would be left open while further analysis of the data was undertaken.	Sep-26	On Track
BoD Pub 11	24-Jun-26	12	Trust Priorties Report	Investigate the reasons for the increase in Whole Time Equivalent staff in the NHS staff infrastructure group	Interim Director of Workforce & OD	Update 29.07.26: Ms Larcum provided an explanation and was asked to provide a summary paper for further clarification to the Resources Committee	Aug-26	On Track
BoD Pub 13	24-Jun-26	15	Maternity and Neonatal Report	Bring an update to the Board on progress towards a solution towards continuing the work of the LMNS	Director of Midwifery		Sep-26	On Track
BoD Pub 14	24-Jun-26	16	Infection Prevention and Control Annual Report	Report to the Board on the detailed reasons why the Trust benchmarks so poorly against others in infection prevention and control, and the solutions to the root causes	Chief Nurse		Sep-26	On Track
BoD Pub 15	24-Jun-26	17	10 Point Plan: Improving Resident Doctors' Working Lives	Invite the Resident Doctor Peer leads alongside the Trust's Senior Lead for Resident Doctor Experience to present at a Private Board meeting	Medical Director	Update 29.07.26: Dr Stone advised that she would invite the leads when they began in post. The due date was deferred.	Sep 26 from Jul 26	Delayed
BoD Pub 16	29-Jul-26	6	Colleague's Story	Ensure that feedback from the apprenticeship survey is shared with the Board	Interim Director of Workforce & OD		Sep-26	On Track
BoD Pub 17	29-Jul-26	12	Well-Led Action Plan Q1 Progress Report	Discuss with Mr Taylor how the action plan might be re-formatted to provide a clearer update on progress	Chief Executive		Oct-26	On Track
BoD Pub 18	29-Jul-26	12	Well-Led Action Plan Q1 Progress Report	Amend the wording of Action 14.4 to describe the work on understanding the impact of violence and aggression, and amend the due date to Q4	Chief Nurse/Associate Director of Corporate Governance		Sep-26	On Track
BoD Pub 19	29-Jul-26	12	Well-Led Action Plan Q1 Progress Report	Progress actions to strenghten the dissemination of learning across the organisation	Chief Nurse		Sep-26	On Track
BoD Pub 20	29-Jul-26	13	Trust Priorities Report	Raise the issue of the lack of ethnicity coding with the Health Inequalities lead	Deputy Chief Operating Officer		Sep-26	On Track
BoD Pub 21	29-Jul-26	13	Trust Priorities Report	Provide an explanation of the difference between Community Response Team (CRT) referrals and 2-hour Urgent Community Response referrals.	Deputy Chief Operating Officer		Sep-26	On Track
BoD Pub 22	29-Jul-26	13	Trust Priorities Report	Investigate the discrepancy between the number of complaints recorded in the narrative as opposed to the graph in the report.	Chief Nurse		Sep-26	On Track
BoD Pub 23	29-Jul-26	15	Freedom to Speak Up (FTSU) Quarterly Report	Add data from previous quarters to the report as a comparison.	Freedom to Speak Up Guardian		Oct-26	On Track
BoD Pub 24	29-Jul-26	16	Trust response to post death care and key actions following the Fuller enquiry	Source the evidence of the review of progress against the Fuller report undertaken in 2025 for Miss Smith and Mr Barkley.	Medical Director		Sep-26	On Track
BoD Pub 25	29-Jul-26	18	Annual Complaints report	Investigate if complaints data relating to delays in treatment can be split into non-elective and elective care.	Chief Nurse		Sep-26	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

September 2026

True North – Introduction

York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

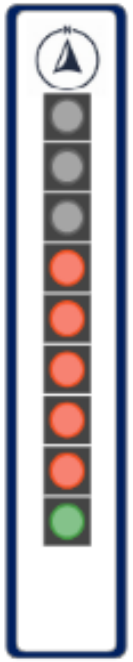
This is the single point of reference to measure our progress.

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

The True North Report is a monthly report on the Trust’s key transformational objectives measured by eleven key metrics for 2026/27 that have been identified as YSTHFT critical priorities.

True North – User Guide

Understanding the Thermometer Reading (Examples Only):



3 do not have a monthly trajectory

5 are not achieving monthly trajectory

1 is achieving monthly trajectory

Indicator has improved since previous month

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

Indicator has deteriorated since previous month

Objective Status (top right of indicator page):

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

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

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

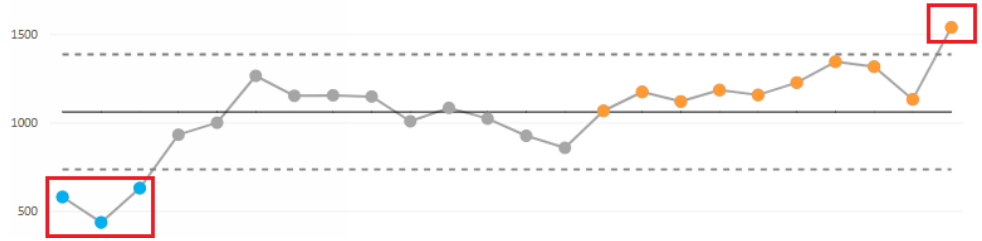
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

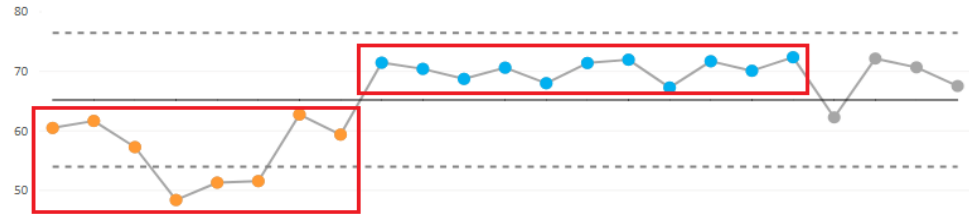
These lines (limits) help to understand the variability of the data and are set to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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



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



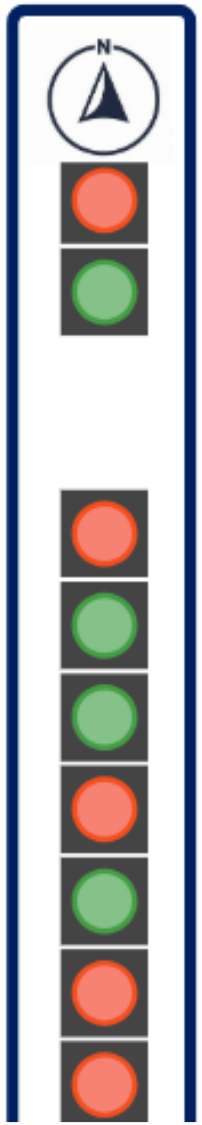
Trend: Counts the number of occasions there is a run of 7 consecutive points going in the same direction.



True North Report

Performance Improvement Overview

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



Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

Urgent Emergency Care: Reduce the proportion of Type 1 attendances

Achieve below 28% by March 2027

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

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

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

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

Elective: Cancer: Improve the Faster Diagnosis Standard

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

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

Achieve 67.1% by March 2027

Community: Increase 2-hour Urgent Community Response Compliance

Achieve over 70%

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

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

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

Workforce: Reduce the Monthly Sickness Absence rate

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

Finance: Achieve Sustainable Finance

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

True North Report

Objective Status ⊗ Down Is Good

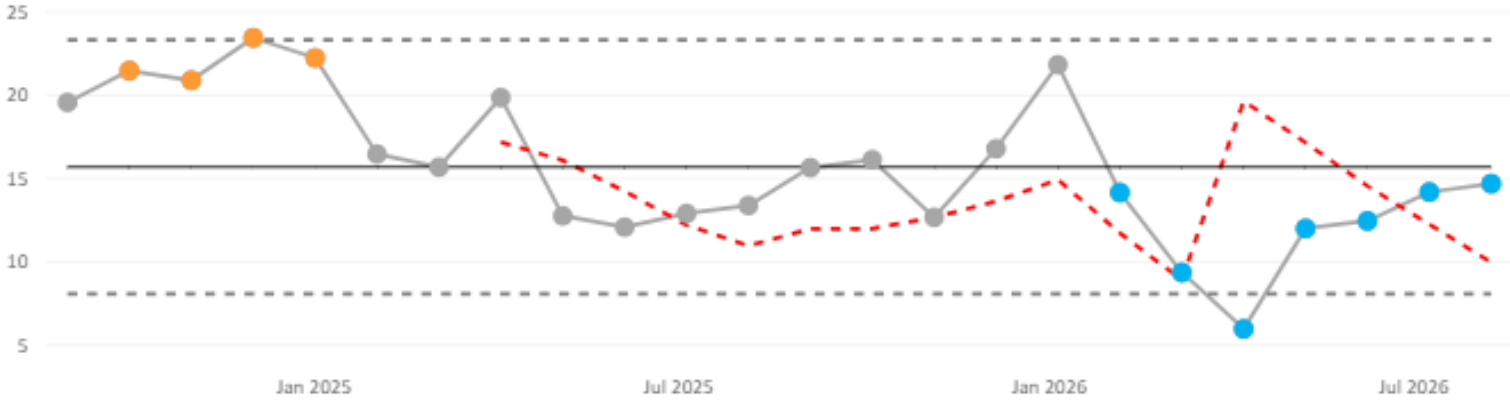
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

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

2 found

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

Occurs

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

Does Not Occur

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target Mar 2027
Value	13.3%	15.6%	16.1%	12.6%	16.7%	21.8%	14.1%	9.3%	5.9%	12%	12.4%	14.1%	14.6%	5%
Trajectory	10.9%	11.9%	11.9%	12.6%	13.6%	14.9%	11.7%	8.9%	19.6%	17.1%	14.5%	12.2%	9.9%	

What are the organisational risks?

- Long waits in ED are associated with an increased risk of patient harm and poorer patient experience
- Patients waiting increase the risk of overcrowding and associated hospital-acquired infections
- Sustained underperformance may lead to increased regulatory oversight
- Reputational risk
- Recruitment and retention issues
- Financial pressures

How are we managing them?

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

What are the current challenges?

- Some days with very high attendance levels at each site.
- Workforce: capacity, skill mix, absence rates including some days with over 10% nurse sickness absence level in ED.
- Financial constraints mean limited options for testing new ways of working.

What are we doing about them?

- Improvements already made to Nervecentre and further improvements coming in Tranche 2 which could increase efficiency in processes.
- A four-week First Assessment bay (FAB) trial commenced in Scarborough Emergency Department on 12 August 2026 as part of the UEC recovery programme. This has resumed on 14/09/26, however one challenge is the medics cover.

True North Report

Objective Status Down Is Good

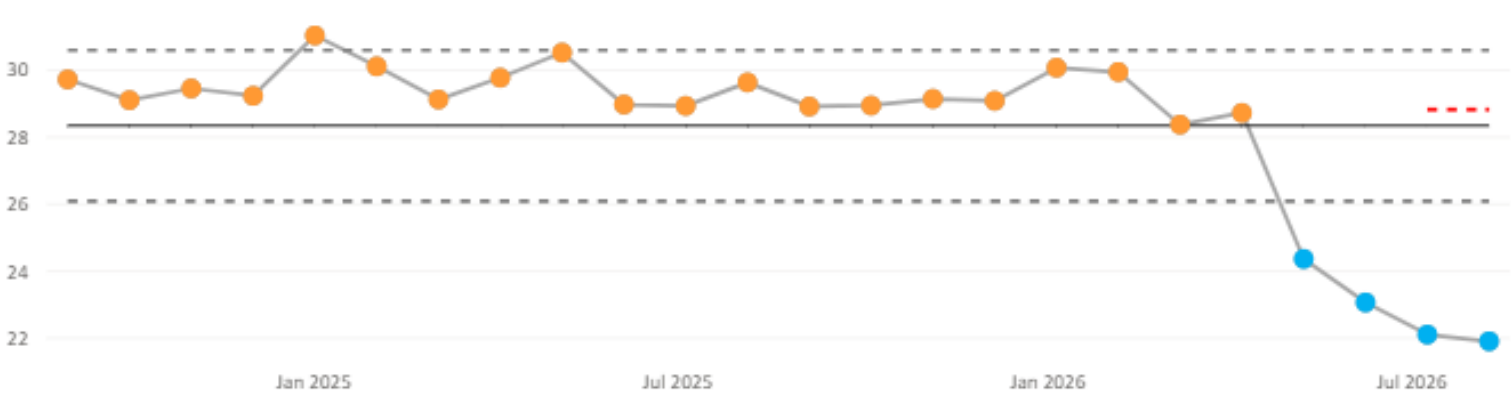
Urgent Emergency Care: Reduce the proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero

Achieve below 28% by March 2027

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

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

5 found

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

Occurs

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

Does Not Occur

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target Mar 2027
Value	29.6%	28.9%	28.9%	29.1%	29.1%	30.1%	29.9%	28.4%	28.7%	24.3%	23%	22.1%	21.9%	28%
Trajectory												28.8%	28.8%	

What are the organisational risks?

- Extended length of stays contribute to high bed occupancy rates.
- This in turn causes poor flow out of Emergency Departments and Emergency Assessment Units.
- This leads to overcrowded departments and long waits, which are linked to patient harm.
- Periods of severe operational pressure can result in the temporary use of escalation areas

How are we managing them?

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

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

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

What are the current challenges?

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

What are we doing about them?

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

True North Report

Objective Status ○ No Trajectory

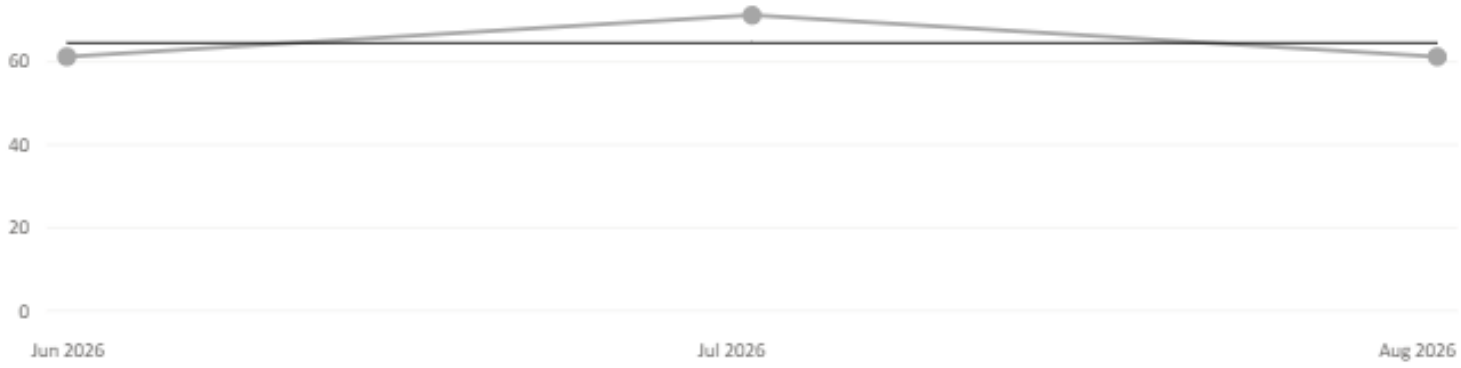
Urgent Emergency Care: Reduce the number of patients treated in non-designated areas

Ensuring patients accessing urgent and emergency care receive timely assessment, treatment and escalation in the right clinical environment, with minimal use of corridor or temporary care spaces. Values are an average of daily data over the month.

Lead Director: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy & Emma George

Committee: Resources & Quality



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

	Jun-26	Jul-26	Aug-26	Target Mar 2027
Value	61	71	61	0
Trajectory				

* Values are an average of daily data (for June 2026, the average is for available data only). The monthly trajectory will populate from September 2026. The trajectory is subject to change as it has been calculated using June 2026 data only

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

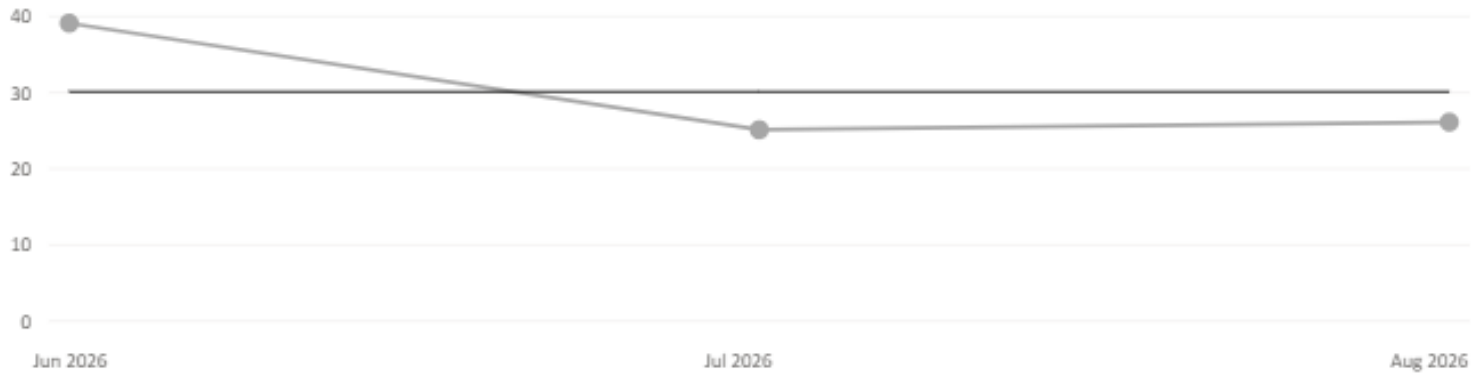
True North Report

Objective Status ○ No Trajectory

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

Ensuring all patients receive care in the right place, at the right time, in the right clinical environment- with no corridor care spaces in use.
Values are an average of daily data over the month.

Lead Director: Joe Hague
Operational Lead: Vicky Mulvana-Tuohy & Emma George
Committee: Resources & Quality



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

	Jun-26	Jul-26	Aug-26	Target Mar 2027
Value	39	25	26	0
Trajectory				

* Values are an average of daily data (for June 2026, the average is for available data only). The monthly trajectory will populate from September 2026. The trajectory is subject to change as it has been calculated using June 2026 data only

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

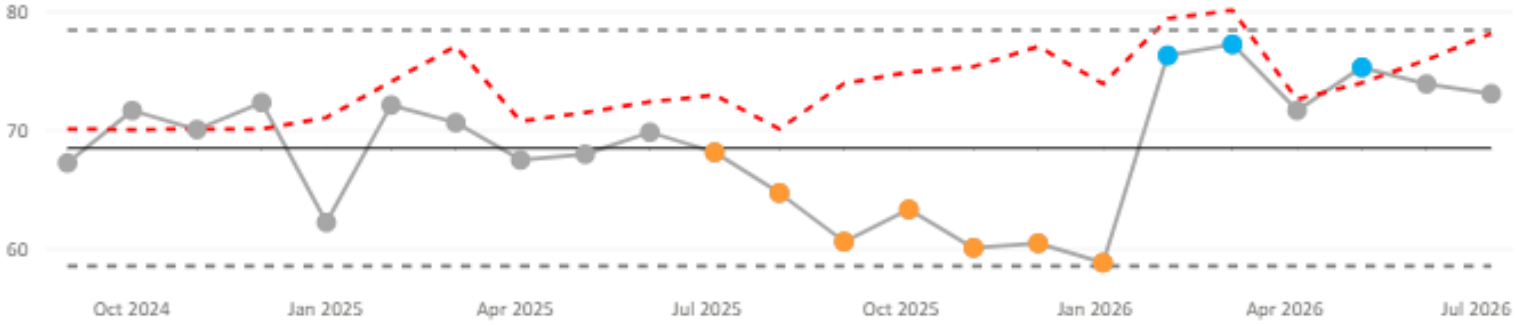
True North Report

Objective Status ⊗ Up Is Good

Elective: Cancer: Improve the Faster Diagnosis Standard

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

Lead Director: Claire Hansen
Operational Lead: Kim Hinton
Committee: Resources



Is there special cause variation?

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

0 found

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

Occurs

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

Does Not Occur

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Target Mar 2027
Value	68.1%	64.7%	60.6%	63.3%	60%	60.4%	58.8%	76.2%	77.2%	71.6%	75.2%	73.8%	73%	84.3%
Trajectory	72.9%	70%	73.9%	74.8%	75.3%	77%	73.8%	79.3%	80.1%	72.5%	73.9%	75.9%	78.1%	

What are the organisational risks?

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

How are we managing them?

- Twice weekly Trust cancer PTL meeting with a focus on patients breaching FDS with clear escalation routes. Monthly cancer delivery group to oversee focused pathway improvement plans for all specialities with docus on gynaecology, colorectal and urology
- Clinical harm reviews for patients who breach 104 days to identify level of harm and learning
- Fortnightly diagnostic improvement meeting with modalities
- Delivery of the cancer actions

What are the current challenges?

- Skin, gynaecology and colorectal pathway delays which impact Trust overall position.
- Full coverage of skin referrals not yet accompanied with picture impacting ability to triage patients effectively, resulting in increasing demand and deteriorating performance.
- Diagnostic delays in endoscopy and imaging
- Increase in suspected cancer referrals in 26/27 above planned levels.
- Histopathology delays in reporting

What are we doing about them?

- Continued prioritisation of cancer activity in Q2 26/27.
- Ongoing discussion with ICB for long term plan post November 26 when LES expires.
- Delivery of cancer system development funding scheme (£900k). Initial schemes commenced June 2026
- Ongoing support around PTL management with additional weekly meeting to review thematic issues by tumour site.
- Review of impact of histopathology action plan on improved turnaround time

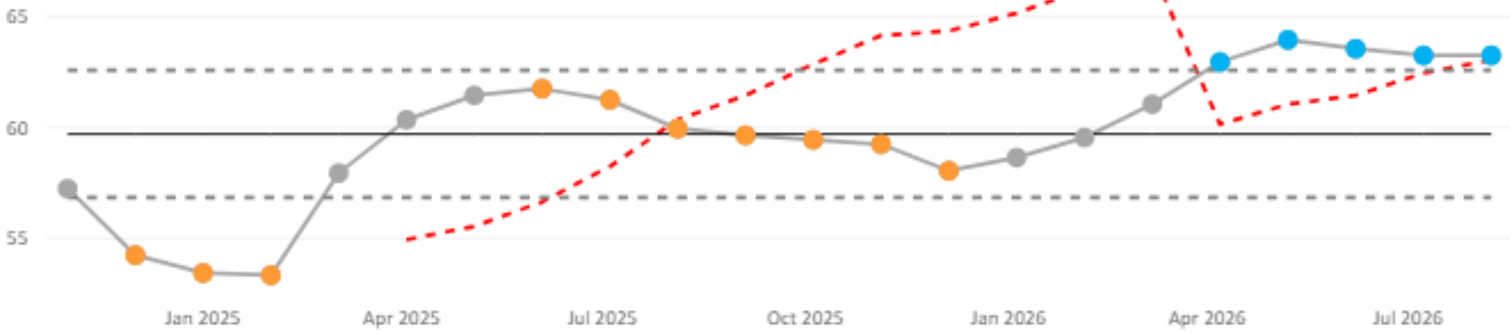
True North Report

Objective Status — Up Is Good

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

Achieve 67.1% by March 2027

Lead Director: Claire Hansen
Operational Lead: Kim Hinton
Committee: Resources



Is there special cause variation?

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

8 found

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

Does Not Occur

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

Occurs

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target Mar 2027
Value	59.9%	59.6%	59.4%	59.2%	58%	58.6%	59.5%	61%	62.9%	63.9%	63.5%	63.2%	63.2%	67.1%
Trajectory	60.3%	61.4%	62.8%	64.1%	64.3%	65.1%	66.2%	67.1%	60.1%	61%	61.4%	62.4%	63%	

What are the organisational risks?

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

How are we managing them?

- Delivery of specialty-level RTT recovery plans aligned to agreed trajectories.
- Additional targeted outpatient capacity
- Strengthened RTT performance governance through weekly recovery meetings, fortnightly operational reviews and monthly RTT Board oversight.
- Ongoing waiting list validation and PTL management using the LUNA methodology.
- Monitoring of productivity measures.

What are the current challenges?

- Continued growth of GP referrals (4% 26/27 YTD increase from same period in 25/26)
- YTD Delivery of 1st OP planned activity below planned levels
- Workforce vulnerabilities to deliver planned capacity
- Large overdue follow up backlog
- Booking and scheduling processes, late notice capacity reduce effectiveness of chronological booking
- Delays in capital schemes to deliver additional capacity

What are we doing about them?

- Implementation and roll out of Single Point of Access for 10 specialties by Oct 26.
- Delivery of outpatient productivity schemes (reduce DNA, standardise templates, OP utilisation, PIFU and reduction in N:FU ratio) to increase first OP capacity. Increase each consultant clinic by 1 NP in Q3 and Q4.
- Implement additional targeted non recurrent capacity
- Work with ICB to reduce GP demand back to 26/27 planned levels
- Targeted waiting list validation
- Implement 2weeks of RTT clinics per specialty through Q3 and Q4

True North Report

Objective Status Up Is Good

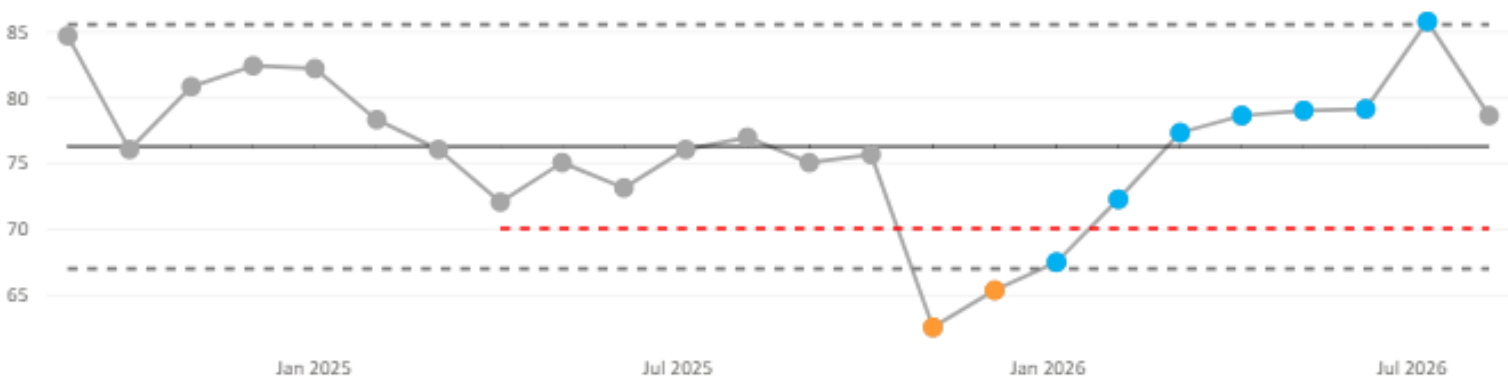
Community: Increase 2-hour Urgent Community Response Compliance

Achieve over 70%

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

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

3 found

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

Does Not Occur

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

Occurs

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target Mar 2027
Value	76.9%	75%	75.6%	62.5%	65.3%	67.4%	72.2%	77.3%	78.6%	79%	79.1%	85.7%	78.6%	70%
Trajectory	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	

What are the organisational risks?

- Demand out strips available capacity
- Reduced confidence in service
- Increased attendance to the ED departments
- Failure to achieve the minimum 70% target

How are we managing them?

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

What are the current challenges?

- Periods of concentrated referral activity can create operational capacity challenges
- Geographical spread can make the allocation of visits more difficult
- Referrals for UCR and home-based intermediate care at home remain high.

What are we doing about them?

- We are creating a case for change for a new community model. This will see a shift in resource to home based teams and address the geographical challenges
- Team have built in daily validation of the clocks to ensure belter quality of data.

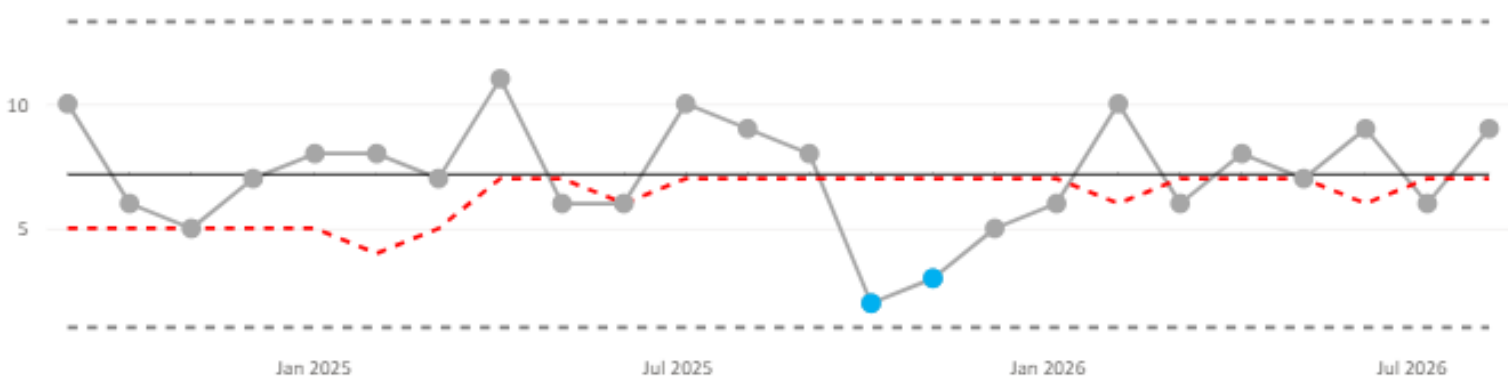
True North Report

Objective Status ⊗ Down Is Good

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

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

Lead Director: Joe Hague
Operational Lead: Sue Peckitt
Committee: Quality



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

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

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

- Cases are not consistently reviewed.
- Learning not shared widely across the organisation, limiting overall improvement.
- VIP score compliance is not available to view by the IPC team since the commencement of Nervecentre
- 5 cases over the threshold, year to date

What are we doing about them?

- Care group reduction action plans in place and monitored via IPSAG.
- MSSA case review has commenced via the Datix process.
- Progress against improvement plan reported via IPSAG, PSCE and quality committee
- Cannula audit has identified that improvements in skin cleansing prior to insertion and hand hygiene need improving - these are themes in the IPC education being delivered in the IPC months of quality (September and October)

True North Report

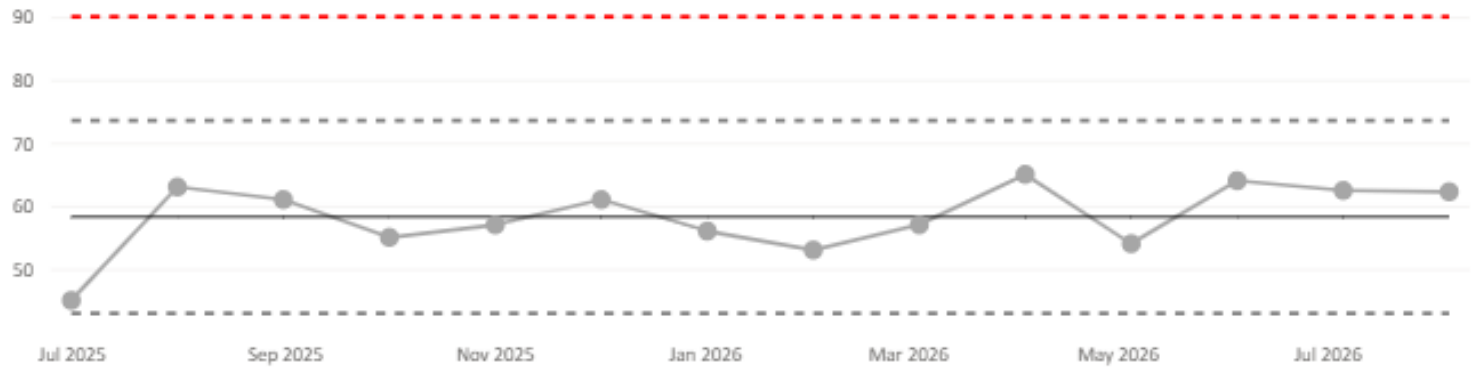
Objective Status Down Is Good

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

Lead Director: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy

Committee: Quality



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target Mar 2027
Value	63%	61%	55%	57%	61%	56%	53%	57%	65%	54%	64%	62.5%	62.2%	90%
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	

What are the organisational Risks ?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

True North Report

Objective Status — Down Is Good

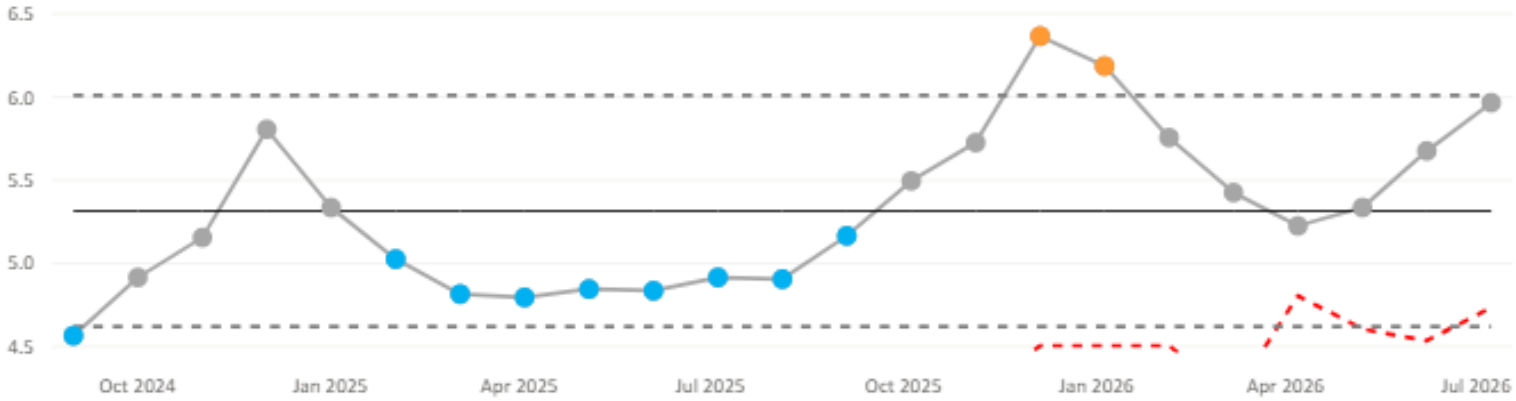
Workforce: Reduce the Monthly Sickness Absence rate

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

Lead Director: Lydia Larcum

Operational Lead: Nic English

Committee: Resources



Is there special cause variation?

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

3 found

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

Occurs

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

Does Not Occur

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Target Mar 2027
Value	4.9%	4.9%	5.2%	5.5%	5.7%	6.4%	6.2%	5.8%	5.4%	5.2%	5.3%	5.7%	6%	4.7%
Trajectory	4.2%	4.2%	4.2%	4.2%	4.2%	4.5%	4.5%	4.5%	4.2%	4.8%	4.6%	4.5%	4.7%	

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

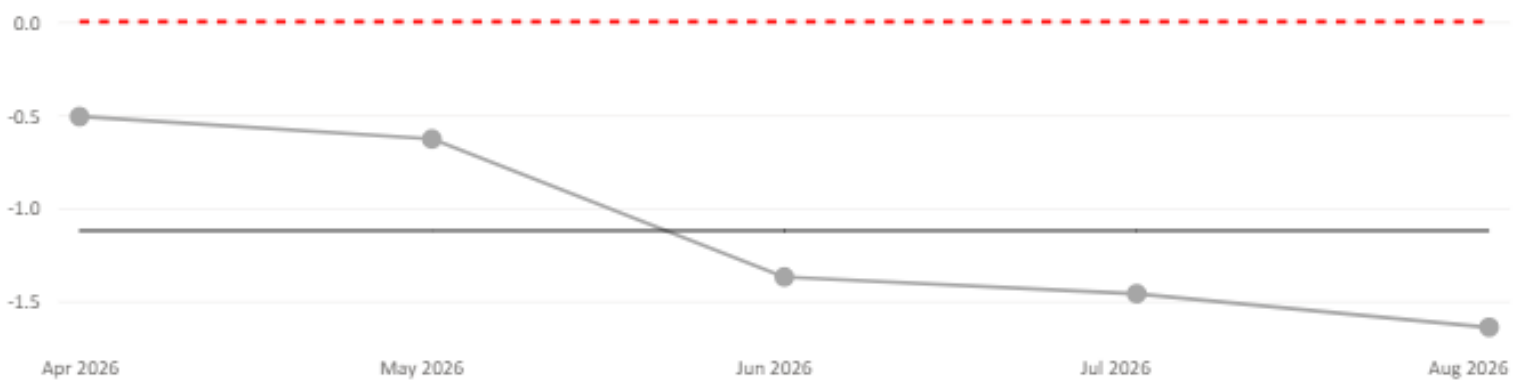
True North Report

Objective Status | Up Is Good

Finance: Achieve Sustainable Finance

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

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



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Value	-0.5%	-0.6%	-1.4%	-1.5%	-1.6%
Trajectory	0%	0%	0%	0%	0%

Target Mar 2027
0%

What are the organisational risks?

- **Failure to Deliver the 2026/27 Financial Plan** - The most critical financial risk is the Trust's potential failure to deliver the 2026/27 financial plan.
- **Waste Reduction & Productivity Programme Delivery Risks** – delivery of the financial plan is reliant on delivery of £65.6m WRAP programme.
- **Cash Position** - deterioration in the Trust's cash position may require cash support from November 2026.

How are we managing them?

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

- Business as usual controls: PRIM / FRM / Exec Comm / SFI / SoD.
- Further to the above, newly introduced Financial Improvement Boards (FIB) are in place for each Care Group and Corporate function for specific focus on delivery of the WRAP programme.
- KPMG opportunities to be built into overall WRAP programme.

What are the current challenges?

- In August WRAP delivery falls £6.6m short of the YTD target, the deterioration from July is due to 5/12ths of the £4m stretch target in respect of the revised £18.5m deficit plan.
- There is currently a planning gap of £8m (12.1% of overall target)
- Of planned schemes still to be delivered, £5m WRAP plans are High-Risk, £9.8m Medium Risk and £12.6m Low Risk.

What are we doing about them?

- Continue to monitor delivery of plan / WRAP against monthly target. Commitment to redirect investment funds where delivery of WRAP falls behind target.
- Closely monitor the above in line with activity delivery, as any underperformance may reduce income and adversely affect the net I&E position.
- Ongoing financial recovery support (Fer Gunebakan)
- Ongoing WRAP maturity assessment (Adrian Roberts)

1. EPR Update: Nervecentre Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- The second phase (Tranche 2) of our EPR programme was successfully implemented throughout week commencing 24 August 2026.
- Tranche 2 introduced the ability to order pathology and radiology investigations within Nervecentre for urgent and emergency care (UEC) and inpatient services and meant that staff already using Nervecentre in their day-to-day role following Tranche 1 no longer need to go to CPD to order tests and acknowledge test results.
- After successful implementation of Tranche 1 and Tranche 2 the following functionality is now live on Nervecentre – observations & clinical documentation for inpatients, urgent & emergency care, pathology & radiology investigations and results for inpatients and UEC, electronic prescribing & medicine administration (EPMA), and bed management.
- Planning for Tranche 3, which is expected to go live in June 2027, is ongoing. The team are working towards a key design milestone due this month.
- Tranche 3 will include the Patient Administration Service (PAS), theatres, endoscopy, medical device integration, e-consent, and outpatient use of clinical documentation, EPMA & investigations.

2. Continuous Improvement Update Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Following the appointment of Catalysis, Royal Berkshire NHS Foundation Trust and KPMG as our strategic partner to establish and embed our Quality Management System and Continuous Quality Improvement approach, work on the first phase of mobilisation has begun.
- The first Executive orientation session was held on 13th August 2026 followed by the first formal training session on 4th September 2026. A mix of training and applied learning sessions will now take place every two weeks through to the end of February 2026. Individual executive coaching from Catalysis will start in the coming weeks.
- The Trust Board also participated in a Board Development session in August.
- Dates have been set to deliver training to the deputies of our Executive Directors, and others involved in key delivery priorities. This will take place on 12th and 13th October 2026.
- Dates have also been set to train the Senior Leadership Teams of our Care Groups along with their aligned finance, HR and Business Intelligence support teams. These start on 2nd November with one formal training day per month for four months. This will be suplemented by weekly support sessions on the ground to help with delivery of daily management.
- In the meantime, we continue with the delivery of quality improvement training and where targeted, the Improvement Team are supporting priority areas with an improvement approach. This includes supporting the eradication of corridor care and achieving a reduction in long lengths of stay.

3. Efficiency Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Waste Reduction and Productivity Dashboard — All Care Groups | August 2026

26/27 position • Reset: select All Care Groups | Care Group: All Care Groups | Directorate*: All Directorates

Executive Summary

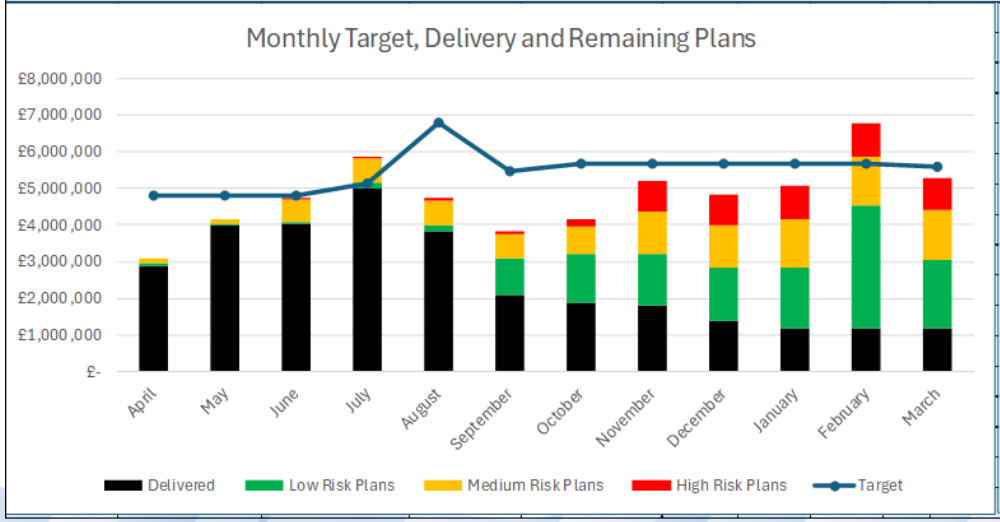
Programme Summary Position	Full Year	YTD Position
Target	£65,785,699	£26,327,064
Delivered	£30,414,661	£19,710,785
Variance	**-£35,371,038**	**-£6,616,279**
Addititional Plans to be delivered		
Planned Low Risk	£12,626,834	£542,060
Planned Medium Risk	£9,847,997	£2,149,023
Planned High Risk	£4,887,046	£183,334
Total Additional Plans	**£27,361,877**	**£2,874,417**
(Planning Gap)/Over delivery	**-£8,009,161**	**-£3,741,862**

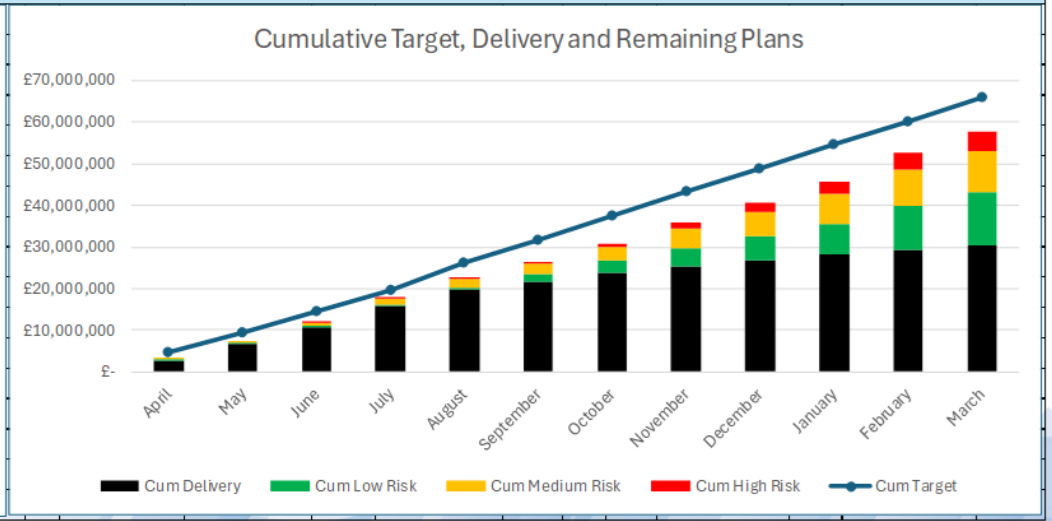
WTE Plan	238.34	**WTE Delivered**	47.91

Scheme Governance											
Total Number of Live Schemes							**152**				
EQIA Outstanding							51		34%		
Pre-Pipeline							7		5%		
Opportunity							33		22%		
Plan in Progress							10		7%		
Fully Developed							102		67%		
	Plans	**%**	**Delivered**	**%**				**Plans**	**%**	**Delivered**	**%**
Recurrent	£37,730,842	57%	£18,496,163	28%			**Pay**	£25,680,749	39%	£12,380,960	19%
Non Recurrent	£20,045,695	30%	£11,918,498	18%			**Non Pay**	£31,780,426	48%	£17,814,338	27%
Total	**£57,776,538**	88%	**£30,414,661**	46%			**Income**	£315,363	0%	£219,363	0%
							Total	**£57,776,538**		**£30,414,661**	

YTD Period Name	Aug-26

In Year Plan Profile





Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Chair's Report
Director Sponsor:	Martin Barkley, Chair
Author:	Martin Barkley, Chair

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

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

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

No ☒ Yes ☐

Report History
Board of Directors only

Chair’s Report to the Board – September 2026

1. I have continued to visit various wards and services at Scarborough and York Hospitals as well as the new Community Diagnostic Centre in Scarborough. Through conversations with colleagues during these visits and 121s, I pick up valuable insight and issues which I share with the Chief Executive as appropriate.

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

3. The last of this year’s excellent Member/Governor Constituency meeting took place a couple of weeks ago. Members of the Trust who attended the meeting asked very good questions and raised a number of concerns and suggestions which I have communicated to the Executive. All four meetings were a great example of accountability and transparency conducted with respect and politeness.

4. Earlier this month I chaired a joint meeting between the Trust Board and the Council of Governors. There were just two items on the agenda but both of significant importance. The first was a briefing and discussion about the Trust’s emerging clinical strategy and the second was to gather ideas and suggestions about what arrangements the Trust should establish to have effective arrangements for public and patient participation if the legislation currently going through Parliament is approved with the clause of removing the powers of Councils of Governors and the requirement for Foundation Trusts to have such Councils. A Task and Finish Group is being established which will prepare recommendations based on the discussion at the joint meeting for consideration at the next meeting of the Council of Governors and the January meeting of the Trust Board.

Martin Barkley
Trust Chair

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Chief Executive's Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Clare Smith, Chief Executive

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides an update from the Chief Executive to the Board of Directors in relation to the Trust's priorities. Topics covered this month include:

- Thirlwall Inquiry final report
- Care Quality Commission updates
  - Maternity
  - Easingwold renal unit
- Bridlington Care Unit closure
- Nervecentre rollout
- Our improvement journey

- Coming off corridors
- Our Big Conversation
- Star Award nominations

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

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation

Chief Executive's Report

1. Thirlwall Inquiry final report

I must start my report this month with some reflections following the publication of Lady Justice Thirlwall's final report into events at the Countess of Chester Hospital NHS Foundation Trust. The report sets out deeply distressing findings about what happened at the Trust together with recommendations for the wider NHS.

My thoughts are first and foremost with the families at the heart of these terrible events. What happened was appalling, and I recognise the profound and lasting pain experienced by the families affected.

I also recognise that the report, and the discussion surrounding it, may be difficult and upsetting for colleagues working in neonatal services. It may prompt strong personal or professional reactions, particularly for those who have cared for very sick babies, supported bereaved families or raised concerns about care.

Every day, our neonatal teams provide highly skilled and compassionate care to babies and families in some of the most difficult circumstances imaginable. Learning from this report does not diminish that commitment; it is about ensuring that everyone is supported to provide the safest possible care, and that concerns are heard and acted upon.

The Government is considering the recommendations in full but in the meantime the Secretary of State for Health has committed to commencing a number of actions from the report, and NHS England has written to Trusts to outline these.

As a Board we will have the opportunity to carefully consider the report and its recommendations as well as how we will respond to the immediate asks.

We are also ensuring colleagues who may be affected by the report, in particular those working in neonatal services, have the support they need, and we are working with our Maternity and Neonatal Voices Partnership (MNVP) to ensure parents and families of babies on our units are able to ask questions or raise concerns.

2. Care Quality Commission updates

2.1 Maternity

The Care Quality Commission (CQC) has now published the findings from its inspections of our maternity services at York and Scarborough, which took place in April, and I am delighted to say that both services have been rated 'Good' overall, with all five domains assessed by the CQC rated as 'Good'. This was a follow-up to the 2023 inspection, which rated services as inadequate.

This is a significant improvement and something I know our maternity teams have worked incredibly hard for, so I must say a huge and heartfelt thank you and well done to every colleague who has played a part in this.

These reports are an important milestone on our improvement journey for our maternity teams. They have had to hear some difficult messages, respond to significant concerns

and make changes, while continuing every single day to care for women, babies and families.

There is a lot in these reports that our colleagues should feel proud of. Inspectors saw improvements in safety, leadership, incident management, triage, staffing arrangements, equipment and the maternity environment. They also recognised stronger governance and teamwork, alongside a culture where colleagues feel able to speak up, learn when things go wrong and make changes as a result.

However, what struck me most was what women themselves told the inspectors. They spoke about our colleagues being kind and supportive, taking the time to listen to them and understand what mattered to them.

There is much that we collectively do well, and the reports represent a moment to recognise that. But, as we know, there is also much more we need to do to improve care across our whole Trust. What our maternity teams have shown us is that improvement is possible when we listen, learn and act together.

Finally I would like to give a special mention to our Director of Midwifery, Sascha Wells-Munro, our maternity leadership team and every colleague who has played a part in this improvement. They should all feel incredibly proud of what has been achieved.

2.2 Easingwold renal unit

In further positive news, the CQC has now published its report on the Easingwold Renal Unit following its inspection in May. I am really pleased to share that the unit has been rated Good across all five domains: Safe, Effective, Caring, Responsive and Well-led.

This was the team's first inspection, which makes the result an especially brilliant achievement. My warmest congratulations and a huge thank you to everyone involved for the care, commitment and hard work behind this report.

3. Bridlington Care Unit closure

The Board of Directors accepted the recommendation to close Bridlington Care Unit at an extraordinary meeting on 19 August.

The decision was reached after careful consideration of the recommendations made by the East Riding Health, Care and Wellbeing Overview and Scrutiny Sub-Committee (OSC) in May 2026, the work undertaken during the subsequent three-month pause, the findings of the structured engagement programme, the options appraisal, operational evidence and the assurance provided by NHS Humber and North Yorkshire Integrated Care Board (ICB).

We have finalised the transition plan and, at the time of writing, have agreed with the clinical teams to cease admissions and work towards a final closure date of Friday 25 September. Colleagues have been informed and we are supporting them with their moves to their new posts.

It is important to say that this decision does not mean we do not recognise the level of opposition to the closure in the local community. The majority of people who responded to

our survey opposed the closure and raised concerns about alternative provision, and it is important we acknowledge that openly.

Through the engagement we have undertaken, and in many conversations I have had with local people since joining the organisation, I have heard how much the hospital matters to local people and I recognise the need for a clearer and more ambitious plan for its future. We must listen to these concerns.

We are already working to increase the services available in Bridlington, particularly planned surgery and outpatients, and what we have learned through the recent engagement will help shape our wider Clinical Strategy and future service planning.

Thank you to everyone who shared their views and personal experiences. We are listening, and we will continue the conversation with colleagues, residents and our partners about the future of health and care in Bridlington.

4. Nervecentre rollout

Following the successful implementation of Tranche 1 of our Nervecentre Electronic Patient Record programme, we have now successfully completed Tranche 2 during August and September.

Tranche 2 introduced pathology and radiology requesting through Nervecentre for urgent and emergency care and inpatient services, representing another important step in our digital transformation programme.

The experience of implementing Tranche 1 provided valuable learning, which informed our planning and approach to this next phase. All of this learning from the first two tranches will be reflected in planning for the third and final Tranche which rolls out next summer. The final Tranche will be a significant undertaking and will once again require focussed and dedicated effort across the Trust.

5. Our Improvement Journey

I have talked in previous reports about the importance of creating an environment where every colleague feels empowered to make change happen. In my First 100 Days report, I committed to bringing in expert support to help us embed a Continuous Quality Improvement approach across the Trust.

As part of that commitment, we are working with Catalysis, supported by Royal Berkshire NHS Foundation Trust and KPMG. Together, they have supported more than 20 other NHS trusts and will bring a wealth of experience and valuable learning to our own improvement journey.

We are now well into the initial period of education and mobilisation. A great deal of work is taking place behind the scenes so that, when we begin involving colleagues more widely, we can roll this out in a thoughtful, consistent and systematic way.

I am truly excited about what this could mean for us. I believe it has the potential to transform how we improve, and I know from the many conversations I have had with colleagues that this is something people across the Trust want to see too.

At our most recent Senior Leadership Forum earlier this month, colleagues heard more about our Continuous Quality Improvement (CQI) journey and the part every member of staff will play in making improvement part of everyday work.

We set out an ambitious vision: a future where colleagues are motivated to improve as part of their day job, understand how their work contributes to our Trust strategy, use improvement methods with confidence and are curious about how data can help make a difference for patients.

Our approach to CQI brings together improvement methodology, leadership development, organisational culture, management systems and sustainable results. At its heart is the need to create the right culture, behaviours and leadership conditions for improvement to flourish.

One of the key messages was that improvement efforts often fail not because the technical solution is wrong, but because the surrounding culture and systems remain unchanged. Engagement, communication, leadership behaviours and a real sense of ownership often determine whether an improvement is sustained.

Examples from other NHS organisations show what this approach can achieve: clearer communication, stronger staff engagement, better alignment between frontline teams and organisational priorities, and measurable improvements in patient flow and waiting times. I am looking forward to seeing what we can achieve together.

6. Coming off Corridors

One of the other priorities that I shared in my 100-day report is ending the use of corridors and unplanned spaces for patient care. In every conversation I had, this came through as the single biggest frustration, concern and risk to the quality of care we provide.

We should be caring for patients in a space which supports safe and dignified care, however, over time, corridor care has become part of our everyday reality, and in some cases, something we have begun to normalise.

If we do the right thing for every patient, every day, patients will be safer and have a better experience, colleagues will have a better experience delivering care, and we can rebuild a shared sense of pride in what we do.

I recognise this is a big organisation-wide undertaking and for us to be successful we need to ensure colleagues have access to the tools and support they need to turn their ideas into reality. It is also important that it is clinically-led, with ideas coming from our frontline teams.

An oversight team led by Joe Hague, our Chief Nurse, has been created to support colleagues and oversee our progress across the organisation to improve patient and colleague experiences and eliminate corridor care permanently.

Throughout July and August, the oversight team engaged with colleagues to explore change ideas to support our aim of removing corridor care permanently.

During September, we have built on this engagement work and have had a trust-wide focus on removing corridor care as our priority. Senior clinicians and operational staff have been supported in freeing up more time to be on the wards and in our Emergency Departments to provide that senior decision-making support. They are using this time as an opportunity to listen, help tackle care delays as well as supporting the implementation of our internal professional standards.

Clinical and operational teams are being empowered to make changes and understand what we need to focus on longer-term to sustain improvement and remove corridor care permanently.

The work will not stop now that we are at the end of September. We will continue to build on the momentum we have developed during this month of dedicated focus. We are committed to supporting our organisation to eradicate corridor care.

7. Our Big Conversation

When I shared my priorities shaped by what colleagues told me during my first 100 days in the Trust, I committed to having a Big Conversation about our values: what they mean now, how we live them every day, and how together we create psychologically safe environments where everyone feels welcome, respected and able to speak up.

I made that commitment because colleagues described very different experiences of working here, and because we know we can do more to make our shared values feel real and consistent for everyone.

Our values of Kindness, Openness and Excellence were co-created more than six years ago. Since then, almost half of our workforce are new to the Trust, and many colleagues tell us they do not always experience those values in day-to-day working life.

The Big Conversation is our opportunity to reconnect with our values, reflect on the behaviours and standards we want to see, and agree what they require of us now. Most importantly, it is a chance to shape together how we treat each other, how it feels to work here, and how that can help us provide even better care for our patients.

Our values shouldn’t simply be words on a poster or something we talk about when things are going well. They should shape how we treat each other when things are difficult, how decisions are made, how leaders behave, what we expect of one another and, importantly, what happens when those expectations aren’t met.

We have now completed the first stage of our Big Conversation, where all colleagues were invited to take part and share their thoughts. I read many of the contributions and there was real honesty in the conversation, including about the things that are difficult and where we need to do better. Colleagues shared over ten thousand contributions, which have now been analysed.

The headlines are that, largely speaking, people recognise and are comfortable with our values and the standards described in our current behavioural framework. The challenge is that people do not feel these are lived out by all colleagues, every day, and that we lack

consistency in how we hold each other accountable when these standards of behaviour fall short.

We are now finalising a proposed refresh of the standards to help us address this, linking in with the framework that underpins our new improvement method, which has values and standards of behaviour at its core.

I will share more about this work as it develops, in particular the action we are taking as a result and how this will influence the way our Trust leads, behaves and improves.

8. Star Award nominations

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

Date: 30 September 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

August 2026

Amy Gomes, ACCS ST1-ST2 Anaesthetics **York** **Nominated by a colleague**

Even when she was on a different part of the hospital working in a different unit that day, Amy took time when it was less busy and when it was safe to do so to check in on ICU. That day, ICU was extremely busy, to the point staff were feeling overwhelmed. She helped clerk a patient in and checked in again later in the day. This is a consistent pattern from someone who is both kind and compassionate and who also looks after her colleagues.

Matthew Squires, FY1 General Internal Medicine **Scarborough** **Nominated by a colleague**

Matt is a compassionate and kind practitioner who always puts the patient first, and his communication skills are impeccable. On this occasion, there was a patient with a new poor prognosis who was unfortunately placed on the palliative care pathway. Matt was the practitioner to break the news to this patient, but did this in the kindest, most compassionate manner. He had the patience to answer all the patient's questions and talk to them about their fears and wishes.

Having this conversation is an area Matt feels inexperienced in; however, his delivery, patience and overall kind and empathetic manner are something that truly should be celebrated. It is a pleasure to work with Matt; he really is a star!

Corinna Crowther, Student Midwife **York** **Nominated by a colleague**

Corinna is a third-year student midwife who is currently case-loading (giving continuity to several birthing families from booking through to birth and the postnatal period). She called me on a Sunday recently to ask if she could accompany me on a routine day five visit to see one of her case-loading clients, whom she had attended during her labour and birth.

It was a real pleasure to witness the affection that the couple demonstrated towards Corinna; she had clearly made a massive difference to their quite challenging and traumatic birth experience. I believe this was almost certainly due to Corinna's kind and loving care and the fact that she had built up their trust in the preceding months. Corinna clearly demonstrated going above and beyond when she also explained that she was in between night shifts and had got up during the day, especially to see them.

Corinna has been offered a midwifery job in Scarborough, and I feel we are very lucky as a Trust to have such a caring and diligent newly qualified midwife amongst our staff. If she ever moves across to York, I can't wait to work with her!

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

I am nominating the team on Ward 36 for the care they gave to a patient recently seen by the Older People's Mental Health Assessment and Liaison Team. The patient had been admitted following a serious overdose and told me they had been very worried about how they would be treated because of what had happened. It was lovely to hear them talk so positively about their time on Ward 36. They said they felt safe, cared for, and treated with kindness and respect by everyone they met.

It was clear the team were living the Trust values, particularly kindness and compassion. At a time when the patient felt very vulnerable, the team created an environment where they felt accepted rather than judged. The difference this made to the patient's experience was obvious, and I wanted to make sure the team received the recognition they deserve.

Josmy Thomas, Physiotherapist **York** **Nominated by a colleague**

I am nominating Josmy Thomas for outstanding and compassionate care and exemplary initiative. Recently, Josmy was assessing a patient who was deeply distressed after a car accident, had sustained rib fractures, and was worried about her husband’s whereabouts and condition.

Despite having no immediate information, Josmy took personal ownership of the situation. She first contacted the patient’s daughter, who also did not know where he was. Refusing to leave the patient in uncertainty, Josmy went the extra mile: she searched systematically through Nervecentre patient records to locate him. She confirmed he had been admitted to the ED and was stable. Josmy then promptly shared this information and reassurance with the patient, transforming a moment of fear into relief and gratitude.

This was not just a task completed; it was a powerful act of kindness that protected the patient’s dignity, reduced anxiety, and upheld a family’s need for timely, accurate information. I wholeheartedly recommend Josmy Thomas for the Star Award.

Steve Hannan, Security Officer, and Daniel Nix, Security Officer **York** **Nominated by a colleague**

There was a team from Full Sutton HMP in attendance at the hospital, and there was a problem with the Security vehicle they had brought to site. This meant the team on site had to wait for this to be recovered and wait for a new vehicle to be dispatched. The weather was very hot, and two York Hospital Security team members purchased some refreshments out of their own money to give to the team to make sure they were hydrated. This, for me, is demonstrating the Trust's values and behaviours and showing exemplary behaviour, and I want to thank them. Well done.

Michelle Rhodes, Payroll Officer **Tribune House** **Nominated by , colleague**

Whenever you call Michelle with a query, she is always helpful. If she is unable to answer straight away, she will get back to you. Nothing is too much trouble for her, and she is always polite and helpful.

Nathan Brasier, Healthcare Assistant	**Scarborough**	**Nominated by a colleague (1) and a colleague (2)**

Nomination 1

Nathan is brilliant with all patients. He is always calm and patient with anybody he comes across. We had an aggressive patient on the ward that wouldn't listen to anyone but Nathan.

Nomination 2

Thank you to the incredible Nathan for his compassion, dedication, and hard work every shift. His kindness, patience and commitment make a real difference to the lives of our patients and their families. We appreciate everything he does. Also, thank you for always going that extra mile by helping and making the shift less stressful. Nathan deserves recognition for the exceptional care he provides.

Danielle Smith, Senior Healthcare Assistant	**Scarborough**	**Nominated by a colleague (1) and a colleague (2)**

Nomination 1

Danielle has gone above and beyond for all colleagues and patients. When I joined the Trust, Danielle was allocated as my buddy and was approachable, informative, friendly and outgoing. She always puts a smile on everyone's face and always goes the extra mile to help those in need, patients and staff alike. Danielle taught me a lot while I was supernumerary, was always happy to go the extra mile to help me understand my job role and allowed me to learn and grow.

Nomination 2

Danielle is an integral part of the team. She is always willing to help anyone in need. She is good with patients and a hard worker.

Cherry Ward	**Scarborough**	**Nominated by a colleague**

Cherry Ward is a nice ward. Staff are always kind and willing to help, no matter the issue. Everyone always tries their utmost to care for the patients as individuals and to get them back home where they need to be. It is a great team of individuals.

Hentry Joby, Staff Nurse	**York**	**Nominated by a colleague**

Hentry is a hard worker who never complains and is consistent with her standards of patient care. She is a team player and always willing to go the extra mile to ensure theatre cases are organised and set up with a smile on her face.

Evelyn Barnwell, Admin Assistant **York** **Nominated by a colleague**

Evelyn consistently goes above and beyond in everything she does. She wears many hats and approaches every challenge with a positive "can do" attitude, no matter how busy or complex the task. Evelyn makes a tangible difference through her dedication, professionalism and willingness to help others. She is highly methodical, logical and meticulous in her work, ensuring that tasks are completed accurately and to the highest possible standard. Whether troubleshooting issues, managing administrative processes or helping colleagues navigate new systems, Evelyn approaches every piece of work with care and attention to detail.

What sets Evelyn apart is her ability to work independently and take ownership of problems while also knowing when to collaborate with others to achieve the best outcome. She proactively identifies solutions, follows issues through to completion, and never hesitates to support colleagues when they need advice or assistance. Time and again she demonstrates initiative, persistence and determination, often resolving issues that others would struggle to untangle.

Evelyn embodies the Trust values of kindness, openness and excellence in her everyday behaviours. She is approachable, supportive and generous with her knowledge, always willing to help colleagues. She speaks openly and honestly, offering constructive ideas and challenging processes where improvement is needed. Her commitment to excellence is evident in the quality of her work, and her drive to ensure tasks are completed thoroughly rather than simply getting them finished.

Evelyn's contribution often happens behind the scenes. Her reliability, professionalism and unwavering commitment make a difference to staff across disciplines and the Trust. She is someone the team can always rely on and an outstanding example of what it means to be part of our Trust. Through her dedication, initiative, positivity and willingness to go above and beyond, Eve has made a significant impact and is richly deserving of this recognition.

Ceri Willis, Clerical Officer **Archways** **Nominated by a colleague**

I am nominating Ceri because she makes such a positive difference to everyone they meet. Her kindness, warmth, and genuine care shine through every single day. Ceri is always the first to greet patients with a smile and a friendly face, helping people feel welcome and at ease. She brings that same kindness to the team too. No matter how busy things get, she always has time for others, whether that's offering a helping hand, listening, or simply brightening the day with their positive attitude.

Ceri makes everyone feel valued and included, and she creates such a welcoming atmosphere for both patients and colleagues. The NHS is built on compassion, teamwork, and putting people first, and Ceri embodies those values every day without ever seeking recognition. They are one of those people who quietly make the workplace a better place to be, and I can't think of anyone more deserving of this nomination.

Wendy Whetton, Operating Department Practitioner, Lucy Rose, Staff Nurse, and Nicola Ibson, Operating Department Practitioner	**Bridlington**	**Nominated by a colleague**

I am nominating Wendy, Lucy and Niki for a Star Award in recognition of their outstanding teamwork, professionalism and commitment to patient care. While working in Bridlington Orthopaedic Theatre, the final patient on our operating list required an urgent transfer to Scarborough Hospital for a higher level of care. Wendy and Lucy willingly stayed beyond the end of their shift to escort the patient alongside the ambulance crew, ensuring the patient was safely transferred. They remained with the patient until they were stable, and a full clinical handover had been completed, demonstrating exceptional commitment to ensuring continuity of care.

As ambulance crews are unable to transport staff back to Bridlington due to operational demands, Wendy and Lucy were left in Scarborough at the end of the transfer. Recognising this, Niki kindly stayed beyond the end of her own shift to drive to Scarborough, collect them and return them to Bridlington Hospital so they could retrieve their vehicles and travel home safely.

Working in Bridlington can often feel particularly challenging when a patient deteriorates. Escalating care is not simply a phone call - it requires staff to accompany patients during transfers, often extending well beyond their contracted hours. Despite this, Wendy, Lucy and Niki demonstrated unwavering dedication to both their patient and one another. Their actions are a perfect example of our Trust values in action:

- Kindness – showing genuine care and compassion for both the patient and each other
- Openness – working together, communicating effectively and supporting colleagues without hesitation
- Excellence – going above and beyond to ensure safe, seamless, high-quality patient care.

This was an exceptional example of teamwork at its very best. They placed the needs of the patient first while also ensuring their colleagues were supported and safe. Their professionalism, selflessness and willingness to go the extra mile reflect everything our Trust stands for, and I believe they are thoroughly deserving of this recognition through a Star Award.

Transport Team **York** **Nominated by a colleague**

I am nominating our Transport Team in recognition of the consistently outstanding support they provide across the Trust, and particularly to thank them for stepping in at the eleventh hour to help the Communications Team ahead of our recent public engagement events in Bridlington.

At very short notice, we needed many display boards transported to Bridlington Spa. Despite already having busy workloads, the team rearranged priorities, made additional journeys and went out of their way to ensure everything arrived safely and on time. Their willingness to help meant our events could go ahead as planned and created a professional environment for engaging with local communities.

This is far from an isolated example. The Transport Team are always there when we need them, helping with Celebration of Achievement and long service events or responding to last-minute requests that make a real difference. Nothing ever seems too much trouble.

I would particularly like to recognise Phil Bland and Michael Cunningham, whose support on this occasion was exceptional. However, this nomination is for the whole team because this example reflects the attitude they demonstrate every day. The Transport Team truly live our Trust values. They are dependable, helpful and always willing to go the extra mile – quite literally. Their professionalism, flexibility and positive attitude are hugely appreciated, and they richly deserve this recognition for the invaluable contribution they make across our Trust.

Kelly Cauley, Operational Manager **York** **Nominated by a colleagues**

Kelly is an exceptionally hard worker and goes above and beyond every single day; however, this has never been more evident than in the last six months. Due to vacancies within the team and a Trust restructure, there has been substantial disruption and considerable upset amongst the staff, some of whom were having their roles changed or were losing their current roles.

Kelly has gone over and above to support the impacted staff members on all sides, and everyone else affected by the ripple effect of these changes. Due to ongoing sickness and a further vacancy within the team, she has found herself covering numerous roles, as well as trying to keep on top of her own ever-increasing workload.

Her commitment and dedication to the department, team and patients have been exceptional. She continues to find time for everyone, regardless of their role, and makes sure everyone feels valued and supported in whatever way she can. Kelly is a credit to the team. Her dedication, professionalism and support for all those around her make a huge difference to the team and most definitely do not go unnoticed. On behalf of us all, thank you, Kelly.

Eliza Kirk, Staff Nurse **York** **Nominated by a colleague**

Eliza is compassionate towards patients, very understanding, and brilliant at her job.

Charlie Oldfield, Operating Department Practitioner **York** **Nominated by a colleague**

During a set of night shifts, Charlie helped in other areas that he was not assigned to as it was very busy. He always goes that extra mile in patient care. For example, he got his patient a sandwich at 4am as the patient had to be cared for in theatres PACU because no beds were available on a ward. He went that extra mile, ensuring his patient was cared for and catered for. Nothing was too much.

We also had a patient in resus that we attended to in the early hours. Unfortunately, this patient needed end-of-life care. Charlie helped organise a side room bed for the patient and family on the stroke ward. We then took the patient to the ward after the family came to the hospital. As the patient had an airway device in situ, it was discussed whether this should be removed before taking the patient to the ward or removed on the ward. Charlie was involved in deciding to remove it on the ward with the doctors. We took the patient to the ward, made the patient comfortable in the bed and presentable for the family. Then it was time to remove the airway device.

I think Charlie is very knowledgeable in his field and in other areas, and he showed great care and respect, and always kept the patient's dignity. He is a credit to all ODPs, and I find him inspiring.

Kathryn Thorpe, Healthcare Assistant **York** **Nominated by a colleague**

She has just passed her NA course with flying colours. Every day she works incredibly hard and puts her best foot forward. Every day she upholds the Trust's values; supporting patients and staff, making her colleagues laugh, and proving how amazing she is. She is an asset to the NHS!

Molly Carter, AHP Senior Support Worker, Katie Squire, Generic Therapy Assistant, Gary Milson, Generic Therapy Assistant, and Maddi Kirkman, Generic Therapy Assistant **York** **Nominated by a colleague**

The generic therapy assistants of the Elderly Therapy Team at York Hospital have lived the Trust values over the past year, ensuring that the needs of our elderly patients across wards 28, 29, 35, and 37 are consistently met. Our therapy assistants work diligently to ensure their caseload is completed on each ward daily and demonstrate excellent teamwork by cross-covering wards to help each other.

The most encouraging aspect is that our therapy assistants consistently complete their workload whilst ensuring the dignity of each patient is maintained. It is often the case that family members, ward staff, and patients themselves will ask for assistance with tasks outside of their role, and our therapy assistants will endeavour to complete them with great compassion whenever possible.

As a qualified occupational therapist, I am very much reliant on the support of our therapy assistants to assist with the practicalities of patients' discharge and daily tasks completed to reduce boredom and the risk of deconditioning in hospital. We are very grateful for the hard work, effort, and patient-centred care delivered.

Kheira Haffiane, Research Nurse **York** **Nominated by a colleague**

Kheira's substantive role is as a Research Nurse, but she is also an exceptional advocate for equality, inclusion and belonging through her role as Vice Chair of the Trust's Race Equality Network. She approaches both roles with remarkable enthusiasm, dedication and an unwavering commitment to making a positive difference for others.

Kheira is deeply passionate about improving the experience of colleagues across the organisation. She generously shares her expertise, supports others with kindness and empathy, and consistently champions equity and inclusion in everything she does. Through her engagement with colleagues, managers and senior leaders, she influences change at every level, helping to create a more inclusive culture where people feel valued, respected and able to thrive.

What makes Kheira's contribution even more inspiring is the dedication she shows beyond her substantive role. While undertaking a master's degree in research and reducing her working hours to support her studies, she continues to give her time, energy and expertise to advancing race equality across the Trust. Much of this work is carried out in addition to her normal responsibilities, reflecting her genuine commitment to improving the lives and experiences of those around her.

Kheira embodies the Trust's values of kindness, openness and excellence. Her passion, integrity and determination make a lasting impact on colleagues and the wider organisation. We are incredibly fortunate to have someone with her dedication, compassion and drive working within our Trust. Thank you, Kheira, for everything you do. Your commitment does not go unnoticed, and this nomination comes with enormous gratitude and appreciation for the difference you make every day.

Pierre Gomez, Retail Catering Manager **York** **Nominated by a colleague**

Pierre was one of the very first colleagues to welcome me when I joined the Trust four years ago, and, from that moment, he has been a constant source of support, encouragement and kindness. I can honestly say that he is one of the most supportive people I have had the privilege of working with. He has always been there for me, championing both me and the work that I do. His advice, encouragement and unwavering support have made a real difference, and he always takes the time to check in and see how I am doing. Knowing that Pierre is in my corner has meant more than I can express.

Beyond his support for others, Pierre is an incredibly passionate advocate for racial equality. He works tirelessly to improve the experiences of colleagues within his own directorate and across the wider Trust, always striving to make our organisation a more inclusive, compassionate and equitable place for everyone.

I believe Pierre deserves this recognition because people like him are truly special. His kindness, integrity, commitment and genuine care for others shine through in everything he does. He makes a positive difference to the lives of so many colleagues, often without seeking any recognition in return. Thank you, Pierre, for your friendship, your support, your advocacy and the positive impact you have on everyone around you. This nomination is truly deserved.

Carter Angliss, Domestic Assistant **York** **Nominated by a colleagues**

Carter is very good and helpful with everybody in Ward 36. He works very hard, and he makes sure our ward is clean. He is one of the reasons why we scored stars in our recent cleaning audit. He is always happy to help and cheerful whilst working. He is the best cleaner we have had so far on Ward 36. Our patients even recognise how hardworking he is. His work has been noticed by all the staff.

York Cashiers **York** **Nominated by a colleague**

The York Cashiers' Office is a historically under-appreciated department, but they are so often relied upon by patients, relatives and members of staff that they deserve to be recognised for the work they do.

They ensure that reimbursement of expenditure is completed in a timely fashion and in line with financial controls, but they always do so in a kind, caring and compassionate manner, regardless of whom they are talking to. They often help patients on low incomes or claiming benefits to reclaim their travel expenses, and they talk through the process with these patients calmly, knowing how difficult it can be when you've never had to claim before. I have also seen them explain the process for reimbursement to new members of staff, guiding them to the correct place when there's something missing or unclear.

On top of this, they maintain a sizeable cash float at York Hospital, handle patient monies which are banked for safekeeping, take in lost property and do their utmost to reconnect it with its owner, and do so many more things that I don't notice because it keeps everything running smoothly. Everything is completed to a high standard, with all items documented such that if a query is raised, they always know exactly where to find the information we need. I've also known them to be of help to other cashier units when unusual situations crop up, as they almost always have the answers.

My team works closely with York Cashiers, but we work off-site, and sometimes I feel that people don't recognise how much they do for us. They're tucked away in a small office away from the main corridor and, due to the need to ensure the security of the money we hold, aren't often seen outside that office (except on daily banking rounds), which means the service they provide is often overlooked, but is of vital importance to our patients and extremely helpful to our staff. I can't stress enough how important their work has been to me as I've moved through the Financial Accounting Team, and how welcome I've always felt whenever I've gone across to them or contacted them about anything.

Georgina Flatt, Matron **York** **Nominated by a colleague**

I am nominating George for a Star Award following a particularly difficult situation on the ward. We were dealing with a very distressed patient, and, at times, the situation felt quite overwhelming for both the patient and the team. George was able to quickly build a strong rapport with the patient and adjusted her approach in a way that really helped to calm things down. Her ability to de-escalate the situation made a huge difference, helping the patient feel safer while also ensuring the safety of everyone around them. She was a strong advocate for the patient throughout, making sure their needs were always at the centre of what we were doing. At the same time, she supported the wider team so we could move forward with the care that was needed.

What really stood out was how calm and focused George remained, even though the situation was emotionally and physically demanding. She never lost sight of the patient's needs and handled everything with professionalism, compassion, and a personal touch. George played a key role in helping both the patient and the team get through a very challenging experience. Her dedication and ability to stay calm under pressure make her truly deserving of this recognition.

Security Team **York** **Nominated by a colleague**

I am nominating the Security Team who supported Ward 34 and a patient during a particularly challenging period of their stay. Over the course of three days, the team took the time to build a strong rapport with the patient. They showed genuine care and consistently advocated for the individual, adapting their approach during very difficult moments to ensure the patient felt supported and understood. Despite being under significant pressure at times, the team remained calm and focused, always prioritising the safety and wellbeing of everyone involved.

Their communication and compassionate approach helped to de-escalate situations and create a safer environment for both the patient and staff. Their teamwork and support were outstanding, and their presence made a real difference during what was a very demanding situation. I believe they are truly deserving of recognition for their dedication and professionalism.

John Norman, Specialty Registrar | **York** | **Nominated by a colleague (1) and a colleague (2)**

Nomination 1

Mr Norman is an exemplary surgeon and member of the orthopaedic team. He demonstrates all the traits that are looked for in a doctor and surgeon, both from his patients and his team. Mr Norman provides excellent support and mentorship to his SHO resident doctors, giving them the space to develop their skills but providing oversight and insightful advice when needed. He is a strong advocate for his patients and will go the extra mile again and again, no matter how busy the take.

It has been a true privilege to work under Mr Norman, and I have learned a huge amount about leadership, organisation, and excellence from him. He exerts full control over the orthopaedic department and emergency admissions when on-call, meaning patient care is both prompt and high quality. He is the best registrar I have worked under, and, through his clear demonstration of excellence, I would want no other orthopaedic surgeon treating me or my family. He has inspired me to go the extra mile, and I can say with certainty he is a huge asset to any team he is in.

Nomination 2

John has been an exceptional registrar to work with during my Trauma and Orthopaedics rotation and is a shining example of an excellent colleague, mentor, and clinician. John regularly goes above and beyond for both his patients and colleagues.

As a junior member of the team, John personally helped me develop my understanding of Trauma and Orthopaedics and mentored me through bedside teaching and short tutorials. During difficult on-call shifts and nights, John has always made himself approachable and encouraged juniors to ask him if they had any concerns or queries. When workloads increased, John has supported juniors by actioning tasks he would not be expected to do, such as discharge summaries and simple ward patient reviews. John always maintains a patient-centred approach to his clinical work, which sets him apart. He always reviews patients pre- and post-op and develops an excellent rapport that visibly puts them at ease, especially before serious and daunting hip operations. When difficulties do arise, John is always the level head that juniors look to for support. He fully assumes the responsibilities accepted of him, and when referrals to coroner/death certificates are required, he is the first to put himself forward.

I have noticed the incredible difference John contributes to the Trauma and Orthopaedics department. The weeks he is scheduled to work run seamlessly and often consolidate and clarify outstanding issues raised in previous weeks. It has been a pleasure to work with Mr Norman. Throughout my foundation training programme, if there was one individual I could nominate for this award, it would be him.

Becky Harrison, Physiotherapist **Malton** **Nominated by a colleagues**

We are nominating Becky for a Star Award in recognition of her exceptional commitment and dedication in leading the purchase and installation of an interactive projector for the Children's Therapies Department. This project required considerable perseverance and coordination. Becky successfully secured charitable funding, organised a trial of the equipment with the supplier, and managed the complex logistics of working with both the company and the Estates team to ensure the projector was installed successfully.

The interactive projector will have a significant and lasting impact on the children and young people in our care. It will enhance therapy sessions by making them more engaging, enjoyable, and interactive, while also improving participation and motivation for both children and their families.

Becky's determination to see this project through from the initial idea to successful implementation has been outstanding. Her enthusiasm, persistence, and commitment to improving the experience of the children and families we support have been greatly appreciated by the entire team. This achievement is a true reflection of her dedication to delivering high-quality, innovative care, making her a thoroughly deserving recipient of a Star Award.

Outpatients Team **York** **Nominated by a colleague**

I am nominating the Outpatients Department at York Hospital for their ongoing support towards me. I have just returned to work after maternity leave and am still breastfeeding my baby; therefore, I need to express while on shift. I was very anxious about how this would be possible and feared I may have to end my breastfeeding journey because of being back at work.

The Outpatients Team have been very accommodating and assisted in providing me with a private room and facilities. They have treated me with such kindness and respect and gone above and beyond to protect my dignity, which is allowing me to continue my breastfeeding journey, something which is incredibly important to me. Without their continued support, I do not feel as though I would have been able to continue this, so I am truly grateful to them.

The entire team have been excellent, and they make me feel so comfortable whenever I need to go down. Not only have they gone above and beyond for me as a member of staff, but they also go above and beyond for the patients that enter their department. Every team member deserves recognition for the excellent care and support they provide; it really does make such a difference. It really has made a difference to me, and I want to thank them all.

Ailsa Grassam, Epilepsy Nurse Specialist **York** **Nominated by a colleague**

Ailsa has had a difficult year - the team lost a colleague, the lead consultant has retired, and she has had lots going on outside of work, but she has continued to be a positive and kind influence on all those she works with. Ailsa has maintained a very stretched service and ensured that her patients do not feel the pressure by being sunny, bright and professional at all her interactions. At the same time as all this, she has just passed her non-medical prescribing course, which she undertook to benefit her service. She is an inspiration.

Emma Davis, Advanced Practitioner Ultrasound **York** **Nominated by a colleague**

Emma is a kind and supportive colleague. She is open and approachable. She has consistently gone above and beyond to accommodate patients. Yesterday, she had a full clinic, but, despite this, she scanned two extra patients who were in urgent need of scans. She has done this many times before when no other scan slots are available elsewhere. Emma never complains and has a wonderful disposition. Working with her is a pleasure, and I always feel happy when I see her in the mornings, as I know my patients will be in a warm and supportive place when Emma scans them.

Natalie Thwaites, Clinical Governance Coordinator **Scarborough** **Nominated by a colleague**

Natalie has worked tirelessly over the last few months as the only Clinical Governance Coordinator while we waited for the other role within the team to be filled. She has done this with a positive can-do attitude and a persistent smile on her face. Nothing has been too much trouble. Since she joined our team, she has been instrumental in getting the department into a much better position with guidelines and coordinating the day-to-day running of the governance team. She is a fantastic problem solver and always has fresh ideas of how we can improve the service. Thank you so much, Natalie - we are so lucky to have you.

David Thomas, 2nd Line IM&T Senior Engineer **York** **Nominated by a colleague**

I am nominating David Thomas for a Star Award in recognition of the significant support he provided during the recent Q-Pulse upgrade. The upgrade process began in March, when we were testing the new system. Unfortunately, the test upgrade did not go as expected and resulted in the loss of access to the current system. I contacted Dave, and he immediately went above and beyond to help restore the system to working order. He recognised the importance of the issue, prioritised the work, and approached the situation with professionalism and an exemplary attitude throughout.

Dave undertook this urgent fix without complaint, despite it being raised at short notice and requiring immediate attention (especially as some of it was user error on my part). When it came to the full upgrade, he prepared the new instances, ensured they were working correctly, and supported the rollout efficiently. His work meant the system was unavailable for only a short period, which made a real difference to users across the service (over 600 of us).

Dave’s responsiveness, technical knowledge, and willingness to support the service under pressure were greatly appreciated. I would like him to know that his hard work, professionalism, and commitment have not gone unnoticed, and I believe he is very deserving of this recognition.

Michael Harrison, Cleaning Operative **York** **Nominated by a colleague**

I would like to recognise Michael for the outstanding work he does for our department. Although he works in the evenings when most of us have gone home, his dedication, attention to detail, and willingness to go the extra mile make a real difference every day and never go unnoticed. I truly appreciate all that he does and wanted to make sure he knows how valued he is.

Dermatology Outpatients **Malton** **Nominated by a colleague**

I received a call from a patient's wife following a Dermatology appointment she and her husband attended at the Diagnostic Centre today. The patient had been feeling very unwell, and they had travelled from Bridlington on hospital transport.

When the patient's wife called, she asked to speak to a senior manager. Naturally, I asked if everything was okay. Her response brought a huge smile to my face - she wanted to make sure someone knew just how incredible our staff had been.

She specifically wanted to thank Lynda on Reception and Kath, our Healthcare Assistant, for the warmth, patience and genuine kindness they showed throughout their visit. In fact, she was so moved by their care that she felt it was important that managers and colleagues knew just how much of a difference they had made.

Some of the things she said were: "These are the kindest people ever", "Malton is the best hospital", and "The managers should know how wonderful the staff are and how much they do." She went on to say that everyone they encountered genuinely cared about patients and that the kindness they experienced was something special. In fact, she was so impressed that she jokingly said she wished she could live in Malton because everyone had been so lovely! She asked me to pass on her heartfelt thanks to Lynda, Cath, and everyone involved in helping them today.

It was one of those conversations that reminds you why we do what we do. The small things we do every day can mean absolutely everything to someone who is having a difficult time.

This message belongs to every member of staff who chooses kindness, compassion, and respect every day. It is a wonderful reflection of our Trust values and the culture we strive to create for our patients and each other.

Thank you, Lynda and Kath, for making such a positive difference. And thank you to everyone across Malton who continues to embody the very best of our Trust. Hearing these kind words truly made my day, and I hope it makes yours too.

Asmita Chatterjee, Physiotherapist | **Scarborough** | **Nominated by a colleague (1) and a colleague (2)**

Nomination 1

Ash daily embodies the Trust values, and her determination and advocacy for her patients to receive the best care should truly be celebrated. Recently, Ash was involved with the care of a complex patient on her ward who had additional needs, complex respiratory issues and a complex social situation. Ash spent additional time with the patient to listen to their concerns, delve into the tasks that were difficult for the patient and the support needs they had around this, manage the patient and family expectations, and to get in touch with various members of the MDT and external services to ensure that the patient would receive the specific support they required to maintain their independence.

She did not give up despite the complexity of the situation or give up advocating for the patient and their needs despite facing challenges multiple times along the way. The patient was thankful for Ash's involvement and for her kindness and compassion in what was a distressing and lengthy admission. Ash was directly responsible for the final plan in place for this patient, which meant they could go home, supported and satisfied.

Ash's determination, care, compassion and resilience never wavered. It is a pleasure to work with Ash and know that the patients have someone who will not give up striving for the best care and outcomes, even when things get tough. Ash truly lives the Trust values and, in many eyes, is a star!

Nomination 2

Asmita (Ash) was fundamental in helping build a concrete rehab and discharge plan for a complex patient on Beech Ward. The patient was admitted for an exacerbation of asthma and had several co-morbidities including Cerebral Palsy, a learning disability, and autism. Ash showed kindness and compassion when working with the patient, who was significantly overwhelmed by the hospital environment. She understood that the patient required very clear goals and worked with her to set them. Ash demonstrated patience when working with the patient and gave the patient the time and space to complete these goals.

Ash liaised across the wider MDT to create a robust discharge plan for this patient, taking into account her very specific needs, challenging unconscious bias where needed, and advocating for the patient in a professional manner. Ash is a shining star!

Philippa Satchwell, Specialty Doctor | **York** | **Nominated by a colleague**

I am nominating Philippa for a Star Award for her continuing work organising and delivering induction to our new paediatric resident doctors. Philippa seamlessly co-ordinates all members of the MDT to deliver high-quality and relevant training that is recognised as being an example of excellent practice within the Trust. She consistently receives positive feedback, including comments that new doctors feel more prepared and confident when starting their paediatric placement. Philippa puts in her own time and effort (including transporting equipment and refreshments back and forth) to ensure the success of the induction programme, which is very much appreciated. Thank you, Philippa.

Clair Murgatroyd, Patient Services Assistant **Scarborough** **Nominated by a colleague**

Clair is a wonderful PSA, and she is excellent with the patients and their families. Clair has organised an activities trolley for the ward with magazines, puzzles and colouring pages, which is wonderful for the patients. It is amazing to see patients doing something fun while being in hospital. I cannot praise Clair enough; the activity trolley is something I would love to see on other wards as well. She has gone above and beyond for patient-centred care, and she has also brought music to patients who settle better to music with a CD player and various CDs.

Soraya Devine, Bank Healthcare Assistant **Scarborough** **Nominated by a colleague**

I am nominating Soraya for a Star Award because I have observed on several occasions the way she speaks to and treats patients when she thinks nobody is listening. She is kind and respectful and really does go above and beyond for every patient on every shift. I would love her to realise that her positive energy and attitude are recognised and appreciated.

Yasmin Gharib, Healthcare Support Worker **Scarborough** **Nominated by a colleague**

Due to staffing levels, Yaz had to work extremely hard to keep on top of essential tasks while maintaining patient safety and dignity. She worked tirelessly and missed one of her 30-minute breaks due to the acuity of the department.

Andrew Smith, Sustainability Data Analyst **York** **Nominated by a colleague**

I am nominating Andrew for his tireless work in supporting the delivery of the Green Plan and ensuring a thorough analysis of data from hundreds of spreadsheets and datasets. His work provides the best and most accurate picture of the Trust's position on its Net Zero journey.

Roles like Andrew's can often be overlooked and remain more in the background, but his recent development of a much more complicated spreadsheet to read and analyse data from hundreds of other datasets will provide us with even more accurate information. Andrew did not have to do this, but his drive for excellence and his willingness to go above and beyond by working many hundreds of hours to ensure we have the best dataset possible is commendable.

While this is not saving lives in the way our clinical colleagues do every day, Andrew's recent work needs to be recognised, and I am pleased to be putting forward this nomination for Andrew to show how much he is appreciated and to recognise his ongoing hard work.

York & Scarborough Hospitals Charity Team **York** **Nominated by a colleague**

The whole Charity team have worked with energy and enthusiasm to raise money for the Tiny Lives Appeal. Every member of the team has worked so hard and been involved in all the events to raise money for the new SCBU refurbishment. The fundraising has now passed its original target of £100,000, which is an incredible achievement. The efforts of the team and the kind generosity of the appeal supporters will make a huge difference to the babies, parents and staff using the new unit. Thank you so much from the whole SCBU team.

Annemarie Simpson-Norris, Senior Healthcare Assistant **Scarborough** **Nominated by a colleague**

Annemarie is a dedicated colleague on our ward and always goes above and beyond to help the patients. Annemarie not only works very hard but has gone the extra mile helping her colleagues when they needed support. She really went out of her way in my case by looking after my terminally ill mother for a few days while I had the opportunity to go and visit my family down in London, whom I haven't seen for many years. Truly an angel in disguise.

Beverly Whitehurst, MUO Pathway Navigator **York** **Nominated by a colleague**

I would like to acknowledge Bev's outstanding hard work, dedication, and commitment in her role as the MUO Pathway Navigator. Her exceptional understanding of patient needs is fundamental to the success of this service, and she consistently goes above and beyond to ensure all timelines are achieved. Bev coordinates every stage of the patient pathway, from referral through to MDT discussion and outpatient attendance. She also completes Holistic Needs Assessments (HNAs), providing valuable insights that help guide consultants and nursing staff in treatment planning and the delivery of appropriate healthcare advice.

Patients have great confidence in Bev and feel comfortable approaching her for support. One patient commented: "Without Bev, this difficult situation would have been impossible. She is kind, thoughtful, and will always find the answers to the many questions I had." This feedback perfectly reflects the dedication Bev demonstrates in ensuring patients have the information, reassurance, and support they need to make informed decisions about their care.

Bev is a passionate advocate, not only for patients but also for the service itself. She continually contributes ideas, drives improvements, and provides unwavering support that enhances the quality of care we deliver, while consistently demonstrating the Trust's values in everything she does. Bev truly deserves recognition for her dedication and commitment. Without her, the service would not be the forward-thinking, patient-focused pathway it is today.

Domestic Supervisors **York** **Nominated by a colleague**

The domestic supervisors have made a difference to my son's (and my) working life. My son has autism and dyspraxia and struggles when things aren't in his usual routine; and the supervisors have gone out of their way to make his work life more bearable. They have tried to keep him based in wards he knows, and if they are unable to, they ensure that he has someone with him to show him the ropes. They have taken him to be assessed when he suffered a panic attack and then came back to check on him several times.

These (what I'm sure feel small to them) provisions have ensured my son has been able to take an active part in a workplace and, more importantly, made him feel valued and respected. It has meant that it is one less thing I need to 'worry' about as I know they look after him. I really can't thank the team enough for being willing and able to go the extra mile to ensure my son can lead a productive working life and contribute back to society.

Cleo Glendinning, Directorate PA and Admin Co-ordinator **York** **Nominated by a colleague**

I am nominating Cleo for a Star Award in recognition of her commitment and flexibility during a prolonged period of staffing challenges across several teams. Throughout this time, Cleo has continued to fulfil the responsibilities of her own role while also providing vital support to other areas experiencing workforce shortages. When ward clerk cover was unavailable, she stepped in to ensure the wards continued to run smoothly and efficiently. In addition, she took on the responsibilities of an administrative support role following a vacancy, maintaining continuity of service while the recruitment and onboarding of a replacement member of staff was delayed.

Cleo has been managing the demands of three separate roles simultaneously. She has achieved this by carefully prioritising key tasks, maintaining focus on service delivery, and ensuring that important operational responsibilities were not overlooked. Despite these additional pressures, she has continued to oversee active recruitment processes, keeping them on track while also supporting her own team and colleagues.

What makes Cleo's contribution even more remarkable is the positive attitude she brings to work every day. She has approached these challenges with professionalism, grace, and humour, helping to maintain team morale during a demanding period. Her willingness to step in wherever needed and her unwavering commitment to supporting services have made a significant difference.

Cleo has consistently gone above and beyond what could reasonably be expected of her, ensuring that services remained effective and teams continued to function despite significant staffing pressures. She is a highly valued colleague who truly embodies the values of our organisation, and I believe she is thoroughly deserving of a Star Award.

Kayleigh Brown, Switchboard Operator **York** **Nominated by a colleague**

Kayleigh went above and beyond to ensure that an upset and distressed patient received the care and medication that she required. The patient was struggling to get through to the Rheumatology Advice Line. With the patient's consent, Kayleigh took the details of the patient and emailed the Rheumatology secretaries, where she got a response from several team members, who then contacted the patient and dealt with her enquiry. Kayleigh went above and beyond because operators are there only to transfer calls and deal with emergencies.

Lewis Swain, EUC Engineer **Scarborough** **Nominated by a colleague**

I am nominating Lewis for a Star Award in recognition of the outstanding support he has given me over the last few months. There have been several occasions when I have been preparing to deliver training in the Blue Room at Scarborough Hospital, only to find that I cannot get the IT to work. I'm certainly no IT expert, and when I can't resolve an issue, especially with a room full of staff waiting for training, it can be incredibly stressful.

Every time I have contacted Lewis, he has immediately dropped what he is doing, left his desk and come to help. What stands out most is the way he does this. He always greets me with a smile, is incredibly patient, and if the problem isn't immediately obvious, he calmly stays with it until he finds a solution. Nothing is ever too much trouble, and he has never once made me feel embarrassed or foolish for not being able to fix something myself.

Lewis is a wonderful example of one of the important cogs in our Trust machine that can sometimes go unnoticed, but whose skills, patience and positive attitude are essential to keeping things running smoothly. He consistently demonstrates our Trust values through the way he supports others. I am very grateful for everything Lewis does and genuinely believe he deserves recognition for the difference he makes.

Diane Watkin, Trauma Co-ordinator **Scarborough** **Nominated by a colleague**

I am nominating Diane Watkin, Trauma Coordinator, for a Star Award for everything she does for Holly Ward and the wider Orthopaedic team. Diane is invaluable to the department and consistently goes above and beyond to support everyone, particularly the resident doctors. Whether she is solving problems, offering a listening ear on a stressful day, or simply checking in, she always makes time to help. She makes everyone feel welcome and supported and is someone we know we can always turn to.

Diane gives 100% in all her work and holds the department together. Trauma and orthopaedics simply would not run as it does without her, and she is hugely appreciated by everyone who works with her. We are incredibly lucky to have her as part of our team.

Cheryl Bellerby, Discharge Liaison Officer **York** **Nominated by a colleague**

Cheryl keeps team spirits up and is always there for fellow team members. The Discharge Liaison Team has been short-staffed lately, and Cheryl has gone above and beyond.

Kacey Rollins, Staff Nurse **Scarborough** **Nominated by a colleague**

I am nominating Kacey for a Star Award in recognition of the outstanding way she responded when an adult patient experienced a seizure in the corridor outside the ward. Although her usual area of expertise is paediatric nursing, she responded immediately, calmly, confidently, and without hesitation, putting the patient's safety first. She demonstrated excellent clinical awareness and remained composed in what was a potentially frightening and unpredictable situation.

What particularly stood out to me was Kacey's willingness to step outside her usual clinical environment and use her skills to support an adult patient when it really mattered. She demonstrated compassion, professionalism and confidence, while working effectively to ensure the patient received the appropriate care and support.

Matthew Miller-Swain, Staff Nurse **York** **Nominated by a colleague**

Matthew regularly supports the ambulatory trauma service with his professional and courteous nature. I am nominating him because he went the extra mile to bring a patient back into hospital, although it was not his responsibility to do so. This not only helped me at a very busy part of the day, but ensured the patient wasn't cancelled for surgery for the second day running. He facilitated the patient's transport to hospital.

Providing that support to me helped me complete all required activities for the day in a timely fashion and relieved pressure on the service. I need to recognise that support and really appreciate this avenue of conveyance.

Jonathan Bates, Facilities Operative **Scarborough** **Nominated by a colleague**

Since starting at Facilities, Jonathan has shown an exceptional understanding and demonstration of the Trust's values. With the patients at the forefront of his mind, he shows an incredible level of care, attention and compassion with everything he does every single day he comes to work. He always has a smile on his face and truly is an amazing representation for the hospital. Great work, Jonathan.

Erin Munro, Staff Nurse **Scarborough** **Nominated by a colleague**

I am nominating Erin for a Star Award in recognition of the exceptional care, professionalism and dedication she demonstrated during a particularly challenging shift. During a night shift, Erin was the only paediatric member of staff covering the entirety of ED. During this shift, she spent most of her time in resus caring for a complex child who required 1:1 nursing care.

Despite being newly qualified, Erin demonstrated an impressive level of confidence, clinical knowledge and managerial skills. She ensured that other children in the department were still being cared for whilst simultaneously stabilising a very unwell child. Despite the significant demands placed upon her, Erin remained calm, compassionate and organised. She was able to recognise when further support was needed and escalated to bed managers and EPIC when appropriate.

Erin continuously advocated for her patient, ensuring that both the child and their mother were supported, listened to and cared for throughout an incredibly difficult and stressful experience. Erin provided valuable guidance to the paediatric medical team, which ensured that the onward journey was in the best interests of the child. Erin even offered to accompany the child on transfer, which meant she would have returned after her shift had finished.

Erin is a fantastic nurse who genuinely cares about her patients. She is compassionate, caring and incredibly dedicated to her role. Erin was born to be a paediatric nurse and is a true asset to the Emergency Department.

Security Team **Scarborough** **Nominated by a colleague**

The Security Team at Scarborough, especially the night team, tackle dangerous situations on a nightly basis. I have personally seen them in action, protecting patients and staff alike, often de-escalating situations before they get out of hand. They are unsung heroes.

Lucinda Buckley, Staff Nurse **Scarborough** **Nominated by a colleague**

Lucinda is a kind and caring person. She runs a FibroScan clinic for the Hepatology service at Scarborough Hospital and is very diligent in how she carries out her work. She keeps us informed of any concerns she has with patients, and she goes above and beyond what is within her role. She has gone the extra mile over the past couple of weeks when there have been emergencies that required her to take the patients to the ED and wait with them until they had been clerked in. She then goes back to her patients who have been waiting patiently for her to perform their scans; this inevitably means her clinic will run very late, but she never complains. She always has a smile on her face.

Yesterday, she was unable to scan a patient due to an accumulation of fluid, and she noticed that they had lost a lot of weight, along with other red flag symptoms. She brought this to my attention and suggested the patient go to the ED for admission and drainage. With Lucinda's expert knowledge and swift action, this patient has since been admitted and will receive further investigations/management plan, etc. If Lucinda had not taken this action, then the outcome would have been very different for this patient. Lucinda is a very humble but dedicated staff nurse. Her empathy, concern and clinical knowledge are excellent, and she is a pleasure to work with. She deserves to have a Star Award to recognise her clinical skills and dedication to the patients.

Emily Rice, IT Trainer **York** **Nominated by a colleague**

I approached IT for some help with managing my CPD clinics, and Emily was helpful and patient with me. She helped me to navigate through some of the new processes - this had been set up for me relatively recently, and I was struggling to work out how to access everything. IT rarely get a mention for the help they give us, but I'd really like her to know how much I appreciate her help and positive approach!

Absalon Abante, Discharge Liaison Specialist Nurse **York** **Nominated by a colleague**

I am nominating Absalon for the exceptional leadership, compassion, and continuous support for colleagues. Abs always treats colleagues with kindness, respect, and understanding. During busy or challenging shifts, they are quick to support others, share knowledge, and help colleagues manage their workload. Abs is approachable and always willing to listen, offering encouragement and reassurance when someone is struggling. What makes Absalon an outstanding leader is his genuine care for others and willingness to go above and beyond, even when he is busy.

Gabriella Valks, Ward Manager **York** **Nominated by a colleague**

I am nominating Gabriella for consistently going above and beyond to support patients, visitors, and staff. She always takes time to listen, reassure others, and offer support, even during busy and challenging situations. Her openness and approachable nature make colleagues feel comfortable seeking advice and sharing concerns. She is a truly selfless and compassionate leader who is always willing to help others. She manages everything calmly and efficiently in the ward.

Her kindness, openness, and genuine care have made a tangible difference to the whole team and the people we support. She consistently puts others first and helps create a welcoming, respectful, and positive environment. I believe her actions strongly reflect the Trust's values of kindness, openness, and excellence.

Laura Wilson, Sister **Scarborough** **Nominated by Hannah Clay, colleague**

Laura consistently demonstrates a high level of professionalism and remains calm and reassuring, even in stressful situations. She is always approachable and willing to help, and if she cannot resolve something herself, she will go the extra mile to find someone who can. She embodies the values of kindness, openness and excellence in everything she does.

Laura is compassionate and patient-focused, always striving to ensure she delivers the very best care and support to her patients. She is open to learning, continually developing her knowledge and skills and generously sharing this learning with junior members of staff, helping to support their growth and development. Laura consistently goes above and beyond, putting her patients and colleagues first and setting an excellent example for those around her. Her dedication, positive attitude and commitment to providing the highest standard of care make her a valued member of the team.

Paediatric Emergency Department | **Scarborough** | **Nominated by a colleague**

I would like to recognise and appreciate the Paediatric ED team for their professionalism, dedication and commitment to providing the best possible care for our patients and their families. The team consistently demonstrates kindness, openness and excellence, particularly during what can often be very busy and stressful situations. Everyone is supportive of one another, always willing to help, and works together to find solutions when challenges arise. There is a strong culture of sharing knowledge, learning from one another and supporting the development of junior staff.

The team continually goes the extra mile to ensure that children and their families receive compassionate, safe and high-quality care. Their teamwork, resilience and commitment to putting patients at the centre of everything they do are truly appreciated. Thank you to the whole Paediatric ED team for everything you do and for creating such a supportive and positive environment for both patients and colleagues.

Honey Dineen, Midwife | **York** | **Nominated by a patient and relative (1) and a patient (2)**

Nomination 1

We'd like to say a huge thank you to Honey, the midwife who looked after Hannah during her emergency cervical stitch. She was amazing from start to finish. We had already experienced the heartbreaking loss of our daughter, Heidi, at 22 weeks, so this was an incredibly scary and emotional time for us. Honey was so kind, caring and reassuring throughout the procedure, helping to keep Hannah calm and making us both feel genuinely cared for. She also looked after Hannah so well afterwards.

At the end of her shift, she gave Hannah a beautiful blue and purple knitted baby hat. She said she didn't think Hannah was "a pink kind of girl" (she was right!) and that she likes to give them to parents to help keep them positive and give them hope. It was such a thoughtful gesture and meant so much to us. Honey really went above and beyond and showed so much kindness and compassion. We can't thank her enough for everything she did during such a difficult few days. She made a lasting difference to us, and we'll always remember her kindness.

Nomination 2

Honey was incredible during my labour on 11 July. Her gentle and empathic nature was such a reassuring presence from the get-go. She listened and genuinely cared about what was important to me, setting up the birth suite beautifully for my arrival with lighting, aromatherapy and a pool.

She supported me with hypnobirthing and breathing techniques, advocated strongly for me in avoiding a more medicalised birth, and provided me with more time for labour to start naturally rather than requiring the hormone drip. She was the perfect balance of attentive and caring without being overbearing. She made my third birth at York a hugely positive and unforgettable experience, and I will be forever grateful. Thank you.

Acute Stroke Unit **York** **Nominated by a patient**

I had a stroke, which was the scariest experience of my life. By the time I arrived at York Hospital, the Stroke Team were already waiting for me. They acted immediately, knowing every minute mattered. The consultant even stayed beyond the end of his shift so I had every possible chance of receiving the clot-busting injection; despite being told there was only a one in 15 chance it would work because of the delay in reaching hospital.

The care I received was exceptional. Every member of the team treated me with kindness, compassion and urgency. Thanks to their expertise and determination, I made a full recovery and went home after one night. When I sadly had another stroke the following morning and returned to hospital, the team were once again outstanding. They were efficient with my scans, assessments and physiotherapy, keeping me informed and making me feel safe throughout.

The Stroke Team truly went above and beyond, demonstrating kindness, openness and excellence in everything they did. I will always be grateful for the care they gave me, and I believe they deserve to be recognised for the incredible difference they make to patients and their families.

The support didn't stop with my care. The team also took the time to support my family, who live in Scarborough. They kept them informed, offered reassurance during such a frightening time, and made sure we all understood the plan moving forward. Their clear communication, compassion and kindness helped ease the worry for my family and gave us all confidence that I was receiving the very best care. They treated us with dignity, respect and genuine compassion, and I will never forget the difference they made to us all.

SDEC **York** **Nominated by a patient**

I would like to thank the whole team in this department for their care. From the lady who wheeled me in, as she could tell I was in a lot of pain trying to walk (sorry, I can’t remember her name), to Tonia and Kieran who helped with my care. Also, to the lady who did the bladder scan and the gentleman offering teas and refreshments (sorry, I also can’t remember their names). Finally, to Dr Ayangbenro, who took time to listen to me and explain everything clearly.

I am sure at times the whole team are under a lot of pressure, but I cannot speak highly enough of their care, politeness and willingness to help me. A big thank you to you all.

Labour Ward	**York**	**Nominated by a patient (1) and a patient (2)**

Nomination 1

If it wasn't for this team, especially Karen and Corinna, I don't know how I would have got through it! Nothing was too much for any of the team involved in the birth and care of my baby. Even when it didn't go to plan, they all reassured us and showed kindness throughout and talked us through every little detail. Every person on the team that day and night was fantastic - from the second we came in, greeting us at the door with a friendly face, to going to theatre and talking us through everything. I wouldn't change a thing! They went above and beyond and were so thankful. Especially for Corianna going back and forth for ice lollies!

Nomination 2

On 1 June, I was transferred from Hull Royal to York to have our baby after being induced a few days before. We arrived and had two midwives, called Kate (midwife) and Katie (student midwife). From start to finish, we felt so comfortable and at ease with both. Unfortunately, they missed the birth by 16 minutes because their shift had ended. Our new midwives quickly stepped into action, and the consultant delivered our baby as soon as they walked onto their shift. We want to thank everybody involved in bringing our little girl into the world and would also like to let both Kate and Katie know that our daughter was named after them: Isabella Katie.

Rosalind Southee and team and Sallie-Ann Guscott, Staff Nurse	**Selby**	**Nominated by a patient**

I had excision surgery on a BCC at Selby War Memorial Hospital on Thursday 23 July. Ms Southee and team performed the surgery. From my first meeting with Ros at York Hospital, she struck me as a person I could trust. She was very welcoming, listened to my fears and explained the procedure. I left the consultation feeling reassured and happy that Ros was going to operate. She was as welcoming, warm and jovial on the day of my surgery. She instilled a sense of calm in the room, including asking my favourite music, which she played during the surgery.

Her team were equally amazing. They worked together, like a well-oiled machine, with wonderful human care and concern for me, the patient, which nurses perform, seemingly, effortlessly. Little considerations such as the music, calling me by my first name, and asking about my life made me feel very calm and relaxed.

Sallie Ann was also a perfect complement to the team. We chatted easily while I waited to be called for surgery. She was kind and attentive throughout the morning. A nervous morning was made much easier for me, due to the combined efforts of your amazing team. Thank you so much, everyone; you are all exceptional people. Thank you, Ros, for your expertise and interest in me, your patient.

Karen Smith, Midwife and Olivia Gaddass, Midwife	**York**	**Nominated by a patient**

At a routine growth scan at 16 weeks and five days pregnant, as I was expecting twins, I found out I had had a silent second trimester miscarriage. Neither of my babies had a heartbeat, and I would need to deliver them in the butterfly suite. I was absolutely devastated and quite terrified. I had been expecting to have an elective Caesarean and had not made it far enough along in my pregnancy to get to antenatal classes, so had not learned much about vaginal birth and what to expect.

I am so grateful that Karen and Olivia were working the night shift on Sunday and delivered my twins. They were with me the whole time and made me feel so well cared for and safe. They talked me through what would happen, what was happening and what I needed to do and answered all my and my husband's many questions. They arranged my twins so gently and beautifully for us to see them, which really brought me some peace and comfort. They kept us informed as to where they and the twins were and what they were doing. They seemed to know exactly what we needed, giving us space, encouragement and support when each was needed. I also wanted to say a special thanks to Rebekah and Nicole who looked after me before and after I delivered.

Aspen Ward	**Scarborough**	**Nominated by a patient**

Every member of staff on Aspen Ward, including the cleaners, was excellent and made my week-long stay there more bearable. Many thanks to each one of them.

Kent Ward	**Bridlington**	**Nominated by Celina Taylor, patient**

I had surgery and was so impressed with the warm welcome from everyone, from the cleaners to the consultants. The ward was extremely clean. The staff were friendly, caring and professional. I felt like I was in a private hospital. I had a side room, and the staff kept popping in to see if I needed anything and apologise for the wait for theatre. I wasn't bothered as I was told I was last on the list. The healthcare assistants were fantastic with the physio after surgery and made sure I was happy using my crutches. This is the way all wards should be in the NHS, and Kent Ward is a shining example of the Trust's values. Well done, everyone.

Nicole Page, Midwife	**York**	**Nominated by a patient**

I am nominating my midwife for a Star Award following the devastating loss of our baby at 16 weeks and five days. She was with me both before and throughout my late miscarriage and delivery, and she was quite simply a godsend that day. She is the most amazing, kind, professional, and compassionate person I have ever met. She is absolutely in the right job; without her presence, guidance, and strength, I truly do not think I would have survived what I went through.

Throughout the entire process, she guided me through every single step. She always made sure I knew exactly what was about to happen, clearly explained all my options, and helped me understand what I needed to do next. Her ability to balance clinical professionalism with profound human empathy gave me comfort when I needed it most. I will forever be grateful to her for how she held us through our darkest hours. She represents the best of the midwifery profession.

Molly Thompson, Midwife **Bridlington** **Nominated by a patient**

Molly was my midwife throughout my whole pregnancy, and she made me feel so comfortable about everything. She didn't judge me for anything, answered all my questions, and made my birth anxiety so much better!

Michelle Hargreaves, Phlebotomist **York** **Nominated by a patient**

I am nominating Michelle, one of the phlebotomists, for a Star Award in recognition of the kindness, compassion and excellence she showed when I attended as a patient. I am an employee of the Trust, but on this occasion, I was attending as a patient after a particularly difficult day. I needed to have my blood taken and had several questions that my GP had advised me to ask. Although Michelle didn't know all the answers, she was completely honest about that and reassured me she would do everything she could to help - her willingness to support me really stood out.

Having my blood taken is never easy, as I often joke my veins don't like sharing, but despite only being in the role for five weeks, Michelle successfully took my blood on the first attempt - something very few people have managed. More importantly, she made the whole experience so much easier. She was warm, funny and incredibly personable, putting me at ease from the moment I sat down. We even discovered we had lots in common - not just our name!

Michelle demonstrated exactly what our Trust values of kindness and excellence look like. Her enthusiasm, compassion and genuine care turned what had been a difficult day into a much more positive experience. For someone so new to the role, she is already a real credit to our Trust. Thank you, Michelle, for making my day that little bit brighter.

Andy Jones Ngong Laigha, Staff Nurse, and Rebekah Garland, Staff Nurse **York** **Nominated by a patient**

One thing that Becky and Andy have in common is a solution-based approach to problem-solving. They follow things through, never content to merely leave a message for someone else to follow up (or not) - they follow it up themselves. Both are caring, calm and capable, a reassuring presence when we as patients feel vulnerable, even scared at times. Good listeners, they also give wise and well-informed advice. I would like to pass on my thanks and appreciation of their efforts: they have made me feel that I am in safe hands.

I have also been very grateful to two staff in the vascular team, Donna and Tammy. Tammy was particularly helpful yesterday in sorting me out with a cannula and checking my pick-line, although right at the end of her shift.

Please pass on my gratitude to these hard-working and caring members of staff.

Rich Atkinson, Porter **Scarborough** **Nominated by a patient**

I am an Armed Forces Veteran of the Corps of Royal Engineers. I was rushed to hospital with acute abdominal pain. I learned that Armed Forces Champions were active within York and Scarborough hospitals. After contacting them, I was referred to Rich as my contact. He proved a great morale boost during a very difficult period, as I'm not a resident in this area. His friendliness and camaraderie were second to none. We now remain good friends, and he has invited me to the many Armed Forces events in Scarborough. He is a true advocate of the Trust and deserves recognition for volunteering in this essential role.

Claire Collins, Midwife **Malton** **Nominated by a patient**

Claire is compassionate, caring and willing to listen, all while providing the best care she can. She got the appropriate help for me while I dealt with postpartum depression and listened to me when I needed it the most. She got toys for my one-year-old, and nothing was too much trouble. I truly believe she is one of the best and most caring midwives around and deserves the recognition!

Charlotte Lowery, Deputy Sister **York** **Nominated by a patient**

Charlotte and her team in SDEC restored my faith in York hospital. They are excellent and work properly as a team in times that are challenging. Charlotte works to meet the needs of all patients but understood and cared deeply for my situation with my terminally ill grandad. I just needed to be out in time to see him for a family meal. Charlotte made it possible.

Amy Quill, Staff Nurse **York** **Nominated by a patient**

Having found myself on both SAU and Ward 14, Amy was one of the nurses who was around me for most of my stay. Although working nights, she was warm and friendly, and nothing was too much trouble. She made me feel at ease, and I looked forward to her coming to work. She was very organised and methodical in her working pattern, which gave me the confidence to trust her abilities. She is a credit to her parents and herself for taking on a role and doing exceptionally well in her field. I'm sure in the future she will achieve great acclaim for herself, and I wish her every success.

Celia Kelly, Midwife **York** **Nominated by a patient**

Celia was amazing following my C-section. The care she provided was wonderful. She was very diligent, and I will forever be truly grateful. An absolute asset to the York midwifery team.

G2 **York** **Nominated by a patient**

After having my twin girls and spending nine days on the G2 ward, I can't tell you how incredible this team is. They provided my girls, my husband and me with the best of care. Nothing was too much trouble; they all helped me during days and nights when I was on my own and needed a rest. They were more than happy to look after my girls and give them the best care and cuddles while I slept. The whole team worked so well together, and they made my stay so much better than I could have imagined. I don't think these members of staff know how amazing they are.

I will be forever grateful for the level of care. Not only medically but also emotionally. There were many nights when I broke down, and the staff were there to listen and talk to me. They explained everything so clearly, and I really felt heard. I have never received such a high standard of care in my life. My girls and I are now home safe and sound, and we will never forget any of the staff who helped us during our time at the hospital. Thank you, G2; you're all rockstars and always will be.

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

I was in and out of hospital during my third trimester, and Helene went out of her way to keep checking in on me and ensuring that I was comfortable. When I was first admitted, it was for an unstable lie, and I had started with contractions three days in - which I didn't realise were the start of labour - I was prone to Braxton Hicks before, so it didn't strike me as unusual. However, Helene stayed with me (along with student midwife Lindsay) and made sure I was comfortable, eventually also convincing me it was the start of something and wasn't just happening in my head.

Every worry or concern I had, Helene was there to listen and comfort me. Even when I was re-admitted a week later, she remembered me and went above and beyond in her job to make me feel comfortable. Because of her, I genuinely think she saved me a lot of stress. She brought a doctor to see me to make a plan, and I was scanned for the first time, where it was found that my daughter had moved positions again. I had to come to the reality that a C-section was the safest thing for my daughter and that leaving her birth to chance would be a potentially dangerous thing to do. I do not think I could have made that decision without Helene.

She listened to me, didn't make me feel silly for my thoughts, was with me every step of the way, and she gave me all the information in an informative way that I understood. She made my hospital stay feel a lot less scary than my other two births. Helene also remembered my worry about missing my second child's birthday and made me feel human for it, not pathetic or ridiculous for it. She truly is a credit to the Scarborough midwives, and I hope she realises how much she helped me and how much I appreciate her. It's something I will never forget.

Taylor Scorer, Healthcare Support Worker **Scarborough** **Nominated by a patient**

I was nervous and scared at my appointment today at the Women's Unit in Scarborough. Straight away, Taylor was so understanding, caring and reassuring, telling me that she would look after me. Throughout the whole appointment, she chatted to me about anything and everything to take my mind off the procedure. She even held my hand, which meant so much to me as I was feeling nervous. Taylor is an asset to the team.

In a world where we can be so quick to complain about the tiniest things, we should also take the time to recognise and appreciate people who go above and beyond. Thank you, Taylor, for making what was an unknown experience for me feel so much easier. Your kindness, compassion and reassurance will stay with me, and I'm incredibly grateful.

Samantha Johnson, Staff Nurse **York** **Nominated by a patient**

Sam is excellent. She cares and works in a way that is pure excellence, to a high standard, and thorough. Sam has restored my trust and confidence in patient care. Can we clone her?

Bridgitte Powell, Admin Assistant **York** **Nominated by a patient**

Bridget Powell, who is the secretary for the Pain Team, has done more to help my care than any consultant could, and should be applauded for this. She has been supportive and knowledgeable.

Marie Lawrence, Healthcare Assistant **York** **Nominated by a patient**

I came to the Day Unit for eye surgery. This is the first medical procedure I have had, and I have never had surgery or been put to sleep before, so I was incredibly nervous. Due to the size of the bay within the Day Unit, I couldn't bring my family member into the room with me, which resulted in me feeling unexpectedly panicked. I became very upset as I didn't realise that this would be the case. Marie was incredibly kind and comforting with me, took my mind off my anxieties, and, by the time I was due for surgery, even had me laughing. She took the time to sit with me while I was upset and calmed me down.

She was so accommodating to my needs and compassionate about how upset I was having to wait on my own, adapting the situation to make sure I was as reassured as possible, even passing messages on to my family member and doing everything that she could to help me. Marie really made the experience of surgery so much better.

I hope that every patient coming into hospital for treatment, surgery or tests has a presence there like Marie so that they feel as looked after and as valued as I did. Marie showed complete kindness, and I couldn't be more grateful when I was feeling so scared about the surgery. Thank you.

Brynn Stewart, Senior Physiotherapist **York** **Nominated by a patient**

I was critically ill during the night, and without this man's care and expertise, I don't think I would have made it. He also showed great comfort and expertise to my husband and son who had come to say a last goodbye. As you can tell I am still here and deeply grateful for his expertise. I have been in York Hospital for 18 weeks in several different wards, and I have been treated with respect, care, gentleness and patience, but this man literally gave me my life back.

Fan Cheng, Consultant, and Gabriela Podosu, Specialist Nurse **York** **Nominated by a patient**

I've been unwell with a couple of headache conditions for years. I had an appointment with Dr Cheng this year where he asked specific questions to help get a clearer diagnosis and get me treatments which have made a huge difference to my life. I struggled to answer his questions, but he was really understanding and gave me the time I needed.

I had my review with the headache nurse yesterday. She was so kind and understanding and went the extra mile to get me treatment the same day. Every time I speak to a headache nurse, I find them to be the kindest and most compassionate people and a credit to the profession. I can't thank the two of them enough for their care and the optimism it gives me that things can get better.

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

Helena made me feel very comfortable.

Ward 27 **York** **Nominated by a patient**

I had day surgery on this ward. All the team members, including the surgical team (resident Felix and anaesthetist Mike), were always caring. Everything was conducted in the most professional of manners, with close attention to me as the patient and appropriate information and checks for awareness and understanding throughout. The whole team did their utmost to ensure that the surgery was completed successfully.

Drew Tordoff, Midwife **York** **Nominated by a patient**

I'd like to thank Drew on G2, who has been our constant support throughout. She started as my community midwife and was always approachable, informative, friendly and professional. She answered any questions I had in a way I could understand, and nothing was too much trouble. I was sad when she left the community but was so happy to find she was there on G2 when my twins were born, and we needed a nine-day hospital stay. She went above and beyond, doing her absolute best to ensure we got the care we needed.

I had a lot of low times due to anxiety. Being a first-time mum, I found it hard with the added stress of high blood pressure. Drew was always there, not only supporting medically, but also emotionally. She really is magic. I genuinely cannot thank her enough. Whenever Drew was on shift, I felt more relaxed knowing that she was there. She made us feel safe and supported in a way I can't begin to explain. She was always happy to help with feeds and cuddles for the girls if I needed rest or was busy with one and the other needed attention.

Drew deserves to know what a difference she has made to mine and my girls' lives; we will never forget her. I feel so very lucky to have had Drew's support. You're amazing and the best midwife I could have asked for.

Cameron McPherson, Staff Nurse **Scarborough** **Nominated by a relative**

We cannot thank our paediatric nurse enough for the exceptional care they gave our daughter during her recent arm operation. From the moment we arrived, Cam was kind, compassionate, and incredibly reassuring, helping to calm both our daughter and us during what was a very worrying time. They went above and beyond to make sure our daughter felt safe, comfortable, and cared for, taking the time to explain everything and check in on her throughout. Our daughter was down longer than we all thought she would be, so Cam offered to check in on us and reassured us multiple times. This led to us not worrying as much as we were.

Their warmth, patience, and genuine kindness made such a difference to our experience. We are so grateful for the outstanding care Cam provided and feel incredibly lucky to have had them looking after our daughter. They are a true credit to the NHS.

Coronary Care Unit **York** **Nominated by a relative**

I would like to express my sincere gratitude to the Coronary Care Unit staff who cared for my husband when he suffered a heart attack. It was an incredibly frightening and stressful time, but every member of the team was kind, compassionate, patient, and highly professional. They not only took excellent care of my husband but also supported me throughout the experience.

I would especially like to thank Claire, Hannah, Gay and Tina. They were so reassuring, took the time to answer all my questions, helped keep me calm, and gave me the confidence to focus on what was happening. Their kindness, understanding, and compassion meant more to me than I can put into words. Please pass on my heartfelt thanks to them and to the entire team. The care and support we received during such a difficult time will never be forgotten.

Vicky Robins, Renal Consultant **York** **Nominated by a relative**

I can't tell you the impact this lady has had on my daughter. My daughter, Ash, recently attended an appointment with Dr Robins, which only happened because somebody made it happen. I am aware Dr Robins doesn't normally see new patients, but because of my daughter's needs, someone made this possible. I am very grateful to whoever that person is. Thank you also to the lady who called following my email to say Ash would not be able to attend her appointment in Selby. This lady was lovely, caring and understanding.

The appointment got off to a bit of a shaky start as we were greeted by a male nurse, and Ash finds it difficult to be around men. When I explained to him that she was struggling in his presence because he was male, he went and got a lovely healthcare assistant, Georgia. She was great with Ash, very reassuring and kind.

Ash was in a shut-down state by the time we got into the appointment, but Dr Robins responded in a way I've never seen from any other doctor. She was so in tune with Ash's needs and began by reassuring her of exactly who was in the room and that Georgia would be coming back, but she'd knock at the door, and after that she would be waiting outside the room. I immediately saw Ash soften and relax at this, and afterwards she told me that this made her feel safe. Dr Robins was sensitive and kind. She was engaging with Ash, looking to build a relationship. When she saw that Ash was struggling to communicate, she moved from asking questions to build a rapport to chatting about what the plan was moving forward. She came up with a plan so next time Ash could come straight into the room and avoid waiting in the waiting room. This was thoughtful.

I'm crying writing this because although Ash found the appointment challenging, what she said to me afterwards moved me so much. She said that Dr Robins gave her some of her dignity back. I can't tell you what an impact you have had on my daughter, Dr Robins. From the bottom of my heart, thank you. There are doctors she's known most of her life, but she said you're the first doctor she has felt immediately safe with. She also said that she felt like she had choices with you. Again, this is so important to Ash. The shift from being told what she's doing to being involved in decisions around her health is important to her, so although she couldn’t communicate very much during this appointment, she felt like you wanted to hear her. Thank you.

Ward 17 **York** **Nominated by a relative**

Our daughter recently spent two days on Ward 17. It was an incredibly difficult time for us as a family. All the staff treated us with kindness and respect. Krystal worked closely with our daughter. She kept us regularly updated and went above and beyond to try and get us the support we needed. I cannot thank them all enough.

Rainbow Ward **Scarborough** **Nominated by a relative**

My daughter is a very anxious little lady, and when we were in and out for nearly a week, the nurses made sure she felt safe and calm, especially one nurse called Adele. We can't thank them enough for keeping my daughter relaxed, providing her with brand new pyjamas, and giving her a gift for being so brave! These nurses and paediatric doctors need recognition! I can't thank them enough for being so kind to us in a time of need. Thank you.

Rad Humenczyk, Clinical Imaging Assistant **Scarborough** **Nominated by a relative**

I escorted my 91-year-old mum to her CT today. After checking in, Rad was the first person we met. My mum was quite anxious and is very deaf, even with her hearing aid. Rad calmed her and explained everything that would be happening. Once she was laid on the scanner bed, I left, and Rad bought me a cuppa. He returned several times, keeping me updated. Within 15 minutes, mum was joining me for a cuppa with plenty of biscuits. I can't thank the team enough for their kindness today, especially Rad.

Fiona Smith, Maternity Support Worker **York** **Nominated by a relative**

I am nominating Fiona for a Star Award for the incredible support, compassion and humanity she showed my family and me during one of the most traumatic experiences of our lives.

My wife was rushed to theatre and put to sleep for an emergency caesarean section for our son. I remained in theatre throughout the procedure and witnessed far more than I should ever have had to. It was an incredibly frightening and overwhelming experience, and in that moment, I was completely lost.

Fiona was the person who found me in that moment. She recognised how horrific the situation was for me and, rather than simply telling me what was happening, she physically held me and guided me through it. She gave me something to hold onto when everything around me felt completely out of control. I remember her reassuring me, supporting me and making me feel like I wasn't facing what was happening alone. Our son then needed a significant amount of newborn life support. While I was terrified and struggling to understand what was happening, Fiona talked me through it. She explained what the team were doing and why, helping me to understand what was happening to my son when I was probably least able to take anything in.

People often say that you don't always remember the words someone says to you in a traumatic situation, but you remember how they made you feel. I remember exactly how Fiona made me feel. I felt reassured. I felt supported. I felt that someone had me. Looking back now, I understand that I shouldn't have had to witness everything that I did that day, and I know how traumatic that experience was. But having Fiona there with me is something I will never forget. Her presence made an unbearable situation feel just a little less frightening. Fiona went far beyond what I could have expected from someone doing their job. She showed genuine compassion at a moment when my family needed it most. She didn't just support me medically or practically; she supported me as a person. I will always remember Fiona for being there, for holding me, for explaining what was happening, and most importantly, for making sure I didn't feel alone. For that, I will be forever grateful. I cannot think of anyone more deserving of a Star Award.

Emergency Department **York** **Nominated by a relative**

We came to York Hospital when my wife had an injured knee and couldn‘t walk. We didn't have to wait long, and Belinda, who examined the knee, was very kind, explained everything, and examined the knee carefully. In short, it was great. We wish to thank her and the whole team for this great experience and the professional help.

Deborah Goldfield, Specialty Doctor Emergency Medicine **York** **Nominated by a visitor**

Doctor Goldfield is an excellent example of what a doctor should be. Kind, professional, and willing to listen and assist everyone despite being rushed off her feet in an extremely busy department. She is an excellent role model for young aspiring healthcare workers and is a real asset to the hospital. Keep up the good work; you are needed and appreciated.

Committee Report

Report from:	Quality Assurance Committee Chair's Report
Date of meeting:	18th August 2026
Chair:	Lorraine Boyd

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

ALERT

* **Health Care Acquired Infections** remain a significant concern and present an ongoing risk to safe and effective care. The Trust is reporting annual infection rates amongst the highest of comparable regional Trusts in every category with the exception of MRSA, in spite of significant focus and some improvement over the past year. An urgent review of actions and further intense focus is underway and will be closely monitored via Patient Safety and Clinical Effectiveness and Quality Committee.

* **Urgent and Emergency Care** continues to flag through True North and TPR metrics as a significant cause for concern and risk to patient safety and experience. This was evidenced through increased risk of patient harm from long waits, corridor care, delayed assessment and treatment, increased complaints and poorer patient experience and increased pressure on workforce and clinical decision makers. The complaints reports triangulated with this risk, with ED generating the highest complaint numbers related to waits, communication failures and concerns regarding deteriorating patients. The Coming Off Corridors workstream is anticipated to start to impact positively to improve the situation in the coming months and progress will be regularly reviewed in Quality Committee

ASSURE

Medicine Care Group

* **T-Coil Hearing Loop System** has been upgraded in Scarborough ED resulting in improved accessibility for those with hearing loss, using aids. Some limitations persist and impact is being monitored

* **Cardiology RTT performance** continues to improve, and delivery plan is on track. Consequently, and as a result of improvements to the complaints management process, complaints and concerns have reduced (15 April: 6 July) providing good triangulating assurance.

* **A Transformation Governance Framework** has been introduced by the Care Group providing greater clarity and strengthened assurance that improvement initiatives are appropriately assessed, monitored and evaluated prior to full implementation.

* **Routine nursing quality dashboards** are unavailable currently as full transition to Nervecentre is underway. Workarounds are in place whilst developments continue. Care Group SLT are confident that the mitigating workarounds should identify any emerging quality concerns.

* **Medicine CG Patient Group Direction (PGD) Governance,** which supports safe administration of medicines in line with national guidance, has been strengthened by the establishment of routine monitoring arrangements with Pharmacy to ensure ED PGDs are, and remain, current.

Maternity

* **Maternity and Neonatal National 10 Point Plan** update was shared, highlighting key delivery activity in July and planned activity for August. Delivery of this plan is the priority focus for the next few months and a bespoke reporting dashboard to support monitoring and assurance is in development

* **Stillbirth and Neonatal Death Data** raises no cause for concern

* **PPH Rates** across the Trust have been below regional and national average since April 2025 and the National Digital Dashboard indicates a reduction in the rolling Trust average over 12 months for PPH >1500 L, demonstrating sustained and continuing improvement and providing good externally triangulated assurance.

* **Diverts and Closures of Maternity Units in July** were discussed with a particular focus on an outcome audit of those women impacted (2) and the learning from this, providing good assurance.

* **Maternity Triage** has been highlighted as an improvement opportunity in recent national reviews. Trust assessment against the National Maternity Triage specification (July 2026) identified 6 red priorities for improvement and a high level plan to address these was shared. Data from July demonstrated a significant reduction in Triage red flag incidents following investment in increased Midwifery Staffing, providing moderate assurance. However, time to be seen by a doctor remains a cause for concern and assurance gap, with 20% of York attendances waiting more than 3 hours or self-discharging due to long wait times. Similar audit is yet to be undertaken on the Scarborough site.

* **Community Equity Midwife Service** was audited to assess impact following the first year of operation. Positive impacts for vulnerable women were identified, although challenges remain on the East Coast due to geography, deprivation and limited staffing. Collaboration with local authorities and partners is ongoing to address health inequalities.

Patient Safety and Clinical Effectiveness

* **Infection Prevention and Control (IPC) Quarterly Report** highlighted poor performance relating to health care acquired infections, including MSSA (a True North Metric), with limited evidence of the level of the impact from actions to date required to meet expectations. Cases are now all reported on Datix and subject to PSRIF review and increased microbiology consultant oversight of reviews. The Trust is a national outlier for Clostridium difficile (CDI) infections, which may be a consequence of the two step identification process undertaken. This is currently under careful review. Further focused improvement actions eg catheter care practices, antimicrobial stewardship etc were shared but nonetheless IPC assurance is currently limited

* **Safeguarding Quarterly Update** demonstrated strong governance and recognition of key risks with active management providing good assurance. Mental Capacity Assessment (MCA) and Deprivation of Liberty (DOL) activity is still inconsistently managed but improving and in relation to DOL, a recent Supreme Court judgement has resulted in uncertainty that it's currently being understood, with legal support.

Patient Experience

* **Concerns and complaints** performance improved in Q1 although targets are not yet met. Communication remains the top theme for complaints and as such is the primary improvement focus, with training initiatives across all staff groups outlined. Ward based complaints were noted to have reduced significantly following the improvement work undertaken on fundamentals of care and communication skills over the past year.

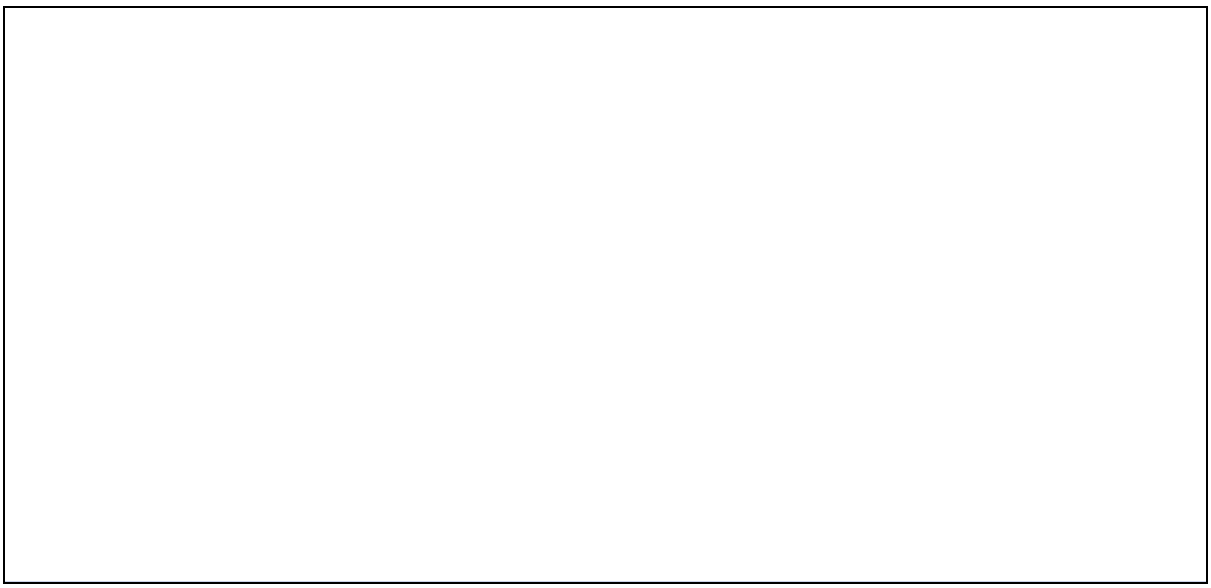
Performance

* **True North Quality Metrics** were reviewed and discussed. Variable progress and assurance were noted, including improving grip and progress in some priority areas, but continued concern and risk is evident in relation to patient flow, long waits, IPC and workforce related service resilience.

ADVISE

* **Maternity and Neonatal Single Improvement Plan** delivery had been temporarily suspended, as agreed by Trust Board, to allow a focus on the National 10 Point Plan, Saving Babies Lives Care Bundle, Maternity Care Bundle and Maternity Incentive Scheme Year 8 from now until the end of the year.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
* **Corporate Risk Register** was discussed, and it was noted that the Risk Committee had made no changes to the risks under the remit of Quality Committee * **CRR58** relating to the impacts of backlog maintenance on patient care was noted to have been static for some time. The considerable mitigating activity underway to reduce this risk was acknowledged but further assurance update was requested on how impacts on patient care are being minimised. * **Neonatal staffing** and related BAPM compliance remain a risk as previously outlined. Clinical cover from senior staff provides short-term motivation and a business case to support longer term resolution is underway. * **Home Birth Service** continues to be largely unavailable through suspension. Of 11 women booked for home delivery in July, none were supported to do so but the Trust, representing a risk to patient choice and experience. * **IPC performance** across the Trust presents a risk to safe and effective care * **Safeguarding Information** remains spread across multiple digital and paper systems, pending introduction of Nervecentre Safeguarding system, representing risks around safeguarding alerts, information sharing and identification of frequent attenders, mitigated by high level of awareness. * **PR1** was addressed through all agenda items.
ASSURANCE GAINED
Overall, the information provided and discussed demonstrated moderate assurance on clinical pathways and quality of care, with evidence of good governance, active oversight and improvement programmes, particularly in maternity safety, safeguarding, patient safety governance and health inequalities work. Assurance is more limited in relation to workforce resilience, IPC performance, sepsis treatment delays, complaints response performance, emergency care pressures and corridor care and neonatal workforce compliance and will require continued scrutiny. In summary:- Medicine Care Group - moderate assurance Maternity -moderate assurance IPC -limited assurance Safeguarding - moderate assurance Patient Experience -moderate assurance Patient Safety and Clinical Effectiveness -moderate assurance



Item 10

Committee Report

Report from:	Quality Assurance Committee Chair's Report
Date of meeting:	22nd September 2026
Chair:	Lorraine Boyd

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

ALERT
***Dermoscopy Local Enhanced Service for GPs** expires November 2026 and at present there is no agreed replacement pathway, leading to a risk that the ability to prioritise dermatology patients according to clinical risk may be compromised. Discussion with Commissioners and GP colleagues are ongoing, with the aim of ensuring there is a streamlined, viably funded pathway that minimises patient touchpoints and is in line with the ambition of an excellent patient experience every time.
ASSURE
***Hyperacute Stroke Service Review and Sentinel Stroke National Audit Programme (SSNAP) data** were discussed, noting the current SSNAP score of E. Evidence of a data driven approach to understanding the areas for improvement was shared and assurance gained, including through external peer review in January 2025, that frontline clinical care is being maintained in the context of challenges with pathway flow, workforce resilience, rehabilitation capacity and some data quality challenges. Good understanding of the underlying issues was demonstrated and a number of mitigating actions outlined. Plans were shared to create a single Stroke Improvement Plan, with clear ownership, milestones and outcomes, to be monitored through a Stroke Improvement Group escalating through Care Group and Trust governance structures, which should lead to an assurance improvement from limited to moderate. ***Community Stroke Service** is a particular area of concern and risk. There is no commissioned Early Supported Discharge Service (EDS) and limited community stroke rehabilitation provision, resulting in a risk that post discharge outcomes are suboptimal and limited assurance.

***Pressure Ulcer Assurance Report Q1 i**ndicated that performance against the Trust's key quality objective of a 20% reduction in Category 2 pressure ulcers was not met. Nonetheless, strong governance with executive oversight in line with the priority status was outlined, as well as a number of improvement initiatives, providing moderated assurance. Inconsistent clinical practice, improving data capture and quality, mattress and seating replacement programmes and increased understating of management of pressure ulcers in end of life and osteomyelitis patients are areas of current focus.

***Histopathology Performance** data was shared confirming improvements, particularly In relation to cancer. A six-point recovery plan includes tracking the pathology performance target list through laboratories, flagging high-risk specimens on arrival so they are prioritised, and rolling out digital improvements.

***Radiology Reporting Discrepancies** data was shared and demonstrated performance in line with expectations. Following review within care group governance structures no clear themes or trends have been identified.

***CSCS Complaints Response Compliance** was 100% in August for both standard and complex complaints

***Nottingham Review, Fuller Inquiry and Human Tissue Authority (HTA) Compliance** assurance was received through the Trust's response to national requirements arising from the Nottingham Maternity Review, the Fuller Inquiry and the HTA's sector-wide compliance assessment, to ensure care after death is dignified and secure with appropriate governance and oversight.The Trust has completed the required Board Assurance Statement, implemented the majority of NHS-relevant Fuller recommendations, and established robust arrangements for mortuary security, access control and governance. A small number of actions remain in progress, primarily relating to governance reporting, safeguarding and awareness of the Designated Individual role, with completion anticipated by the end of September 2026. A time limited Mortuary and Post Death Assurance Committee, chaired by the Medical Director, had been convened and will report by exception through Patient Safety and Clinical Effectiveness Subcommittee and Quality Committee with annual report to Trust Board. The Committee was assured that appropriate oversight arrangements are in place and that no significant risks to delivery have been identified

***National Maternity Safety Initiative** updates provided evidence of progress against AMOS/Nottingham 10 Point Plan, Saving Babies Lives (SBL) Care Bundle, Maternal Care Bundle(MCB) and Maternity Incentive Scheme (MIS) Year 8, the areas of focus agreed with the Board for the remainder of the year, providing good assurance. Delivery of all MCB interventions by March 2027, as required, is at risk as a result of the scale of the work outstanding and reliance on digital development, cross Trust and system engagement, guideline and pathway updates, training, audit and sustained oversight

* Triage

*.**Regional Maternity Heatmap** score is unchanged from August but further reduction is anticipated as a result of recent CQC rating of good across all domains on both sites, and the move from national to regional oversight following NHSE assurance visit in June

***Maternity and Neonatal Quality and Safety Metrics** were presented and provided moderate assurance, limited by some elements having current data unavailable due to meeting timing. There are no areas of concern identified, with all recorded parameters comparable to peer Trusts, including stillbirths and neonatal deaths, PPH rates and incidence of 3rd and 4th degree tears, maternity triage performance. Gaps in training compliance are understood and plans in place to close.

***Maternity and Neonatal Safe Staffing Data** demonstrated an improving position with regard to midwifery staffing levels as a result of targeted investment, however gaps in neonatal staffing persist resulting in an inability to consistently meet BAPM standards and representing a continuing assurance gap and safety risk.

***Maternity Home Birth Action Plan** review provided an update on the Trust response to the Prevention of Future Deaths Report issued by the Senior Coroner in November 2025. Good assurance that immediate safety concerns raised by the Coroner have been addressed through stronger operational controls, training, guidance and governance were demonstrated. The key risk is the establishment of a sustainable workforce and service model for community midwifery and home birth provision.

***Maternity Learning Themes Report** provided assurance that learning from investigations, Mortality reviews, incidents, complaints and concerns is being effectively triangulated to drive improvement. Key themes of patient and family engagement, clinical decision making, Neonatal Resuscitation and stabilisation and PPH were noted along with clearly outlined actions taken in response. Good assurance was gained that the Directorate is embedding learning to improve patient safety, quality of care and patient experience.

***Maternity Inhouse Tobacco Service** is an element of MIS 8 that has been considered at risk. Evidence was provided to suggest that implementation is on schedule for December 2026 with no indication that delivery timeliness are at risk, providing strengthened assurance

***CQC Update Report** provided good assurance regarding actions arising from previous inspections, ongoing engagement with the CQC and the management of open CQC enquiries, Recent inspections of renal and diagnostic services have not identified any significant regulatory concerns. Oversight continues with reporting to Executive and Quality Committees

***Complex Needs Q1 Update** provided assurance that remains positive overall. Statutory requirements are being met, governance arrangements are embedded and key improvement programmes are progressing and on track for delivery. Positive external assurance was gained through the recent NHSE ETOC assurances support visit. Key risks continue to relate to rising demand, workforce sustainability, dementia strategic alignment, consistency in mental health training, Enhanced Therapeutic Observation of Care (ETOC) workforce intelligence and evidence of training impact on practice.

***Nurse Staffing and Quality of Care paper** outlined the complexities of interpreting the data relating to Planned, Actual and Required Care Hours per Patient Day (CHPPD) and provided assurance that careful triangulation of CHPPD fill rates, red flags, workforce data and professional judgment support conclusions drawn from the data, to enable earlier intervention and improved workforce resilience. Red flag activity has been variable over the past 8 months with a marked increase in August, indicating improvements are not yet sustained. Data indicated this activity was largely concentrated within a relatively small number of clinical areas, suggesting that the overall position is being driven by recurring pressures within these areas and not a widespread deterioration across the whole Trust.

***Nursing Workforce Establishment Reviews** are undertaken biannually in line with National Quality Board (NQB) safer staffing guidance supported by recognised workforce planning tools and reported through governance structures to Trust Board. The 2025/26 establishment review recommendations are progressing, however it is recognised that financial constraints have limited full implementation. The strengthened process has improved assurance and visibility of risk.

***Ward Accreditation Programme Development Plan 2026/27** was shared. Clear outcome measures and timelines were included, indicating a robust process and will provide stronger assurance, triangulated with workforce data, Red Flag data and Care Group Excellence Reviews, to support Ward to Board visibility, improved identification of emerging risks and the delivery of safe, effective, person centred care.

***Mortality/ Learning from Deaths Q1 Report** identified no cause for concern. Standard Hospital Mortality Index (SHMI) was 0.896, and remains in line with previous reports. SHMI for common diagnostic groups did not identify any diagnostic group to be of concern.Review of Structured Judgement Casenote Review (SJCR) data indicated improving performance, evident since an increase in trained reviewers.

***Avoidable Harm Recognition** was discussed, particularly in the context of long waits for assessments and treatment. Some assurance was gained that the potential for these harms to have been normalised is acknowledged and work is

underway to Improve understanding and raise awareness. It is anticipated that cancer harm data will become more visible through increased reporting..

ADVISE

*__CSCS Care Group__ attended and presented their current concerns, risks and areas of improvement, providing good assurance.

*__CQC Report on Maternity Services__ (published 3rd September 2026) rated services across both sites and across all domains as good, citing care given with warmth, dignity and compassion and highlighting excellent patient centred care, focused on what matters most to each individual. The hard work and dedication of the Maternity Teams to deliver this significant achievement was recognised and commended. The importance of sustaining and building on this strong foundation was acknowledged and will require continued focus and Board support.

*__CQC Report on Easingwold Renal Unit__ has been given a rating of good.

TPR

*__Research Metrics__ have been added to the TPR providing improved visibility and assurance. Strong set up performance is demonstrated and recruitment to studies is improving.

*__IPC__ performance continues to be of concern and focus with Executive oversight.

*__Rapid Access Chest Pain__ performance was seen to have deteriorated significantly over July and August increasing the risk to safe patient care and demonstrating the continued fragility of the service.

*__Sickness Absence__ was noted to have risen and the impacts of this on quality of care and patient experience was discussed.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

*__CRR Risks__ assigned to Quality Committee are unchanged from August.

PR1 was discussed through :-
*__SSNAP performance__ remains a risk as continued pressure on workforce, bed capacity and community rehabilitation provision will prevent sustained improvement in patient flow without system wide support. (CRR 1016)
*__Pressure Ulcer__ quality objective not met in Q1
*__Dementia Care__ may not be adequately recognised in Clinical Strategy

*__Safe Staffing__ may be compromised by a potential mismatch of funded nursing establishment and current levels of activity and acuity.
*__Dermoscopy__ image accompanying dermatology referrals is at risk, potentially compromising the ability to identify and prioritise those patient at highest clinical risk.
*__Sepsis treatment delays__ impacting on avoidable harms (CRR48)
*__RACP__ deterioration in performance leading to increased risk of patient harms
*__Neonatal staffing compliance__ with BAPM standards remains inconsistent
*__Sickness absence__ impacting potentially on care quality and patient experience
*__IPC__ performance against national standards (CRR 866)

PR3
* __Dermoscopy pathway changes__ and potential risk to relationships with primary care

ASSURANCE GAINED

Information provided and discussion resulted in an overall assessment of moderate assurance. Several services demonstrated clear improvement plans and governance arrangements. However, there remain significant assurance gaps in infection prevention, stroke services, sepsis identification and management, workforce resilience, urgent care flow and corridor care, and estate-related risks, requiring continued focus and oversight.

In summary :-
*Sepsis identification and management - limited
*Hyperacute Stroke Services - limited with route to moderate articulated
*Community Stroke Services -limited
*Dignity and Security in Death - good
*Complex Needs -good
*Maternity -good
*CQC Engagement Activity -good
*Nurse Staffing -moderate
*Pressure Ulcers moderate
*CSCS -moderate
*Mortality/ Learning from Deaths -moderate

Committee Report

Report from:	Resources Committee
Date of meeting:	18 August 2026
Chair:	Helen Grantham

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

ALERT

- **2026/27 WRAP delivery**
  - As at M4 WRAP delivery was £3.7m YTD *(£3.5m for M3)* behind target - £15.8m delivered YTD with £28m (*M3 £23.9m*) full year impact - £17.95m (*£17.2m for M3*) recurrent (FY). While there was continued strong performance against prior years, the trend of monthly underperformance against plan was continuing.
  - Over the next two months to end of Q2, clearer evidence of WRAP delivery, firmer control of workforce run rates and reduced reliance on non-recurrent actions was anticipated.
- **2026/27 plan**
  - The Trust is reporting a year-to-date deficit of £12.1m against a planned deficit of £7.7m (£4.5m adverse variance).
  - Key drivers for underperformance were WRAP under delivery, medical bank spend and drug costs.
  - Bank spend was £12.5m YTD (£3.9m adverse to plan). Priorities had been identified and were shared. There was a need for clearer assurance on actions, responsibility and delivery timelines to close the financial gap.
  - The level of non-recurrent savings remained above benchmark levels. Balancing short-term and long-term delivery was discussed. Learnings would be gained from the temporary turnaround and financial improvement resource in the Trust.
  - Forecasts (by the Trust and NHSE) were provided and an update on Executive plans to improve performance. The Committee asked for a waterfall showing how actions build back to plan delivery. Clear executive and senior leader accountability for implementation would be needed.
- **Sickness absence** had risen. Actions to support colleagues to be well at work and partnership working were discussed, as well as support to line managers.
- **Urgent and Emergency Care focussed review:**
  - Delivery of 2026/27 trajectories in the four key performance areas is off-track. Recovery actions are underway but not yet consistently delivering improved performance metrics. Numerous challenges are impacting services.
- **RTT – progress report**
  - The RTT update report showed deteriorating performance against internal trajectories and national requirements during Quarter 1. Total RTT waiting list increased by 1,323 patients (2.4%), patients waiting over 52 weeks increased by 141 patients (14.2%) from 996 to 1,137. The proportion of patients waiting over 52 weeks increased from 1.7% to 2.0% of the waiting list.

- The Trust benchmarked at 114th of 118 providers for patients waiting less than18 weeks and 93rd of 118 providers for patients waiting over 52 weeks.
- The principal operational constraint remains first outpatient access and the Trust is also experiencing demand growth above planning assumptions, with GP referrals increasing by 5% year to date
- A focused review is underway to identify additional interventions, which will inform the next phase of RTT recovery planning

- **EPRR Update**
  - With the small team delivering EPRR being focussed on unplanned challenges more limited progress had been made on EPRR core standards than had been planned.
- **Echocardiography:** Challenges in echocardiography were highlighted.

ASSURE

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- **2026/27 WRAP and plan delivery –** the Committee undertook its regular focussed review in these areas with:
  - reporting and discussion including the process to identify potential additional opportunities for the 2026/27 WRAP programme
  - an update provided on the process to identify actions to bring the plan back on track with further work to do
  - the need to look at strategic and transformational change was, again, noted.
  - the need to request cash in the short term had reduced following NHSE agreement of the plan. This area would be kept under review.
- **UEC - focussed review:**
  - The review gave background to the current position in UEC and focussed on actions to improve performance, addressing ongoing challenges with access standards, workforce shortages, increased demand, and the need for system-wide support, with detailed discussion of pathway changes, partnership work, and business case development.
  - Performance had increased to above trajectory levels following the implementation of Extended Emergency Medicine Ambulatory Care (EEMAC) and Emergency Assessment Unit (EAU) pathways at both sites and was sustained for eight weeks although performance has fallen back
  - ambulance handover times had deteriorated slightly but were significantly better than prior year. There was ongoing work involving Yorkshire Ambulance Service and the ICB to address remaining bottlenecks and support demand management. to analyse demand patterns and implement high intensity user programmes aimed at reducing unnecessary ED attendances.
  - increased demand and workforce shortages were highlighted, including high sickness rates and a discussion on appropriate staffing and rostering.
  - Recovery plans are supported by detailed governance oversight D
- **YTHFM**
  - an update was provided on the fire impacting Malton Hospital noting the multi-agency response, the safe evacuation of all individuals, phased service restoration, with lessons learned being incorporated into resilience and business continuity planning.
  - a report was provided on the major capital projects, status and next steps – this was in an updated format as requested by the Committee with some

additional work needed to align data with that in the finance report. The position on the hybrid theatre was discussed.

- **RTT Progress Update**
  - The update confirmed that a comprehensive RTT recovery programme remains in place, structured around six strategic priorities covering longest waits, first outpatient access, outpatient transformation, productivity, demand management, and governance and validation.
  - Enhanced operational oversight has been established with particular focus on high-risk specialties.
  - The Trust maintains strong RTT data quality and validation arrangements.
  - A full review of RTT recovery plans is underway during August 2026. This includes a review of productivity opportunities, GIRFT and Model Hospital benchmarking, waiting list validation approaches and additional recovery actions.
- **EPRR Core Standards**
  - a paper was presented on EPRR Core Standards Annual Assurance action plan showing progress to date and planned actions.
- **Risk management and BAF assurance development:** The Committee received the risk management report and noted the development of a revised Board Assurance Framework approach.

ASSURANCE GAINED

- **WRAP 26/27 and plan 2026/27**
  - The Committee gained assurance that the financial position is understood and partial assurance that recovery actions are in place to meet the WRAP targets and plan – governance had been strengthened
- **UEC – focussed review**
  - While the challenges in meeting trajectory in UEC were understood and performance from April showed that consistent use of revised pathways could result in on-trajectory performance, delivery assurance remains partial with all the four key standards off track. The up-to-date position was showing significantly below trajectory performance.
- **RTT update**
  - Assurance was provided that robust governance, performance oversight and validation arrangements are in place to support RTT recovery,
  - However, assurance is partial as RTT performance deteriorated during Quarter 1 and delivery of the current recovery trajectory remains high risk, being impacted by a combination of factors and the existing recovery plan is unlikely to achieve the originally planned improvement trajectory without further intervention. A comprehensive review is underway to identify additional actions and provide updated assurance during September 2026. Priority focus during Quarter 2 was understood and shared.
- **EPRR Core Standards**
  - While there had been less progress than had been expected in advancing compliance against the EPRR Core Standards since the report, the gaps were well understood and an action plan was in place. A rating of partial compliance will be submitted as part NHSE annual assurance on this area
  - The team is considering ways to recoup progress during the winter period.

- **Capital:** The Committee gained assurance around the current status of key capital projects, recognising that key schemes are actively managed, and the revised format of reporting had aided understanding

- **Risk management:** The Committee gained assurance that the BAF reporting process is being strengthened through formal assurance opinions and closer alignment between committee oversight and Board-level strategic risk reporting.

ADVISE

- **2027/28 Financial Plans:** WRAP opportunities which could not be delivered within 26/27 were being captured and the temporary transformation expertise in the trust was supporting on identifying other areas for future progress.
- **2026/27 plan** - has now been agreed by NHSE – £18.5m FY deficit.
- **Diagnostics and Cancer Recovery:** improvements had been seen in diagnostics, cancer 62-day targets, urgent community response, and outpatient productivity
- **Risk Management and Assurance Framework:**
    - An initial discussion took place on the BAF risks under the Committee's responsibility and actions were agreed to facilitate a further discussion in September before making recommendations to the Board for consideration in October.
- **Digital transformation**
    - It was noted that a discussion on this area was planned for the Board with timing to be confirmed
- **Committee**
    - The Committee was keen to add a NED with a clinical background to its membership when available
    - The committee workplan was under review – Board chair's input requested

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- **2026/27 WRAP/plan:** the risk that the Trust may not deliver the full efficiency requirement and overspend elsewhere may continue, necessitating further action planning and escalation and potentially not meeting the Trust plan.
- **UEC:** the risk that UEC performance would not improve to meet trajectory for the reasons referred to above
- **RTT:** the risk that RTT performance would not improve to meet trajectory or deteriorate further for the reasons referred to above
- **Capital delivery:** risks associated within the capital programme, including hybrid theatres and MRI capacity.
- **Workforce:** the risks associated with increased level of colleague sickness absenceand level of bank usage

Committee Report

Report from:	Resources Committee
Date of meeting:	22nd September 2026
Chair:	Jane Hazelgrave

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

ALERT

- **2026/27 WRAP delivery**
  As at M5 WRAP YTD delivery was £19.7m YTD compared to a plan of £26.3m resulting in a £6.6m adverse variance. The FYE of the schemes delivered is £30.4m compared to a full year plan of £66.8m. A further £27.4m schemes are in planning stage leaving a planning gap of £8m. The WRAP shortfall is the biggest financial risk to delivery of the Trusts plan.

- **2026/27 Financial Performance**
  - The Trust is reporting a year-to-date deficit of £14.0m against a planned deficit of £7.8m (£6.2m adverse variance). The in month run rate deficit has started to reduce.
  - Key drivers for underperformance were WRAP under delivery, pay growth (Medical bank) and other non-pay pressures including outsourcing to maintain performance delivery.
- **Cash**
  - Although the Trust has an approved financial plan of £18m, no deficit support has been provided by NHSE. The distribution method has not yet been confirmed. As a result, an application for cash support is being prepared for submission to NHSE in October. Until this is resolved cash remains a significant financial risk.

- **Sickness absence** had risen again to 6.0% compared to a plan of 4.7%. Actions to support colleagues to be well at work and partnership working were discussed, as well as support to line managers.

- **Diagnostics focussed review:**
  - The DM01 performance is ahead of plan at month 5 (see below). The 3 modalities giving greatest concern is NOUS, Urodynamics and Echo cardiology.
  - Current performance relies on non-substantive capacity. Multiple services remain dependent on waiting list initiatives, insourcing and mobile units because of workforce vacancies, sickness, insufficient estate and delayed equipment schemes.
  - Radiology demand is above plan by 5% for internal requests and 10% for external and GP requests; MRI3 has no agreed delivery date, CT3 is delayed to October 2026, MRI4 is forecast for September 2026, and nine of 18 diagnostic service delivery actions were reported off track in August.

- **Performance**
  - UEC and flow remain the most significant operational and patient-safety concern. August performance was behind trajectory across ECS, 12-hour waits, length of

stay and timely discharge, with a particularly material risk at Scarborough linked to medical staffing and senior decision-maker capacity.
  - RTT remains materially off plan across total waiting-list size, the proportion waiting under 18 weeks and 52-week waits. Zero 65-week waits is a significant achievement, but this does not yet demonstrate recovery of the wider elective position
  - Cancer Faster Diagnosis Standard remains below planned trajectory.
  - CYP long waits continue to present a significant recovery challenge.

- **Winter Planning.** A draft winter plan was presented. There are emerging risks as we move into winter about the availability of social care capacity to support discharge following recent bed closures and the pressure from our ambition to have no corridor care.

- **Digital:** Ability to manage Y&S Digital business as usual work, whilst delivering the new EPR is a challenge on processing subject Access requests which has seen a significant increase in volume from 300 a month to just under 400. This has led to overall performance falling below the target of 80% responded to in the statutory deadline. Remediation plans in place.

ASSURE

- **Medical and Dental Bank and agency**

A detailed plan was presented to reduce medical bank and agency expenditure. In high level terms the work includes approval panels, break-payment controls, rate negotiations and wider harmonisation of local medical pay arrangements. A PID was shared in Excel format with a cover sheet, plan-on-a-page, milestones and an equality impact assessment. The Medical Approval Panel has been operating for two weeks and is showing good progress.

- **Diagnostics**

  - Performance has recovered and remains ahead of plan. At the end of August 2026, 78.5% of tests were delivered within six weeks, compared with the submitted trajectory of 76.3%.
  - Long waits: The number of patients waiting more than 13 weeks fell by 87%, from 2,312 in August 2025 to 305 in August 2026. Six-week breaches reduced by 51%, from 5,068 to 2,486 over the same period.
  - Targeted recovery actions are producing measurable benefits. CT performance recovered from 55.2% in April to 90.6% in August, with the CT waiting list more than halving from 3,371 to 1,577 and the 13-week cohort reducing from 294 to seven. Scarborough Community Diagnostic Centre capacity is operational, and modality-level plans are in place across the pressured services

- **Cancer 62-day** performance achieved trajectory and is at its strongest position in the last 12 months

- **RTT over 65 week waits** down to zero

- **EPR And Nervecentre Delivery:** tranche 2 of the EPR programme went live successfully. Tranche 3 is still expected to in June 2027 which is has been made more of a challenge due to the initial delay in the programme. Tranche 3 will include the Patient Administration Service (PAS), theatres, endoscopy, medical device integration, econsent and outpatient use of clinical documentation. With EPMA & investigations that currently do not have nervecentre.

  .
- **Risk management and BAF assurance development:** The Committee received the risk management report and noted the development of a revised Board Assurance Framework approach. There is closer alignment with the principal BAF risks and the work of the board committees.

- **Patient Experience Standards:** NHS England has issued minimum standards of patient experience for elective care. Current initial assessment shows two standards rated Green and six rated Amber. . There is a good understanding of the current baseline position and reporting limitations. Actions have been identified to scope and improve compliance.

WRES/WDES: two comprehensive reports were provided which gave assurance that progress is being made. For the WRES report 2 out of 9 metrics showing a slight deterioration. WDES, 2 out of 11 metrics showed a slight deterioration. The reports will be published on the Trust's website by 31 October 2026

ASSURANCE GAINED

- **Winter Planning:** A draft winter plan was presented prior to submission to the board.

- **Planning 2027/28:** planning has commenced for 2027/28 for the Trust

- **Medical and Dental bank and agency** The Committee gained assurance around the current status of plan and the work taking place

- **Risk management:** The Committee gained assurance that the BAF reporting process is being strengthened through formal assurance opinions and closer alignment between committee oversight and Board-level strategic risk reporting.

ADVISE

- **2026/27 cash** – the Trust cannot maintain its core functions without additional cash support or the resolution of the funding of deficit support.

- **Diagnostics and Cancer Recovery:** improvements have been made but are dependant of NR measures in terms of workforce, out/in sourcing and active resolution of the installation of more scanning equipment.

- **TPR:** A discussion took place about the content of the current TPR. The committee agreed that a more succinct report would be more useful with a more comprehensive executive summary covering all the domains of the report.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• **Risks discussed:** Financial performance including cash and WRAP, Trust wide performance, workforce including increasing rates of sickness, • **New Risks Identified:** Winter funding, receipt of Deficit support funding,

Item 12

Committee Report

Report from:	Group Audit Committee
Date of meeting:	16th September 2026
Chair:	Jane Hazelgrave

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

ALERT

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

ASSURE

External Audit

2025/26
The auditors reported that they were unable to formally conclude the 2025/26 audit and issue an audit certificate until confirmation from the National Audit Office that the group audit of the Department of Health and Social Care has been completed and that no further work is required. This is the same position as last year

2026/27
Planning work has commenced which includes
• An agreed the engagement letter for 2026/27
• Considered the current NHS sector issues and the requirements of the 2026/27 DHSC Group Accounting Manual.

There are no anticipated major changes to the scope, risk profile or approach to the audit, and there are no significant matters that we need to bring to the Committee's attention ahead of the formal 2026/27 Audit Strategy Memorandum. The Audit Strategy Memorandum will be presented to audit committee in the new calendar year.

Internal Audit.

- **YTHFM.**

Six recommendations were overdue and a further seven were overdue but had revised dates; 16 recommendations have been completed. A limited assurance report was issued for procurement and a significant assurance for the Management of capital projects.

- **Trust**

Twenty-six recommendations were overdue. It is worth noting this is higher than the last 3 months

Six reports issued to the Trust since the last meeting. Three reports received significant assurance: Cash Management Debtors and Creditors, Budgetary control and complains, PALs.
Three reports were issued with a limited assurance rating: YTHFM recruitment, Right to work, Complaints

The Medical Director was the executive director in attendance at this meeting, and she discussed the outstanding actions attributable to her. Dr Stone gave the committee assurance that the actions were in the main already actioned with some delayed due to the roll out of Nerve Centre.

Fraud

Two reports were presented to the meeting. The first report set out the latest update on fraud activity since the last meeting and the second report set out the submission made by the Trust for the annual counter fraud standards submission.

Current fraud activity focusses on Recruitment Fraud whereby reference warehouses supply fake references: Proxy Interviews where another person attends an interview on behalf of the applicant and Sickness-Related Fraud, which mostly relates to working in secondary employment while claiming sick pay.

Other items

- Trust Estate Valuation. A paper was presented by the Finance Director on a proposed approach to revalue the Trust estate. The project includes detailed scoping, dedicated project management, validation checkpoints, reconciliation procedures, clear audit trails and support through year-end audit. The indicative programme runs from September 2026 to June 2027. The project includes explicit sign off from external audit.

- Tender Waivers. A report on tender waivers was produced for YTHFM and the Trust. A new process has been introduced across the procurement consortia and improvements have been made across the board to improve systems and processes. This has led to a reduction in the number of requests for tender waivers.

- Losses and compensation. A detailed report was produced that supported the transactions in the year end accounts. It was requested that this work in future form part of the year end audit work.

- Freedom To Speak Up Assurance: The Freedom to Speak Up Guardian presented assurance that the Trust has an established, confidential function and reporting arrangements, while highlighting resilience, culture, detriment management and feedback limitations requiring further organisational action. The set out how the Trust met national guidance with the most significant gap being cover arrangements for the guardian and the lack of evidence to support learning and improving.

  The paper set out the future priorities for 2026/27 including

- Establish a multidisciplinary patient safety triangulation group
- Support wider culture improvement by contributing anonymised Freedom to Speak Up intelligence to the Trust's Big Conversation programme.
- Contribute to the review of the Trust's Behavioural Framework
- Developing the Fairness Champion Network to improve visibility and accessibility
- Develop an agreed organisational process for alleged detriment

- Risk Management including BAF & Risk register

A report was provided on the 2026/27 Quarter 1 Board Assurance Framework (BAF). The Quarter 1 BAF was refreshed following review by Executive Directors and approval by the Board of Directors and includes eight principal strategic risks aligned to the Trust Strategy. The revised BAF also introduces a new Committee Assurance Opinion process in response to the Well-Led Developmental Review and the Trust's ongoing work to strengthen strategic risk oversight. The committee has not been asked to review the risk assigned to the audit committee yet as there is further executive work taking place that may impact the current assessment.

ADVISE

Further work is required to close down outstanding actions, and it is advised that management try to become more proactive in closing down actions.

Management are encouraged to introduce more 'first line' testing of systems and processes rather than relying on IA.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

There are no new risk to escalate to the board.

ASSURANCE GAINED

The annual fraud standards submission is 'Green.'
Four 'significant assurance' reports
Improved processes for tender waivers

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13

TRUST PRIORITIES REPORT

September 2026

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

TPR metric performance to note:
Special Cause Improvement – Pass (defined by NHSE Make Data Count methodology as "improving nature where the measure is significantly higher. The process is capable and will consistently pass the target"):
Operational Activity & Performance – ED – A&E Attendances – Types 2 & 3
Workforce – 12 month rolling turnover rate Trust (FTE).
Workforce - Overall Corporate Induction Compliance.
Workforce - A4C Staff Corporate Induction Compliance.
Digital – Percentage of FOIs and EIRs responded to within 20 working days (monthly).

Special Cause Concern – Fail (defined by NHSE Make Data Count methodology as "concerning nature where the measure is significantly lower. The process is not capable and will fail the target without process design"):
Operational Activity & Performance – RTT – Total Waiting List – Provisional Position.
Operational Activity & Performance – Outpatients – Follow-up Partial Booking (FUPB) overdue (over 6 weeks).
Maternity – Homebirth service suspended – York.
Workforce – Annual absence rate.

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

Information of the Trust's **National Operating Framework (NOF)** performance is included. The page provides the Trust's overall ranking and position nationally against each of the 22 metrics at the end of Q4 2025/26.

For information, comparison against Model Hospital peer group where available is included in performance slides.
The Trusts within this group are; ROYAL CORNWALL HOSPITALS NHS TRUST, MID YORKSHIRE TEACHING NHS TRUST, EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST, UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST, ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST, UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST, UNITED LINCOLNSHIRE TEACHING HOSPITALS NHS TRUST, NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST, EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST and UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST. These Trusts are assessed by Model Hospital to be like ourselves in terms of size, casemix and geography.

True North (TRUN)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-08			14.6%	9.9%	5%
ED - Conversion rate (Proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero)	2026-08			21.9%	28.8%	28%
Cancer - Faster Diagnosis Standard - Declared Position	2026-07			73%	78.1%	84.3%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-08			63.2%	63%	67.1%
2-hour Urgent Community Response (UCR) Compliancy %	2026-08			78.6%	70%	70%
Total Number of Trust Onset MSSA Bacteraemias	2026-08			9	7	7
Response rate overall for complaints and concerns	2026-08			62.2%	90%	90%
Monthly sickness absence	2026-07			6%	4.7%	4.7%
Variance year-to-date to financial plan	2026-08			-1.6%	0%	0%

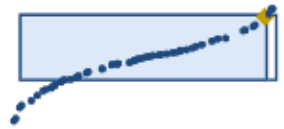
National Operational Framework
Rank Oversight

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

129 out of 134

Latest Rank



Latest Average Metric Score



Latest Average Segment Score



Latest Adjusted Segment Score

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

September 2026

Operational Activity and Performance
Chief Operating Officer Report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Executive Summary

Positive assurance

- Overall diagnostic performance remains ahead of trajectory and provides the strongest current evidence of recovery. However, assurance is qualified by material fragility in NOUS, echocardiography, urodynamics and CT, alongside workforce, equipment and estate dependencies.
- Cancer 62-day performance achieved trajectory and is at its strongest position in the last 12 months.
- Urgent Community Response continues to exceed target performance.
- Strong outpatient productivity indicators maintained through low DNA rates, improved PIFU and effective utilisation of Advice and Guidance.
- Focused reviewed being undertaken in elective tiering to support constructive challenge on plans. Positive feedback on histopathology deep dive, with NHSE assured on actions being progressed.
- Detailed reviewed of cancer and RTT completed in July and August, with additional actions identified to return to improvement trajectories.

Areas giving confidence

- First formal Contract Management Board held with Humber and North Yorkshire ICB, establishing a strategic forum to address demand, pathway redesign and commissioning opportunities across primary care, community and acute services.
- Response from ICB received regarding Paediatric SALT suggesting urgent multi agency meetings to deliver required actions to positively deliver improvements.
- Growing service ownership of specialty-level recovery plans and willingness to adopt new approaches to capacity and productivity challenges through weekly RTT risk meetings, tumour-site oversight, diagnostics delivery governance and Care Group performance meetings.
- Increasing focus on addressing underlying causes of demand rather than solely managing operational consequences.

Key risks and concerns

- UEC and flow remain the most significant operational and patient-safety concern. August performance was behind trajectory across ECS, 12-hour waits, length of stay and timely discharge, with a particularly material risk at Scarborough linked to medical staffing and senior decision-maker capacity.
- RTT remains materially off plan across total waiting-list size, the proportion waiting under 18 weeks and 52-week waits. Zero 65-week waits is a significant achievement, but this does not yet demonstrate recovery of the wider elective position.. In tiering meeting NHSE have confirmed this is the national picture and have reviewed and supported identified actions of the Trust.
- Cancer Faster Diagnosis Standard remains below planned trajectory.
- CYP long waits continue to present a significant recovery challenge.
- Sustainability of diagnostic recovery remains dependent on workforce, equipment and capacity resilience through delivery of the capital programme.
- Continued increase in GP demand across several high-risk specialities.

Operational Activity and Performance
Chief Operating Officer Report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Priority Area	Assurance Position	Q3 Outlook
UEC & Flow	Drivers are well understood and a defined action programme is in place through Coming Off Corridors, Nervecentre optimisation, flow improvement initiatives and strengthened operational oversight but the pace and reliability of implementation are not yet sufficient to demonstrate recovery.	**High Risk.** Some improvement in operational grip and internal processes is expected, however sustained recovery remains dependent on discharge performance limited by the financial landscape across health and social care, community capacity and wider system flow.
Cancer	Improvement in 62-day performance demonstrates that recovery plans are beginning to take effect, supported by strengthened tumour-site oversight and targeted interventions.	**Moderate to High Risk.** 62-day improvement is positive, but FDS remains below trajectory and is dependent on diagnostic and pathology turnaround
RTT & Long Waits	Governance has strengthened through Delivery Boards, specialty-level reviews and focused action in high-risk areas.	**High Risk.** Improvement is expected but delivery of trajectory remains challenging, particularly in relation to 52-week waits and specialties experiencing sustained demand growth. Zero 65-week waits has been achieved, while the broader total list, 18-week and 52-week trajectories remain materially off plan
Diagnostics	The strongest area of recovery, overall performance ahead of trajectory, but uneven by modality with sustained focus through the Diagnostics Delivery Board.	**Moderate Risk.** Performance is expected to remain close to trajectory provided workforce, equipment and capacity risks across NOUS, Echo and Urodynamics are successfully managed.
Outpatients & Productivity	Positive indicators include low DNA rates, strong Advice and Guidance utilisation and increasing focus on pathway productivity, however there was under-delivery of PIFU, which was 5.0% against 5.8%.	**Moderate Risk.** Incremental improvement is expected, with greater benefits anticipated from medium-term transformation initiatives.
Children & Young People	Recovery plans are in place with strengthened oversight of long waits and elective pathways. Paediatric ECS improved from 80.6% to 86.6% but remained short of the 95% March objective; RTT recovery was also not achieved in Head and Neck and Oral Surgery.	**High Risk.** Improvement is anticipated but recovery is likely to be slower than other areas due to workforce and capacity constraints.
Community Services	Strong performance continues within Urgent Community Response, with active development of community alternatives and Hospital at Home models. SLT remains off trajectory with a national workforce constraint.	**Moderate to High Risk.** Progress is expected, though workforce and commissioning dependencies remain significant.
Service Transformation & Demand Management	Stronger partnership working with the ICB and encouraging progress in Dermatology, Pain Management and Paediatric SALT pathway redesign discussions.	**Positive direction, benefits not yet secured:** Significant future opportunity exists, although benefits remain dependent on agreement, implementation and delivery of proposed changes.

Executive Owner: Claire Hansen

Overall assurance remains mixed. The Trust has strengthened its understanding of the principal operational risks and increased the specificity of recovery actions and specialty-level oversight. However, recovery is not yet secure across UEC, RTT, FDS, CYP or several diagnostic modalities. Delivery remains dependent on a combination of sustained internal operational grip, workforce and capital capacity, affordable recovery activity, and timely action by commissioners and system partners. External tiering discussions have provided constructive challenge and have been a helpful test of the Trusts understanding of the issues.

By the end of Q2, the expected position is more controlled but not recovered. Diagnostics should remain close to trajectory if workforce, equipment and mutual-aid mitigations hold, although NOUS and echocardiography remain vulnerable. Cancer 62-day performance should be capable of sustaining recent improvement, but FDS remains exposed to pathology, imaging and endoscopy turnaround. RTT is expected to remain materially off plan despite maintaining zero 65-week waits. UEC recovery remains high risk because internal actions alone cannot fully offset delayed discharge, community capacity and social-care constraints.

Operational leadership and transformation work undertaken during August:

- **External tiering and recovery challenge:** National and regional tiering has been used to test recovery assumptions and secure additional challenge around diagnostics, endoscopy, cancer pathways and RTT productivity.
- **First Contract Management Framework meeting with the ICB:** The first formal Contract Management Framework meeting with the ICB established joint work on referral growth, alternative pathways, activity variation, complex discharge and commissioning-dependent pathway change.
- **Endoscopy improvement work:** An external endoscopy review generated a focused improvement programme covering list utilisation, referral appropriateness, workforce and administrative resilience, and reporting compliance.
- **Care Group performance grip:** Care Group performance reviews have moved recovery discussion to specialty and pathway level, with named actions on workforce, productivity, backlog management and pathway redesign.
- **EPR Tranche 2 implementation:** EPR Tranche 2 progressed through formal readiness and clinical-safety governance to go-live, with enhanced command arrangements and targeted training mitigation. Operational benefits will require continued optimisation and data-quality oversight.
- **Cancer information and governance resilience:** Cancer information processes and capacity are being independently reviewed, with an options appraisal to address workload, resilience and process effectiveness within the available financial envelope.
- **Recruitment activity tied to operational risk:** Targeted recruitment activity has progressed in services where workforce gaps directly affect operational resilience, including Emergency Medicine, paediatrics, respiratory and sonography.

Executive Owner: Claire Hansen

Focus on the Trust strategic priorities:

Strategic Priorities (Q2/Q3)

- **Stabilise UEC and flow:** optimise Nervecentre utilisation, improve Type 3 performance, strengthen ambulance handover processes, maximise EEMAC/EAU utilisation, align workforce to periods of peak demand and progress actions through the Coming Off Corridors programme.

- **Strengthen discharge and community pathways:** progress acute-to-community alternatives, expand Hospital at Home and UCR models, improve delayed discharge escalation processes and support development of the new community service model.

- **Recover and sustain Cancer and Diagnostics performance:** improve FDS delivery whilst maintaining 62-day gains, continue tumour-site recovery plans, strengthen pathology and diagnostic turnaround, expand imaging and endoscopy capacity, and deliver recruitment, insourcing and CDC mitigations.

- **Improve RTT and elective recovery:** maintain zero >65-week waits, reduce RTT52 waits and total waiting list growth through specialty delivery meetings, RTT Delivery Group oversight, single point of access implementation, ARIP investment and focused Pain Management recovery actions.

- **Increase outpatient productivity and demand management:** accelerate PIFU-as-standard, expand template redesign and utilisation work, reduce DNAs and consultant-to-consultant referrals, and deliver NHSE single point of access requirements.

- **Address CYP and Community backlogs:** deliver CYP RTT recovery plans, continue weekly oversight of long-wait cohorts, progress the SLT business case, and develop sustainable workforce models across community services.

Board is asked to note that operational grip is strengthening, but recovery remains high risk and is not fully within the Trust's direct control. Scrutiny should remain on measurable delivery, affordability, workforce and capital dependencies, and the pace of required ICB and local-authority decisions.

Headlines:

- The August 2026 Emergency Care Standard (ECS) position was 67.1%, behind the monthly planned improvement trajectory of 73.3%. Please note, as per a national mandate for 2026/27 100% of Bridlington and 50% of Whitby UTCs are mapped to the Trust for performance purposes and are included as their performance was incorporated into the Trust's 2026/27 planning submission. In the latest available national data (July 2026) the Trust ranked 108th out of 118 providers and 11th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group (June performance saw the Trust at 90th and 9th respectively). ECS Performance for Trust controlled sites was 62.9% in August 2026.
- Average ambulance handover time in August 2026 was behind trajectory at 22 minutes 34 seconds against trajectory of 19 minutes 7 seconds.
- 14.6% of Type 1 patients spent over 12 hours in our Emergency Departments during August 2026, behind trajectory of 9.9%. **This is a True North Metric.**
- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 7.8 days in August 2026, behind the trajectory of 6.1 days.
- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) during August 2026 was 83.3%, against the trajectory of 88.5% submitted as part of the 2026/27 annual planning process. The average delay (number of days after the DRD that a patient was subsequently discharged) was 5.0 days, behind the submitted trajectory (2.7 days).

Factors impacting performance:

- Staffing issues continue, with instances of high levels of absence - medics and nurses - and the need for internal aid.
- Cessation of weekend discharge registrar due to financial constraints.
- Ongoing community health and social care constraints, and additional challenges in local authority partners with absence levels, all causing delays to discharges for patients requiring onward care.

Actions planned in August 2026:

- Submit business case for investment in substantive frontline staff in both Emergency Departments/Emergency Assessment Units.
- Continue breach validation work to ensure accurate performance statistics and support real time operational management.
- Review medical rotas to ensure workforce is aligned to periods of peak demand aligned to establishment.
- Review EEMAC capacity throughout the day and actively transfer suitable patients from the ED once seen by Doctor.
- Agree an escalation trigger for the Paediatric Registrar to attend the ED when waiting times exceed agreed thresholds.

Summary MATRIX 1

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* ED - A&E Attendances - Types 2 & 3 - Declared Position	* ED - Proportion of Ambulance handovers waiting > 240 mins	* ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - 12 hour trolley waits - Declared Position * ED - Proportion of Ambulance handovers waiting > 45 mins * ED - Ambulance average handover time (number of minutes)
COMMON CAUSE / NATURAL VARIATION			* ED - Total waiting 12+ hours - Actual number of all Type 1 attendances * ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs) * ED - Emergency Care Standard (Type 1 level) - Declared Position * ED - Proportion of Ambulance handovers over 15 mins
SPECIAL CAUSE CONCERN		* ED - A&E attendances - Type 1 - Declared Position	

Acute Flow (1)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Proportion of all attendances having an initial assessment within 15 mins	2026-08			78%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-08	L		5.1%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-08	L	F	14.6%	9.9%	5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-08		F	1893	1104	558
ED - 12 hour trolley waits - Declared Position	2026-08	L	F	116		0
ED - Emergency Care Attendances - Declared Position	2026-08			18761		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-08		F	67.1%	73.3%	82%
ED - Emergency Care Standard (Trust level) - Declared Position	2026-08			62.9%		
ED - A&E attendances - Type 1 - Declared Position	2026-08	H	?	12933	11217	11309
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-08		F	49.6%	53%	70.1%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-08	L	P	5809	8255	8324
ED - Median Time to Initial Assessment (Minutes)	2026-08	L		3		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-08	L		21.6%		

Summary MATRIX 2

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

MATRIX KEY

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

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

Acute Flow (2)
Scorecard

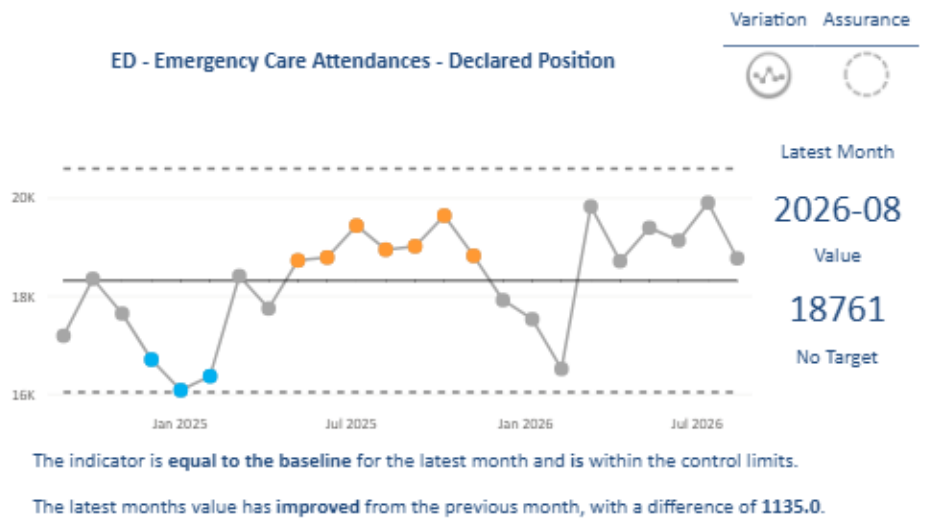
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of SDEC attendances	2026-08	H		6760		
Proportion of SDEC attendances transferred from ED	2026-08	L		48.6%		
Proportion of SDEC attendances transferred from GP	2026-08	L		13.8%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-08	H		91.3%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-08			26.6%		
Number of RAFA attendances (York Only)	2026-07	L		0		
Number of attendances at SAU (York & Scarborough)	2026-07	L		0		
ED - Proportion of Ambulance handovers within 15 mins	2026-08			29.6%		
ED - Proportion of Ambulance handovers over 15 mins	2026-08		F	70.4%	55.9%	49.6%
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-08			22.7%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-08	L	F	4%	1.4%	0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-08	L	?	0%		0%
ED - Number of ambulance arrivals	2026-08			4748		
ED - Ambulance average handover time (number of minutes)	2026-08	L	F	23	19	19

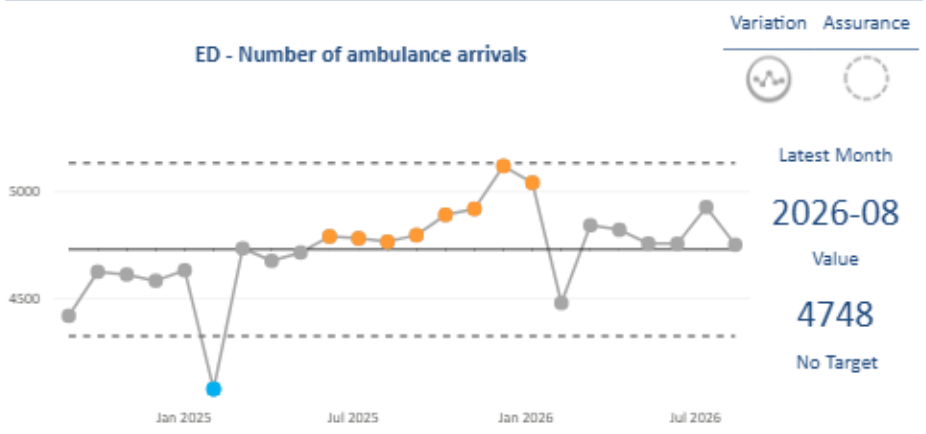
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

The latest months value has **improved** from the previous month, with a difference of **1135.0**.



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

The latest months value has **improved** from the previous month, with a difference of **176.0**.

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

What actions are planned?

We continue to liaise with Yorkshire Ambulance Service and other system partners about available alternative pathways and pathways which could be developed.

This includes working with system partners on the development of neighbourhood plans for York and North Yorkshire. Shaping work has taken place and the initial drafts will be refined through Q3 with an expected formal approval date in March 2027.

What is the expected impact?

Developing more community pathways and proactive strategies for supporting patients could contribute to a reduction in conveyances and attendances at Emergency Departments.

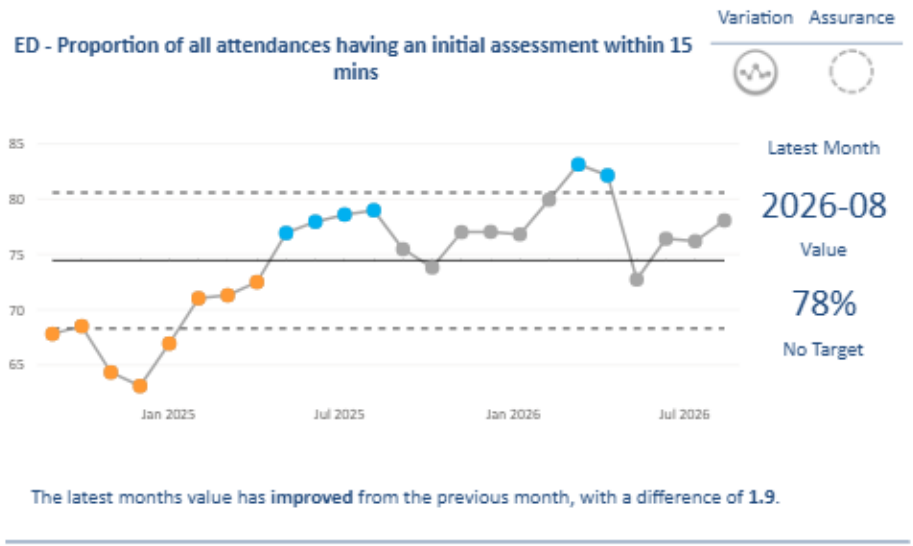
Potential risks to improvement?

Development of strategic plans is complex and medium-term, and not likely to have an impact over the upcoming winter period.

Reducing conveyances and attendances depends on supporting patients and system partners to access appropriate alternative care pathways which is within our sphere of influence but not control.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

What actions are planned?

The proportion of patients having an initial assessment within 15 minutes declined as expected during the early implementation of Nervecentre, and is continuing to recover.

A four-week First Assessment bay (FAB) trial commenced in Scarborough Emergency Department on 12 August 2026 as part of the UEC recovery programme. The model sought to bring triage, early clinical assessment and patient flow coordination into a single front-door process. The primary aim is to reduce clinical risk in the waiting room and ambulance corridor through earlier assessment, prioritisation and management planning. This has resumed on 14/09/26, however one challenge is the medics cover.

What is the expected impact?

A delay to initial assessment contributes to time in the department and delays that can impact four-hour performance.

Performance should continue to recover.

Potential risks to improvement?

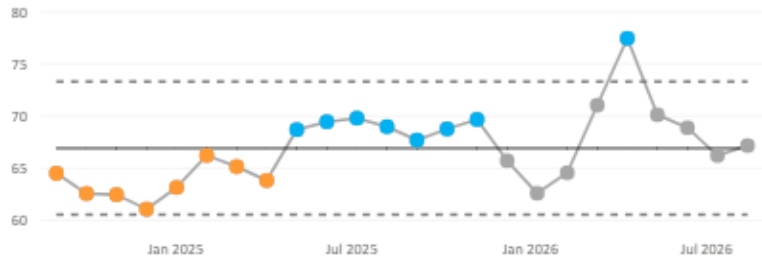
- High staff absence rates meaning FAB trial has not been able to be implemented every day.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)

Variation Assurance



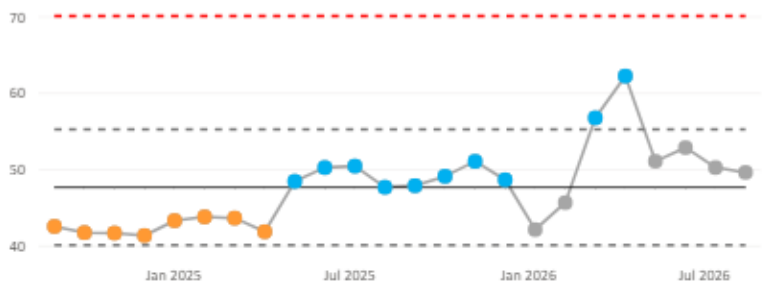
Latest Month
2026-08
Value
67.1%
Target
82%

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

The latest months value has **improved** from the previous month, with a difference of **0.9**.

ED - Emergency Care Standard (Type 1 level) - Declared Position

Variation Assurance



Latest Month
2026-08
Value
49.6%
Target
70.1%

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

The latest months value has **deteriorated** from the previous month, with a difference of **0.6**.

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

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

What actions are planned?

Type 1 performance is in-line with the same time last year, but Type 3 performance remains lower than required and continues to cause the overall position to drop below the same point last year.

Paediatric performance has been below 90%. A new Paediatric action plan has been developed and is being progressed over the coming months. As at end of July the Paediatric ECS 4 hour performance was 80.6% and improved as at end of August 2026 to 86.6%.

Performance increased in March and April when the new EEMAC and EAU pathways were introduced however this was not sustained beyond the introduction of Nervecentre which has added some process complexities to using the pathways.

Breach validation of 'soft breaches' (4-5 hours) continues to be undertaken by the operational team, while clinical teams work towards full adoption of real-time recording.

What is the expected impact?

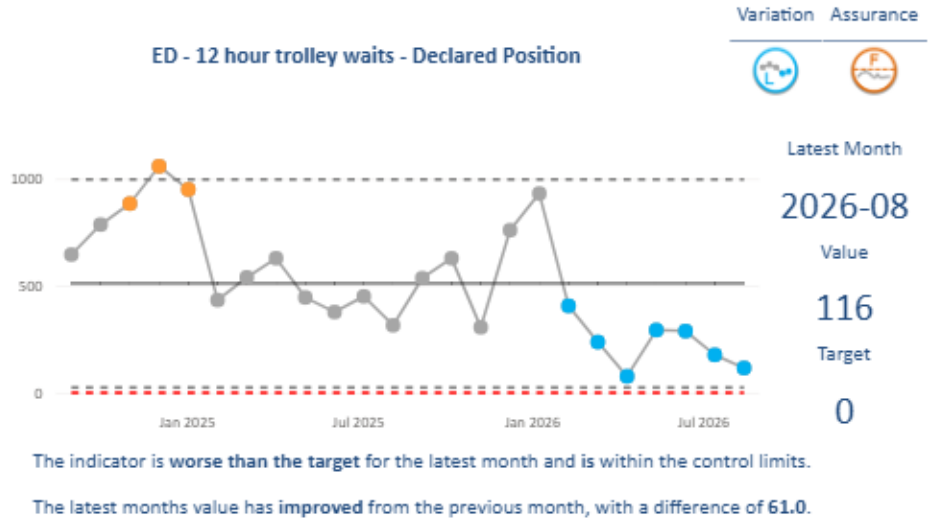
There remains scope to increase utilisation of the EEMAC pathway at York, and Type 3 performance across all sites. This could lead to a ~3 percentage point increase overall to monthly Trust performance.

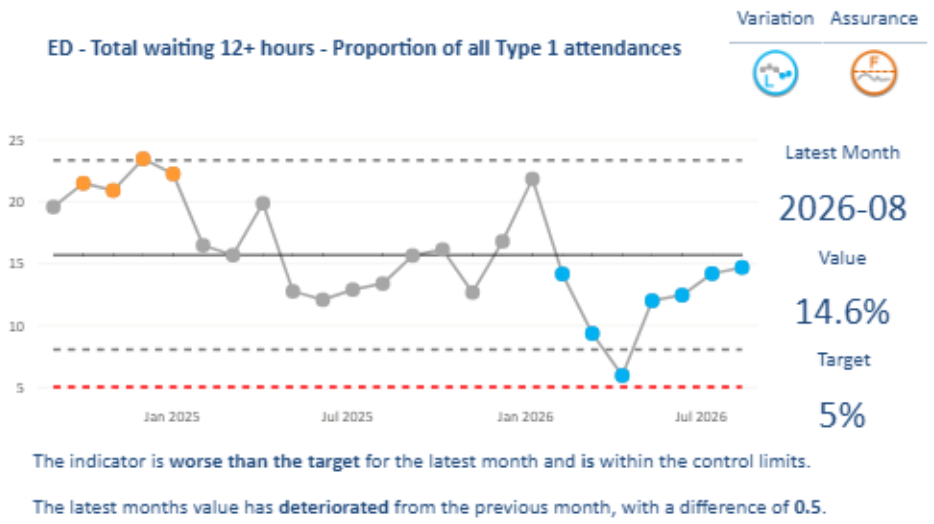
Potential risks to improvement?

- Lack of operational capacity and multiple conflicting priorities.
- Varying levels of clinical buy-in and utilisation of the new pathways.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

The proportion of patients spending over 12 hours in ED is markedly higher in Scarborough than York. One reason for the performance level at Scarborough is the initial time to see a doctor. Low numbers of senior decision makers and medics, particularly overnight, is sometimes driving long waits. A business case is in development for investment into additional medical staffing. In the meantime, there is agreement for short term increases in shifts available however there is often no uptake. Critical shifts are being covered from staff who usually work in York. Recent recruitment adverts now state that medics must work across both sites.

What is the expected impact?

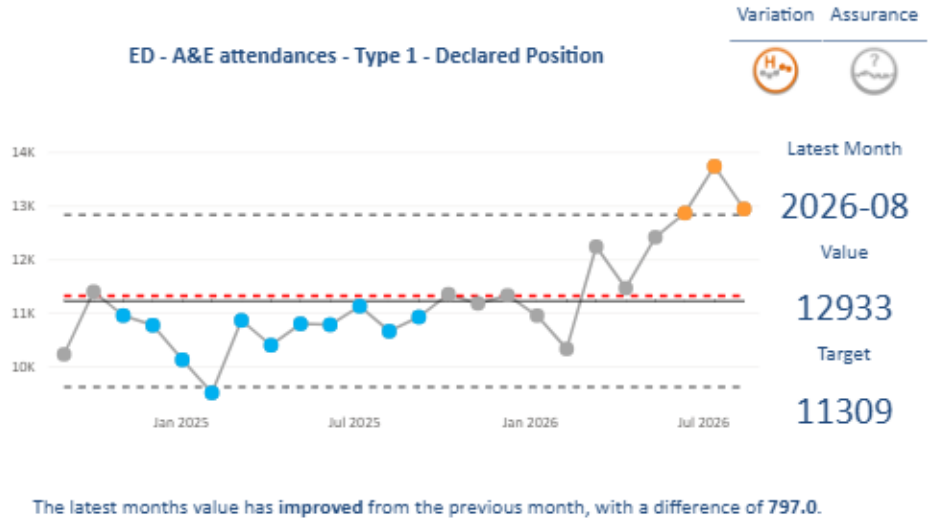
We expect that the wider Coming off Corridors actions taking place in September will support increased flow through departments and increased medical input. This would lead to improved position in September.

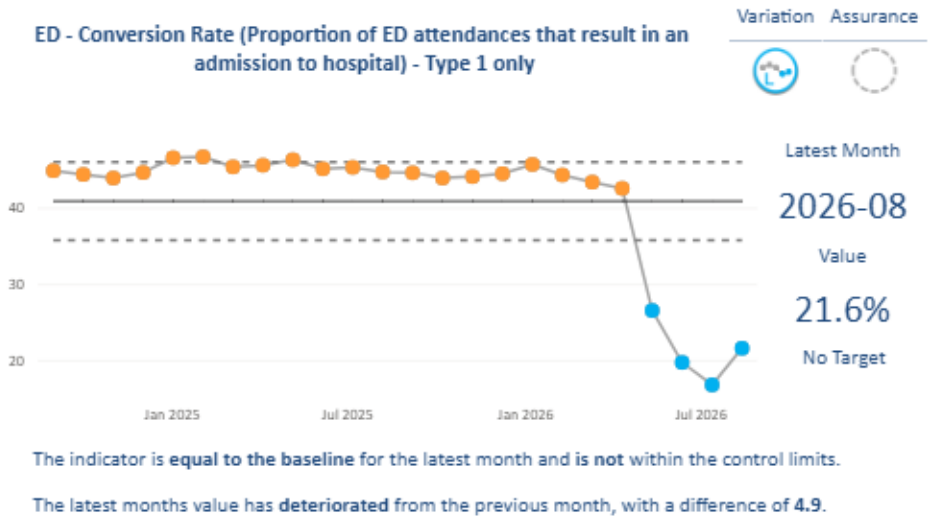
Potential risks to improvement?

- Risk of continued challenges filling rosters.
- Community health and social care capacity remains challenged.
- Limited capacity in ED and acute teams, with high volume of competing priorities for action.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

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

What actions are planned?

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

What is the expected impact?

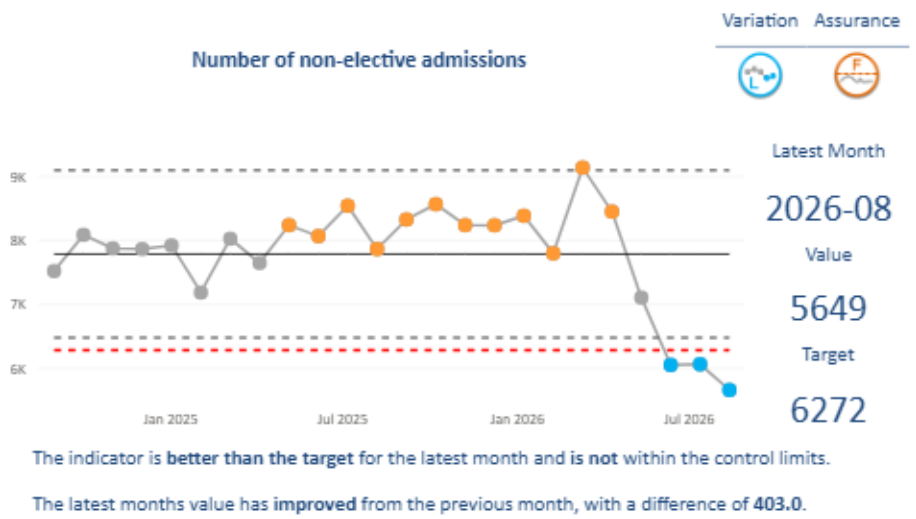
The impact of increased attendances is reduced performance across all key metrics and reduced staff morale.

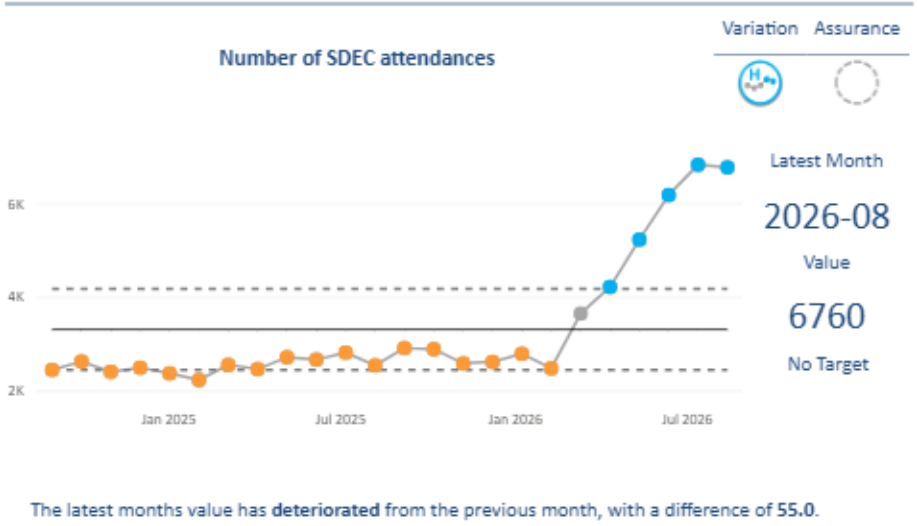
Potential risks to improvement?

There is a risk that the workforce model required to sustain all pathways may exceed the current identified envelope, requiring prioritisation through executive governance.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

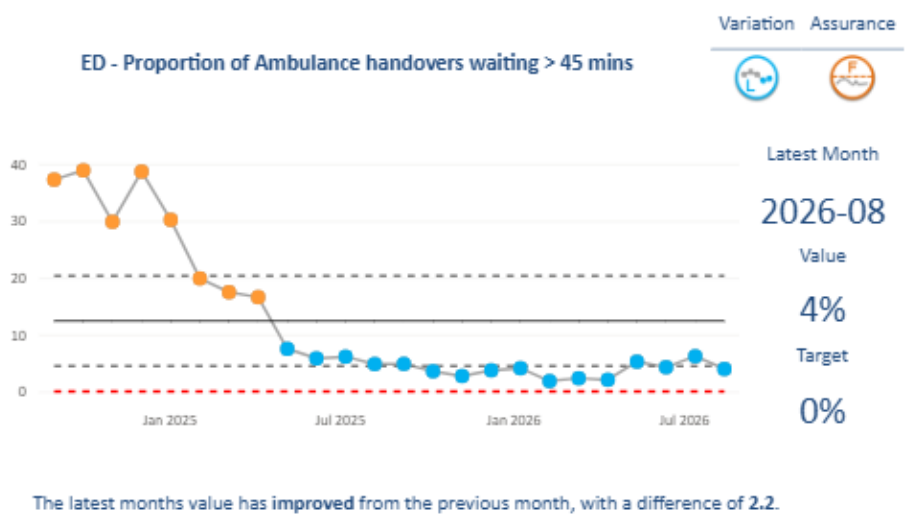
Note: At the launch of Nervecentre, admissions no longer includes admission to Type 5 SDEC areas. This explains the significant drop off in NEL admissions and the corresponding rise in SDEC attendances from May 2026.

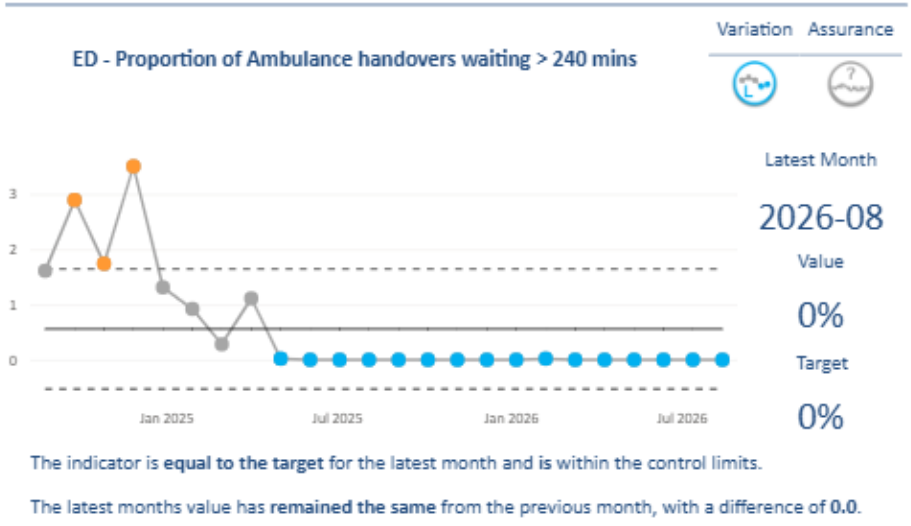
SDEC attendances includes all patients going to EEMAC and EAU, which accounts for the large increase in SDEC activity since their launch in March 2026.

Plan for an Integrated Assessment Unit at York, which will encompass General Surgery, are progressing with specialty engagement sessions planned throughout September and a further workshop about the full acute medical model.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

Actions continue to be taken, both internally and with Yorkshire Ambulance Service (YAS), to reduce ambulance handover delays.

Actions include recirculation of W45 principles to all crews, weekly meetings with YAS Team Leaders to discuss breaches for them to highlight to crews, and ensuring fit-to-sit is consistently applied and clinically safe.

What is the expected impact?

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

Potential risks to improvement?

- High number of competing priorities for the senior ED and acute team, risking ability to complete agreed actions.
- Reliance on behaviour change in YAS crews.

Acute Flow (3)
Scorecard

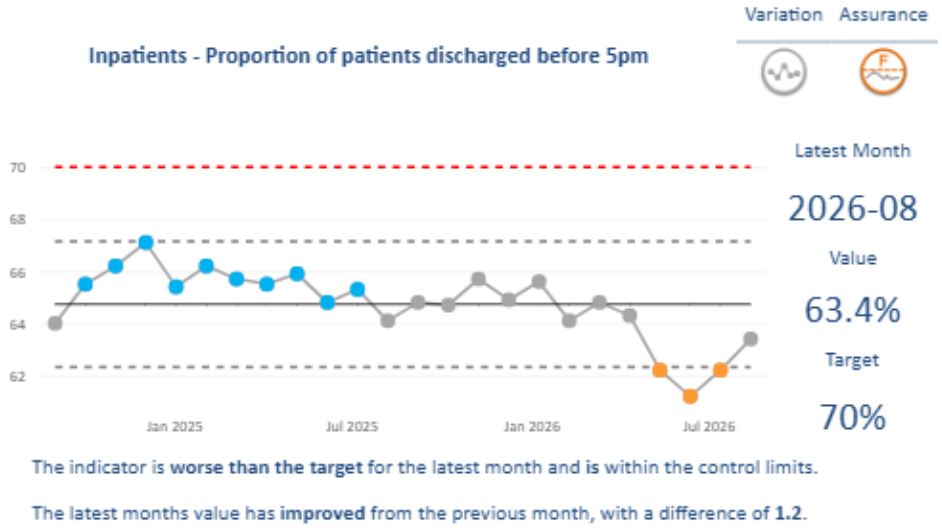
York and Scarborough Teaching Hospitals NHS Foundation Trust

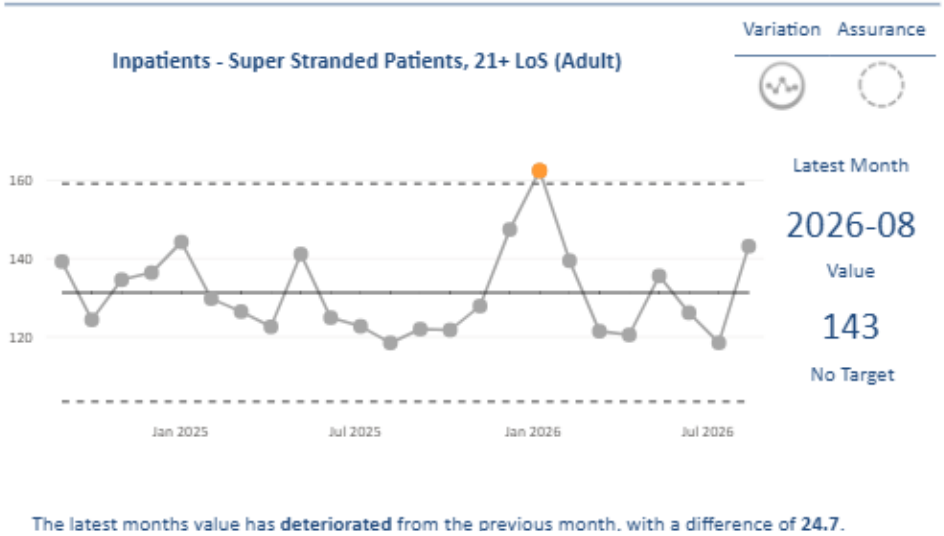
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2026-04		F	78.4%		90%
Patients with Senior Review completed at 23:59	2026-04	L		44.7%		
Inpatients - Proportion of patients discharged before 5pm	2026-08		F	63.4%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-08	H		1774		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-08			18%		
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-08		?	5	2.7	3.7
Number of non-elective admissions	2026-08	L	F	5649	7295	6272
Number of zero day length of stay non-elective admitted patients	2026-08	L		856		
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-08			143		
Overnight general and acute beds open	2026-08		P	880	843	843
Of those overnight general and acute beds open, proportion occupied	2026-08	L	?	90.7%	91.1%	93.2%
Community bed occupancy/availability	2026-08		?	92.4%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

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

What actions are planned?

- The Coming off Corridors programme is giving senior clinicians protected time in September to support earlier discharges. Initial feedback has led to targeted work around improving quality of board rounds. Focus will be on:
    - Ward leadership and owning discharges from day 1.
    - Ensuring the Choice policy is enacted.
    - Criteria led discharge opportunities and trials.
    - Operational grip with escalations being followed through via cross site ops meetings with particular focus on diagnostic delays and speciality reviews.
    - Golden patients being identified and shared with site team to expedite.
    - Focus on timely EDNs which delays early discharges.
    - Long Length of Stay to review our top ten longest staying patients per site.

What is the expected impact?

- More efficient processes will result in earlier discharges
- Positive risk taking and criteria led discharge will lead to reduced LOS and more discharges.
- Ward ownership of discharges by ward managers will create priority over discharge tasks at board rounds reducing delays with documentation such as EDNs
- Unblocking LLOS stay patients will identify thematic issues and cohorts where we need to make changes, including commissioning discussions with system partners where required.

Potential risks to improvement?

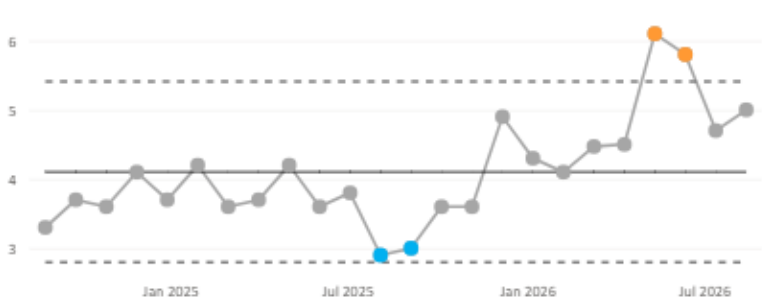
- Ongoing limitations in community health and social care capacity.
- Cultural change at ward level will take time to achieve

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

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

Variation Assurance



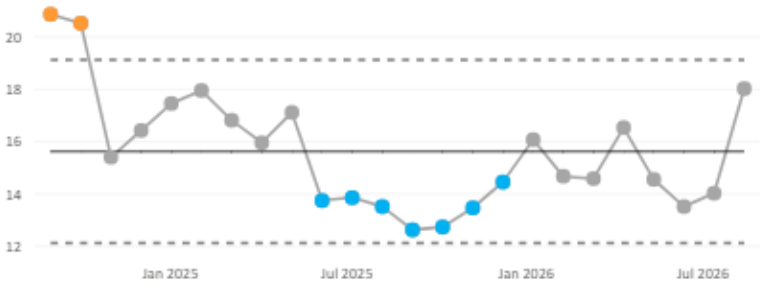
Latest Month
2026-08
Value
5
Target
3.7

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

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

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

Variation Assurance



Latest Month
2026-08
Value
18%
No Target

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

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

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

What factors are impacting performance?

Social care do not work over weekends therefore discharge readiness forms submitted on Fridays are unlikely to be progressed until Monday, causing a delay of 3 days.

Across North Yorkshire, York and East Riding, the recurring themes are broadly consistent:
- Workforce pressures linked to vacancies, sickness and annual leave. This is now improving following the summer holiday period.
- Community team caseload pressures for pathway 3 patients in North Yorkshire.
- Limited availability of care packages, reablement services, bridging support and intermediate care beds.
- Brokerage, governance and approval processes extending discharge timelines.
- Market capacity challenges, particularly for complex care needs and rural areas.
- Limited impact from second-line escalation processes on overall discharge numbers.

What actions are planned?
- Time out with system partners to work through escalation meetings and how delays are actioned internally
- Head of site and patient flow to meet with local authority leads monthly to work through themes to discharges issues and influence service change
- Daily Gold meetings between Head of site and discharge command centre leads to escalate our most complex patients to system support level as required.

Potential risks to improvement?
- Ongoing limited community health and social care capacity to release patients no longer meeting the criteria to reside.
- In CYC discharge to assess will be ending in October 2026

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait - treatment within 31 days of a decision to treat for all cancer patients- Declared position	* Cancer - Faster Diagnosis Standard - Declared Position * Cancer - 62 Day First Definitive Treatment Standard - Declared Position
SPECIAL CAUSE CONCERN			

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard - Declared Position	2026-07		F	73%	78.1%	84.3%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-07		F	74.5%	70.7%	80%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-08	L		181		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-08	L		7.9%		
Cancer 31 day wait - treatment within 31 days of a decision to treat for all cancer patients- Declared position	2026-07		?	97.8%	96.2%	96.3%
Total Cancer PTL size	2026-08			2285		

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

- The Cancer performance figures for July 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 73.0% behind the monthly improvement trajectory of 78.1%. In the latest available national data (June 2026) the Trust ranked 98th out of 119 NHS providers nationally and 8th out of 11 against our Model Hospital peer group (May: 94th and 8th respectively). **This is a True North Metric.**

- 62 Day waits for first treatment service standard in July 2026 was 74.5% , with the monthly trajectory of 70.7% achieved. In the latest available national data (June 2026) the Trust ranked 48th out of 119 providers nationally and 3rd out of 11 against our Model Hospital peer group (May: 59th and 6th respectively). This 62-day position is the highest the Trust has achieved in 12 months.

Factors impacting performance:

- The following cancer sites achieved or exceeded 80% FDS in July 2026: Breast, Haematology and Non-Site Specific. Haematology and Urology achieved above their internal trajectories.

- The following cancer sites achieved or exceeded 75% 62-day service standard in July 2026: Breast, Head and Neck, Haematology, Skin and Upper GI. Upper GI, Gynaecology and Urology achieved above their internal trajectory.

- 31-day treatment standard was 94.6% overall, which was marginally below the national service standard of 96%. This was driven by Colorectal, Gynaecology and Head & Neck and a combination of patient-initiated delays and surgical treatments.

- At the end of July, the proportion of patients waiting over 104+ days equates to 2.0% of the PTL size, this position is stable between 1.5% and 2.6% over the last 6 months. Colorectal, Skin and Lung are the areas with the highest volume of patients past 62 days with/without a decision to treat but are yet to be treated or removed from the PTL, with Colorectal and Skin accounting for 59% of this patient cohort.

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

Actions:

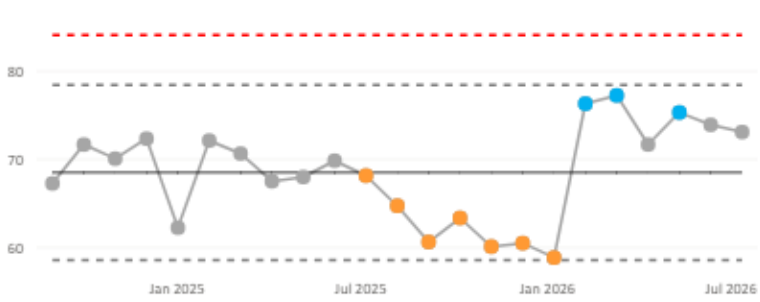
- Please see following pages for details.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Cancer - Faster Diagnosis Standard - Declared Position



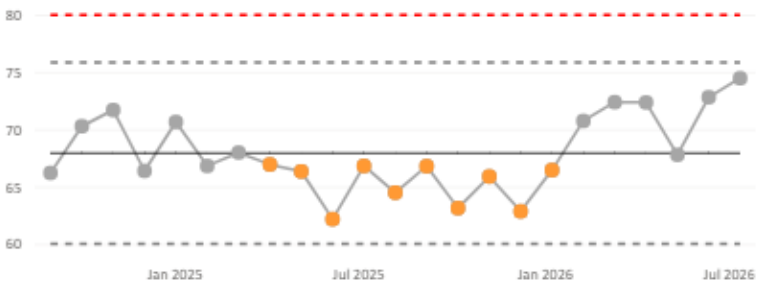
Latest Month
2026-07
Value
73%
Target
84.3%

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

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

Variation Assurance

Cancer - 62 Day First Definitive Treatment Standard - Declared Position



Latest Month
2026-07
Value
74.5%
Target
80%

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

The latest months value has **improved** from the previous month, with a difference of **1.7**.

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

What actions are planned?
•2nd weekly Trust wide meeting implemented to review specific FDS cohort and newly diagnosed patients, alongside new PTL breach process
•Targeted investment and transformation schemes from alliance funding
•Cancer clinical lead and Head of Cancer meeting each care group to discuss actions, transformation schemes and operational processes
•Breach avoidance strategic plan presented to chief executive August 26 with ACOO & COO endorsement

Colorectal Plan -Provisional position of 62.4% against internal trajectory of 75.5%. Review of Prof Rutter report and recommendations for maximising endoscopy capacity. Interim additional FT capacity being provided to reduce current waits, particularly on East Coast. Awaiting alliance input on Colofit next steps, alongside pathology interface feasibility. FT nursing frailty expansion in progress, target Q4 to go live.
Gynaecology Plan -Working group initiated for IOTA ADNEX one stop model and SOP progressing, with alliance funded national training course booked. Senior operational gaps mitigated in part with involvement of head of cancer running tumour site PTL meetings with ops appointments now complete.
Skin - Ongoing risk around dual running of telederm and non telederm pathway (c.30% refs received do not have image), new clinical lead commences in post in coming weeks. Additional capacity actively being sought for recovery of current position with risk to both FDS and 62 day.
Lung - Cancer alliance providing support for PTL oversight due to operational change. 6 new Respiratory consultants commence in post September (note not all cancer specialist), reducing reliance on ad hoc capacity. FT nurse lead clinics in pre go –live and EBUS business case approved.

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

Potential risks to improvement?
- Financial constraints impacting ability to provide additional activity- SDF cancer sprint activity planned
- Cancer performance dependent upon diagnostic and pathology capacity and recovery plans. Risk around pathology TAT in gynaecology, Endoscopy recovery plan in place, pathology improvement plan currently on much longer-term basis.
- Patient related breaches in July account for 9.6% compared to 7.3% in June

Headlines (Provisional performance):

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

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

- The Trust's **RTT Total Waiting list position** provisionally ended August 2026 behind the trajectory submitted to NHSE as part of the 2026/27 planning submission: 57,913 against the trajectory of 53,507 (+4,406).

- The Trust was provisionally behind the trajectory for the proportion of the **patients on an RTT waiting list under 18 weeks** at the end of August: 58.4% against 60.8%. In the latest available national data (June 2026) the Trust ranked 110th worst out of 118 NHS providers and 10th worst out of 11 in our Model Hospital peer group (unchanged from May: 110th and 10th respectively).

- The Trust is provisionally behind the **RTT patients waiting over fifty-two weeks** trajectories submitted within the 2026/27 planning submission; 1,286 waiters and 2.2% of the total RTT Total Waiting list against the trajectories of 691 and 1.3%, respectively (+595 and 0.9%). Validation before submission is expected to improve but not deliver performance against the trajectories. In the latest available national data (June 2026) the Trust was ranked 91st worst out of 118 NHS providers and 8th worst out of 11 in our Model Hospital peer group for the proportion of the TWL waiting over 52 weeks (May: 93rd and 9th respectively). Nationally at the end of June 2026 there were 6,693,433 patients on the national TWL, of which 100,029 (1.5%) were waiting over 52 weeks.

- The Trust was ahead of the trajectory for **RTT patients waiting no longer than 18 weeks for a first appointment** submitted to NHSE as part of the 2026/27 planning submission with performance of 63.2% against the end of August 2026 ambition to be above 63%. There is no nationally available comparative data for this metric. **This is a True North Metric.**

Factors impacting performance:

- 4.6% increase in GP referrals compared to 2025/26 (2,915 additional referrals YTD). April at +5% from previous April, +1.4% in May from May 2025, +9.7% in June from June 2025, +0.3% July from July 2025 and +6.9% August from August 2025 (4.6% YTD). There have been significant increases in several specialties, namely; Pain Management (+37%), Paediatrics (+17%), Respiratory (+24%), Neurology (+25%) and Gastroenterology (+59%). The Trust continues to engage with the ICB to understand the drivers and the opportunities to mitigate with a flow of referral data from the Trust .
- Not delivering planned levels of 1st outpatient activity in Q1, which is required to deliver level of clock stops in planned improvement trajectory.

Actions:

- Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

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

Referral to Treatment (RTT)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List - Provisional Position	2026-08			57913	53507	49360
RTT - Waits over 78 weeks for incomplete pathways - Provisional Position	2026-08			0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Provisional Position	2026-08			0		0
RTT - Waits over 52 weeks for Incomplete Pathways - Provisional Position	2026-08			1286	691	0
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-08			58.4%	60.8%	67.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-08			17.7		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-08			2.2%	1.3%	0%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-08			63.2%	63%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-08			2.2%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-08			12.6%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-08			68.5%		

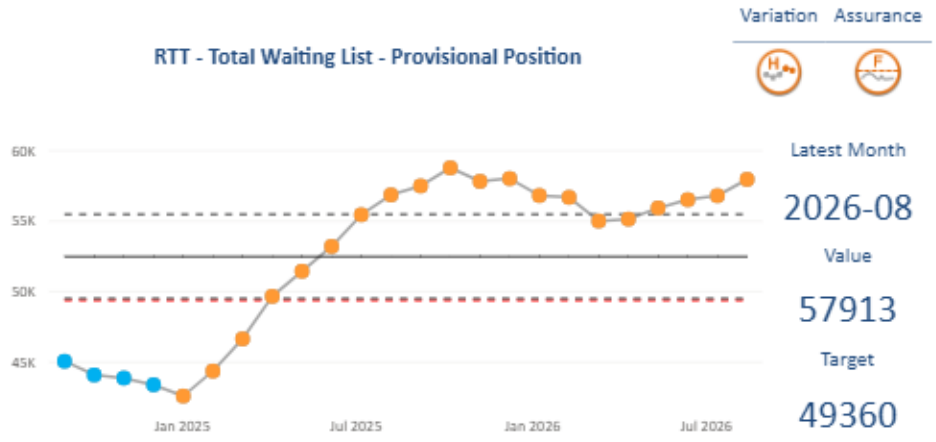
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

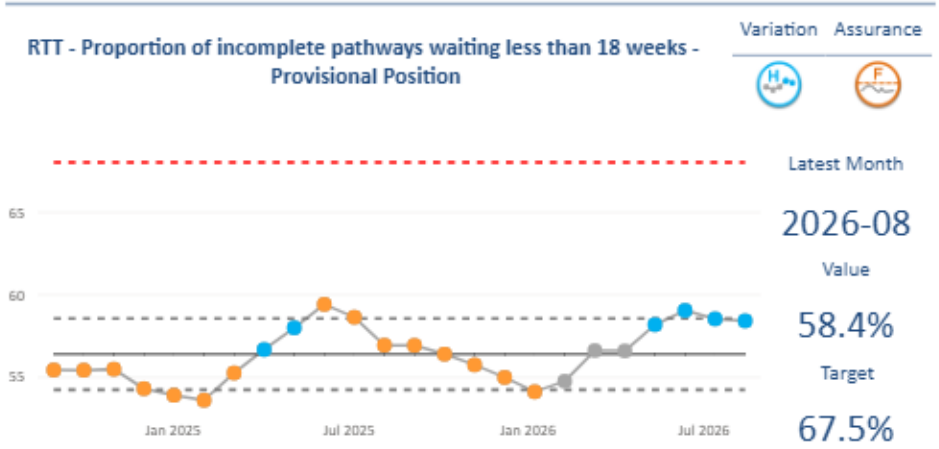
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **1153.0**.



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

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

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

What actions are planned?

- The Service Delivery Plan has a comprehensive list of actions to support the delivery of increased productivity and RTT performance improvement, these are monitored through the RTT Delivery Group.
- Focused regular BAU discussions to identify action to improve scheduling discipline and chronological booking ongoing with care groups and outpatient services.
- Delivery of single point of access in Q3 should reduce demand and support longer term reduction in TWL.
- Review of additional recovery actions undertaken in August 2026 and added to the Service Delivery Plan.
- ICB contract discussions ongoing to review referral thresholds.

What is the expected impact?

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

Potential risks to improvement?

- Increase in GP referrals in YTD 2026/27 compared to 2025/26 (up 4.3%).
- Impact of delayed capital builds (CDC, Hybrid theatre, MRI, VIU, SGH Roof and RAAC), resulting in reduction in capacity and increasing waiting times.
- Proportion of first attendances of all attendances remains below model hospital average.
- Availability of activity related investment for high risk specialties as identified in plan

KPIs – Operational Activity and Performance

Referral to Treatment RTT (2)

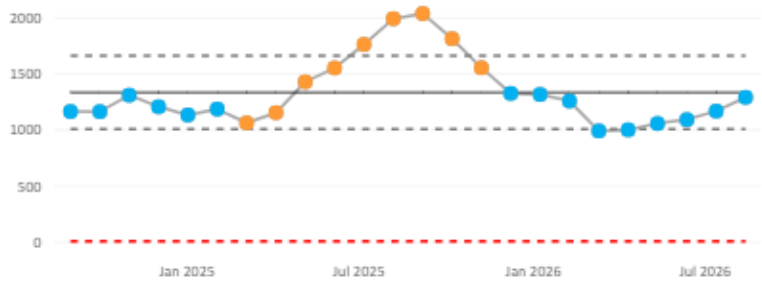
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

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



Latest Month

2026-08

Value

1286

Target

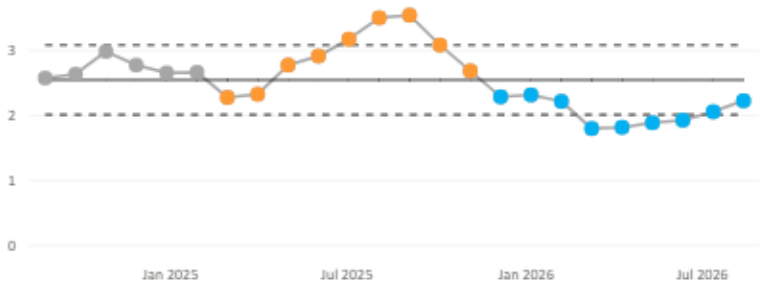
0

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

The latest months value has **deteriorated** from the previous month, with a difference of **123.0**.

Variation Assurance

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



Latest Month

2026-08

Value

2.2%

Target

0%

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

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

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.

Target: SPC1 & SPC2: Aim to have zero patients waiting more than 52 weeks by March 2027 as per activity plan.

What actions are planned?

- Weekly monitoring of RTT52 week waits throughout the month with weekly trajectory in place. Scope of weekly meeting expanded in April 2026 to monitor full pathway metrics rather than focus on longest waiters. Maintaining zero RTT65 week waits remains a priority.
- Focused on improvement actions for Pain Management who are the service with most significant variance from plan. This includes funded additional capacity, commissioning discussions, review of other providers, request through NHSE tiering for external clinical review of pathways.
- Investment funding approved for pain, colorectal and upper GI to prioritise 52-week activity.

What is the expected impact?

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

Potential risks to improvement?

- A small number of long waits are affected by patient availability and scheduling complexity; these are being actively managed through weekly oversight.
- Diagnostic performance.
- Capital Programme delays (RAAC replacement, CT replacement, Roof replacement, OP procedure rooms and hybrid theatres) which will impact on Diagnostic and theatre capacity at Scarborough and York through construction phases.
- Impact of diagnostic delays and prioritisation of cancer resulting in increase in 52-week waiters.
- Volume of 1st OPs on PTL, risk of breaches due to pathways of care resulting in longer waits and increase in RTT52 weeks.

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

Headlines:

- For the month of August 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 5.8% with performance of 5%. Y&S has three specialties in the upper quartile of Trusts within the NE&Y region (Clinical Haematology, Physiotherapy and Rheumatology).

- Rapid Access Chest Pain (RACP) seen within 14 days was at 52.9% below the target of 99% (July: 70.7%). The performance drop was caused by unexpected consultant absence in August. The service expect to recover to pre-August levels in September. Clinic slots have been ringfenced for RACP patients and additional triaging has taken place.

Factors impacting performance:

- In the latest North East & Yorkshire Region provided Outpatient data (Aug 26) the Trust is above the national provider median for Pre-Referral Specialist Advice Utilisation at 20.4% v 8.6% and Diversion Rate at 75.8% vs 22.1%, PIFU at 5.2% v 4.2% and best in region for DNA rate.

- The Trust's DNA rate remained at 4.3% in August 2026. The Trust has one of the lowest DNA rates in the country, the national average is 5.6% (NHSE).

- Digital letters for Radiology – we have now reached 62% of letters via Synertec. We saw increased utilisation of Synertec among our most recent adopters, with 71% of Mammography letters and 91% of Lung Screening Service letters being sent via the service.

- Digital Clinical Letters - Since the expansion of the pilot to Rheumatology, Neurology and Pain Management we have now had over 500 documents sent in one day. Ophthalmology are waiting for some referral groups to be added onto CPD, and they can then expand to the rest of the specialty. Reconciliation process has been working well, with further refinements being made. Trust wide roll out plan will be agreed in October 2026.

- Improvement actions for PIFU for agreed specialties are delivering sustained improvement in PIFU.

Actions:

- Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Outpatients - DNA rates	* Outpatients - Proportion of appointments delivered virtually (SO17a) * Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)
COMMON CAUSE / NATURAL VARIATION	* Outpatients: Follow Up Attendances (Activity vs Plan) * Proportion of elective admissions which are day case	* Outpatients: 1st Attendances (Activity vs Plan) * All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days* * Day Cases (based on Activity v Plan) * Electives (based on Activity v Plan)	
SPECIAL CAUSE CONCERN			* Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)

Outpatients & Elective Care
Scorecard

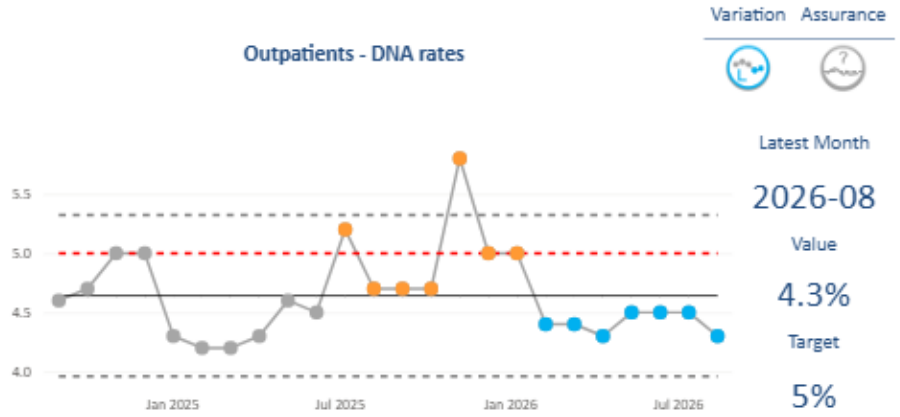
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2026-08	H	F	22.5%		25%
Outpatients - DNA rates	2026-08	L	?	4.3%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-08		?	18073	21765	23266
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-08		P	37478	54640	55935
Outpatient procedures	2026-08			12984		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-08	H	F	31414		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-08	H	F	5%	5.8%	6.6%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-08	H	F	52.9%		99%
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days*	2026-08		?	3		0
Day Cases (based on Activity v Plan)	2026-08		?	5991	7187	7781
Electives (based on Activity v Plan)	2026-08		?	620	769	660
Proportion of elective admissions which are day case	2026-08		P	90.6%		85%
Outpatients: All Referral Types	2026-08			22984		
Outpatients: Consultant to Consultant Referrals	2026-08			2341		
Outpatients: GP Referrals	2026-08			11055		

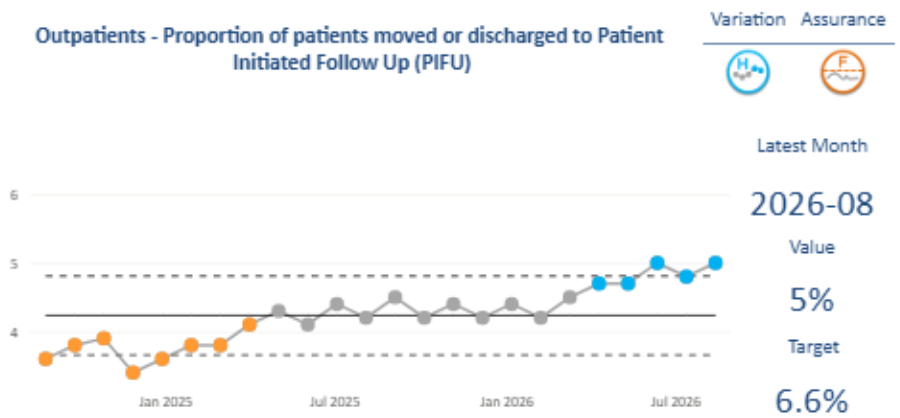
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

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



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

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

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

What actions are planned?

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

- GIRFT clinic template standards audit completed. Specialties have amended templates to reflect improvements, with further actions identified. A full GIRFT self assessment tool has been developed and sent out for completion in August 26. Systematic review with operational and GIRFT clinical lead to commence in September 26.

- Outpatient utilisation project commenced to increase utilisation to 90% and has seen continued improvement since April 2026.

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

What is the expected impact?

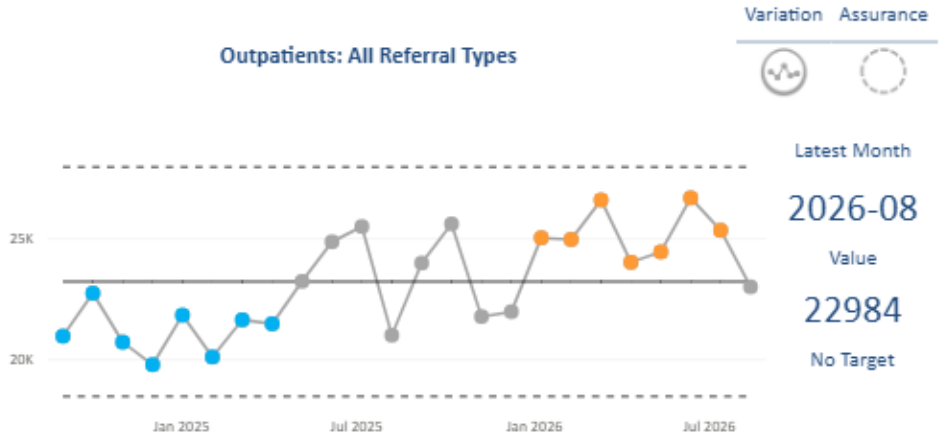
- PIFU improvement to 6.6% (March 2027).
- Delivery of 1st Outpatient plan and reduction in new to follow up ratios.
- Reduced demand for high-cost additional capacity.

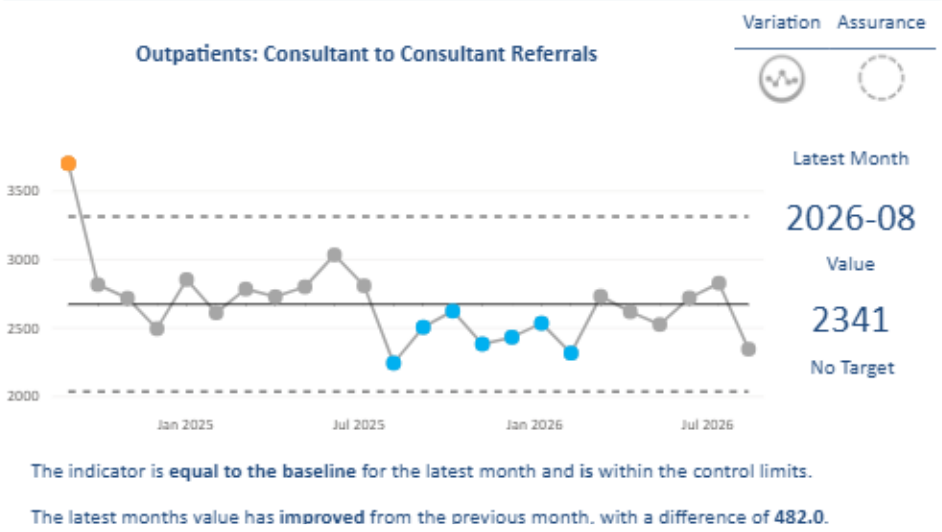
Potential risks to improvement?

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

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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

What actions are planned?

- Commenced with scoping project to reduce consultant to consultant referrals (C2C) by 10% from April 2026 (compared to 2025/26). YTD C2C are down by 12% (-1,880 referrals) compared to the same period in 2025/26.
- ICB conducting review of GP referrals to identify outlying practices for further discussion and education.
- Single point of access proposal approved by Executive Committee in June. Plan required to deliver in 10 specialties by October 2026 in line with NHSE roadmap, these have been identified through review of impact on RTT performance. The Trust currently has 4 specialties with single point of access via gateway (REI); Clinical Haematology, Dermatology, Rheumatology and Neurology. A project group has been established with colleagues from primary care involved and clinical workshops are well advanced with the project on plan.

What is the expected impact?

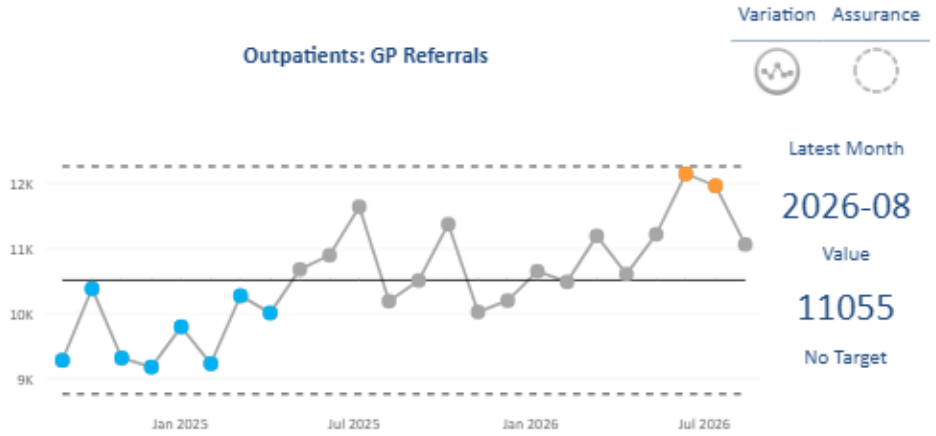
- Reduction in internal demand and reduction in open referrals.
- Reduction in GP demand.
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

Potential risks to improvement?

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

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **improved** from the previous month, with a difference of **901.0**.

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

Please see previous page

Headlines:

- Trust DM01 performance at end August 2026 was 78.5%, an increase from 77.7% in July and exceeding August trajectory of 76.3%.
- Total waiting list saw a slight increase from 11,236 in July to 11,581 in August, however 6-week breaches and 13-week breaches both saw a continued improvement.
- In the latest available national data (June 2026) the Trust ranked 71st worst out of 118 NHS providers and 7th worst out of 11 in our Model Hospital peer group (May: 78th and 7th respectively).

Factors impacting performance:

- Whilst overall performance has increased to above trajectory level, there are still significant challenges in some modalities which need targeted action to recover or sustain performance and prevent impact on the overall Trust DM01 position including CT, NOUS, Echocardiography and Urodynamics.
- CT saw significant performance recovery over June and July, returning to trajectory in June with performance of 87.9% against plan of 87.7% and increasing to 92.9% in July against plan of 90.3%. Performance has seen a drop in August, currently standing at 90.6% which is 0.4% under the trajectory of 91%.
- Non-Obstetric Ultrasound (NOUS) 6-week performance increased marginally by 0.1% from 67.8% in July to 67.9% in August, against trajectory of 74.7%. The sonographer team at York have significant workforce vacancies with only circa 40% establishment currently in place. We continue to use Yorkshire Health Solutions (YHS) to support however due to their own staffing issues they are unable to deliver sufficient activity to recover Trust performance.
- Clinical space is a challenge for Echocardiography, along with clinical staffing due to vacancies and sickness. Capacity and demand analysis has shown under provision of 30-35% without running additional lists. This is due to a shortfall in staffing for CDCs and room availability at York hospital.
- Staffing shortages continue to impact Urodynamics activity resulting in a build-up of backlog. Recruitment is underway with posts offered however onboarding and training is likely to take some months so there is likely to be a deterioration in performance until these staff can fully deliver capacity.
- Delay in installation dates for new equipment in both MRI and CT. Ongoing intermittent equipment breakdown impacts on ability to deliver planned activity.
- Workforce challenges in multiple modalities due to staff shortages caused by vacancies, sickness, and maternity leave. Recruitment is challenging in many areas, particularly imaging and physiological modalities, due to a national shortage of trained staff.

Summary MATRIX

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

MATRIX KEY

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

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

DIAGNOSTICS – National Target: 95%

Scorecard

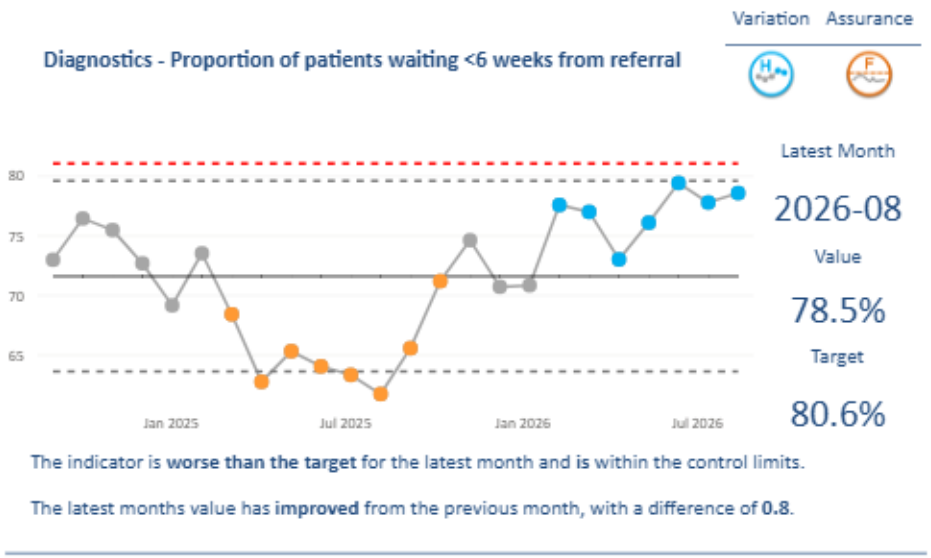
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Diagnostics - Proportion of patients waiting <6 weeks from referral	2026-08	H	F	78.5%	76.3%	80.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-08	H	F	92.1%	81.8%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-08	H	F	90.6%	91%	91.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-08		?	67.9%	74.7%	77.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-08	H	F	97.3%	84%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-08	H	?	100%	82.8%	86.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-08	H	?	92%	77%	80%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-08	L	?	30.1%	76.8%	79.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-08		?	84%	95.8%	95.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-08		?	82.7%	94.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-08		F	42.9%	74.7%	84.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-08	H	F	87.6%	82%	86%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-08	H	?	83.7%	83.5%	85.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-08		?	79.4%	66.4%	69.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-08	H	?	86.6%	84%	86%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

What actions are planned?

Endoscopy: Clinical endoscopist currently in training, due to be signed off in Q3 2026/27, which will provide an additional 4 lists per week at York. Nurse recruitment on going. On Track for recruitment into vacant posts and required competency training by end of Q4 2026/27

Imaging: Continued use of YHS to support with NOUS performance however this is unlikely to provide sufficient capacity to recover performance. We have three current NOUS consultant vacancies which impacts the MSK Ultrasound service. Interviews took place in March 2026 but there were no appointable candidates. Recruitment is ongoing but there is a lack of candidates nationally. Staffing vacancies in MRI are being mitigated by use of RMS insourcing to retain core capacity until recruitment can be completed to return to full substantive establishment. Radiographer workforce review and associated action plan have been developed and will go forward through governance routes for discussion and agreement.

Physiological: Two posts recruited to in mid July for Urodynamics, though the staff members will require a period of training once commenced in post so performance recovery likely to take some months. Insourcing through Yorkshire Medical Solutions (YMS) is taking place to mitigate capacity over the coming months until we can return to establishment.

Two staff currently in recruitment process for bank Echocardiographer posts resulting in a minimum of 20 additional slots per week at York, aiming for staff to be in place by end September. An application has also been made to NHSE for 1WTE Echocardiographer to provide appropriate staffing levels at the CDC and deliver underutilised capacity. Funding also approved for staffing to be used for valve clinic which should release staffing to allow for circa 1 day of additional DM01 activity. Applications are underway within the trust for an additional room / equipment to deliver additional capacity. We do not anticipate recovery of Echocardiography performance to trajectory level until we have sufficient staffing and clinic capacity and as yet there is no defined timescale for this.

What is the expected impact?

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

Potential risks to improvement?

Ongoing issues with equipment breakdown and recruitment challenges.

Summary MATRIX

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

MATRIX KEY

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

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

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

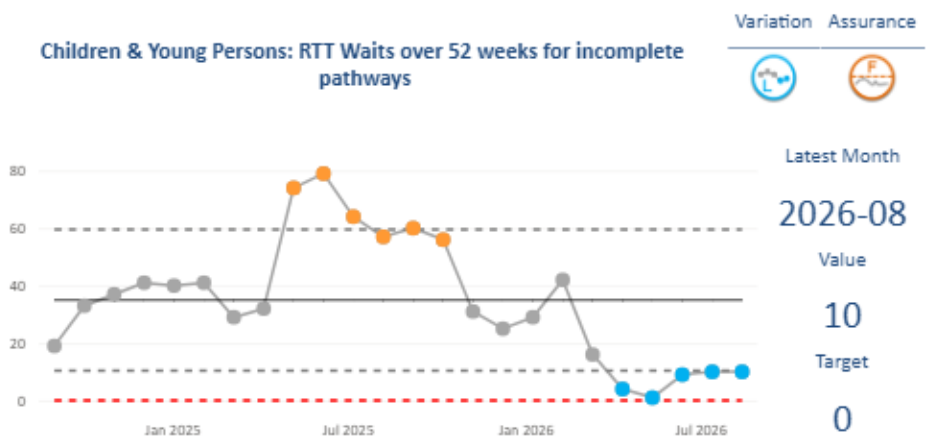
Executive Owner: Claire Hansen

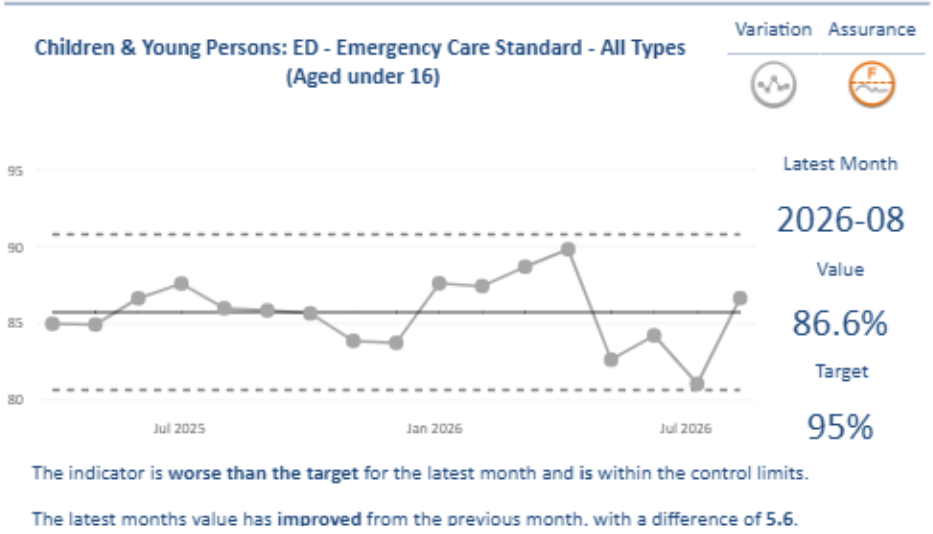
Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2026-08		?	4		0
Children & Young Persons: ED - Emergency Care Standard - All Types (Aged under 16)	2026-08		F	86.6%	94.1%	95%
Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Aged under 16)	2026-08			84.5%	94.1%	
Children & Young Persons: ED Attendances - Type 1 only (Aged under 16)	2026-08			1976		
Children & Young Persons: RTT - Total Waiting List	2026-08			4516		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-08	H	F	66.1%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-08	L	F	10	0	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi





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

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

What actions are planned?

SPC1:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 weeks wait for patients aged under eighteen. Zero RTT40 week except ENT and Oral Surgery is an internal target but was not delivered (provisionally ten at the end of July).

- Head and Neck were planning to deliver zero RTT52 week waiters by the end of July 2026; this was not achieved with eight patients waiting at month end. Due to clinician staffing levels Oral Surgery are not forecasting recovery and delivery of zero until Q3.

SPC2:

- The team are closely monitoring paediatric time to initial assessment, triage and clinician review separately by site.
- A new Paediatric action plan has been developed and is being progressed over the coming months. As at end of July the Paediatric ECS 4 hour performance was 80.6% and improved as at end of August 2026 to 86.6%.

What is the expected impact?

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

Potential risks to improvement?

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

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			* Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list * Percentage of people on waiting lists for Children's Community Services per system who are waiting 18 weeks or less as proportion of entire Children's waiting list * Number of people on waiting lists for CYP services per system who are waiting over 52 weeks
COMMON CAUSE / NATURAL VARIATION	* Number of open Virtual Ward beds	* Proportion of intermediate care beds occupied by people with no criteria to reside * Proportion of Virtual Ward beds occupied * Total Urgent Community Response (UCR) referrals * 2-hour Urgent Community Response (UCR) Compliancy % * Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list * Attended Community Care Contacts	
SPECIAL CAUSE CONCERN			

COMMUNITY
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Proportion of intermediate care beds occupied by people with no criteria to reside	2026-08			22%	23.5%	20%
Number of open Virtual Ward beds	2026-08		P	33	33	33
Proportion of Virtual Ward beds occupied	2026-08			39.4%	82%	82%
Community Response Team (CRT) Referrals	2026-08			607		
Total Urgent Community Response (UCR) referrals	2026-08			581	473	514
2-hour Urgent Community Response (UCR) care Referrals	2026-08	H		211		
2-hour Urgent Community Response (UCR) Compliancy %	2026-08			78.6%	70%	70%
Attended Community Care Contacts	2026-08			36580	37360	41283
Number of District Nursing Contacts	2026-08			21046		
Number of Selby CRT Contacts	2026-08			2974		
Number of York CRT Contacts	2026-08			4306		
Referrals to District Nursing Team	2026-08			1963		

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of Adults (18+ years) on community waiting lists per system	2026-08			670		
Number of CYP (0-17 years) on community waiting lists per system	2026-08	L		1392		
Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list	2026-08	H	F	58.2%	63.9%	78%
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	2026-08		?	99.7%	99.6%	99.6%
Percentage of people on waiting lists for Children's Community Services per system who are waiting 18 weeks or less as proportion of entire Children's waiting list	2026-08	H	F	38.3%	46.8%	63.7%
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-08	L	F	423	418	0

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Number of open Virtual Ward beds

Variation Assurance



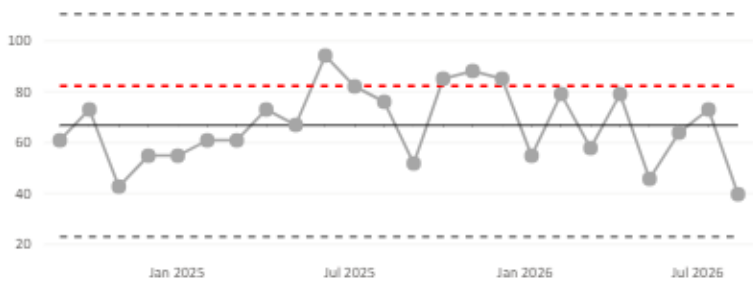
Latest Month
2026-08
Value
33
Target
33

The indicator is **equal to the target** for the latest month and **is not** within the control limits.

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

Proportion of Virtual Ward beds occupied

Variation Assurance



Latest Month
2026-08
Value
39.4%
Target
82%

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

The latest months value has **deteriorated** from the previous month, with a difference of **33.3**.

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

Please note: Graphs show all 4 Virtual Wards. The Trusts virtual wards are made up of Frailty Virtual ward (12 beds) Heart Failure Virtual ward (10 beds) and Vascular and Cystic Fibrosis with 11 beds between them. FVW and HFVW are operationally managed by community services but delivered in partnership with acute colleagues. **DATA IS A SINGLE DATA POINT SNAPSHOT ON A SINGLE DAY AND NOT REPRESENTATIVE OF OVERALL MONTHLY PERFORMANCE.**

What actions are planned?

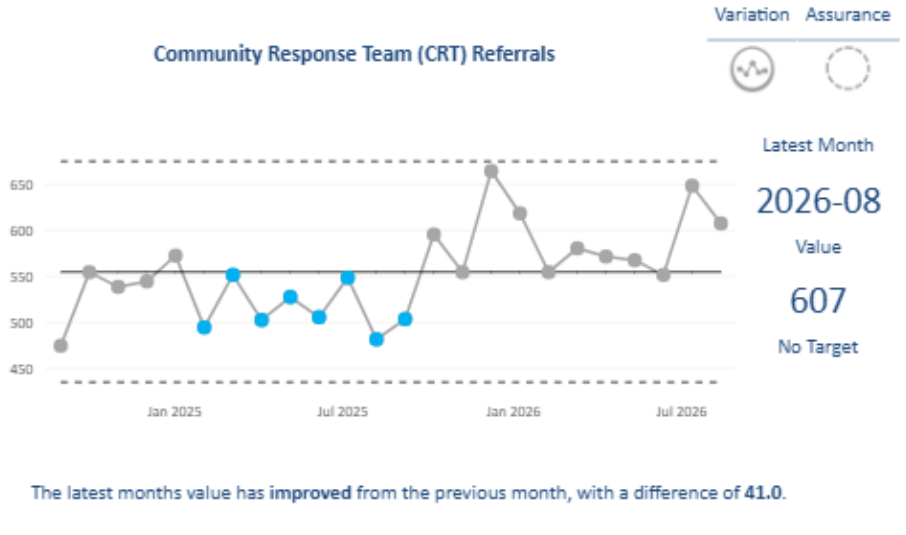
- The Frailty Virtual Ward / Hospital at Home model remains keen to expand to Selby following a successful test. To meet GIRFT requirements and further expansion, investment is required. The care group are creating a case for change for a new community model this will see a shift in resource to home based teams which includes hospital at Home expansion.
- The Heart Failure Virtual Ward continues to successfully run its admission avoidance pathway at York, and the service model has recently expanded to include early support discharge. Charitable funds have been agreed to fund a further 6 months whilst a business case is completed. This will also incorporate senior medical cover in line with GIRF requirements.

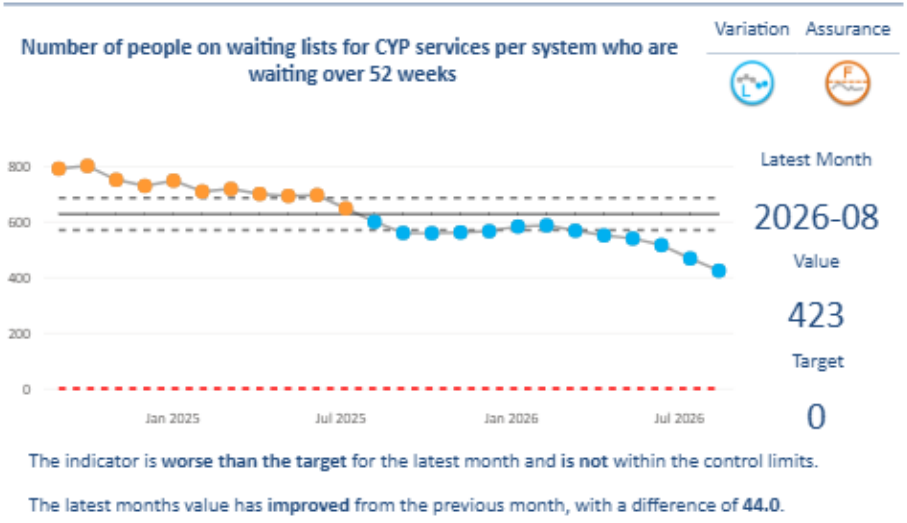
Potential risks to improvement?

- Challenges regarding the medical cover can sometimes cause instability in the service. This is the driver for the reduced occupancy in June as there is no provision for clinician cover for periods of leave.
- The care group are creating a case for change for a new community model this will see a shift in resource to home based teams which includes H@H expansion.
- The system partners are supportive of this approach as part of the Selby neighbourhood model and SHAR.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton





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

The Trust achieved the 2-hour Urgent Community Response target with performance of 78.6% against the 70% target. **This is a True North Metric.**

What actions are planned?

SPC1: Referrals for UCR and home-based intermediate care at home remain high and performance has improved. Team have built in daily validation of the clocks to ensure belter quality of data. Selby UCR medical gap is currently going through recruitment. We are creating a case for change for a new community model this will see a shift in resource to home based teams and address the geographical challenges.

SPC2: Speech and Language Therapy: the Trust is involved in regional and national work. Additional WTE mitigation included in 2026/27 plan. Service behind the trajectory for the end of July (423 against end of month ambition to be at or below 418). Commissioning discussions with the ICB have been instigated.

What is the expected impact?

Medical response will be covered by core team whilst recruitment and induction is completed in September . The case for change will see and expansion of the Intermediate care and UCR team resource.
SLT – the service is exploring all options to reduce the long waiting patients. The Request for Help phone line and resources available through the Trust's website have been well received by patients and their families.

Potential risks to improvement?

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

September 2026

Executive Owner: Karen Stone and Joe Hague

Highlights: IPC

- Klebsiella bacteraemia – **4 cases under** the year-to-date threshold.
- An IPC Team time out session was held with the Chief Nurse/DIPC on 25 August 2026

Concerns / Risks :

- C. difficile **4 cases over** the year-to-date threshold
- E.coli bacteraemia **4 cases over** the year-to-date threshold
- MSSA bacteraemia **5 cases over** year-to-date threshold. 1 MRSA bacteraemia reported in August against a zero-tolerance threshold
- Pseudomonas bacteraemia -**8 cases over** the year-to-date threshold
- CPE incident on ward 11

Next Steps:

- The IPC improvement plan is being refreshed following the meeting with the Chief Nurse and will be monitored through IPSAG.
- A C.difficile improvement plan has been developed with ward 36 as they have 7 attributed cases, the highest in the organisation. On-going support and review meetings in place.
- IPC months of quality are September and October. A series of walk rounds, awareness sessions, and fun activities for raising IPC awareness and compliance are planned.

Highlights: Pressure ulcers

In August, 69 Category 2 pressure ulcers reported, against a monthly target of 60. Pressure ulcer rate (all categories) = 3.3 per 1000 bed days, against a target of 4.

Concerns / Risks:

- Appropriate seating equipment to support patients is not consistently available in all ward areas.
- An increase in mattress failure due to cell twisting has continued to be an issue, a cell retrofit at Scarborough and Bridlington have been completed. York Site has had 450 retrofits completed, with 317 outstanding, with ongoing discussions occurring with the company regarding next steps. **Next meeting with all stakeholders is 17th September**

Next Steps:

- The Tissue Viability Nurse (TVN) team has continued virtual sessions to support accurate identification and categorisation of pressure ulcers. **Extra sessions provided for Matrons who are taking on Cat 2 validation from 1st September.**
- 91 patient chairs, funded via charitable funds, have been delivered (30 Scarborough and 61 York) and are in progress of being distributed to Elderly care areas at York and Scarborough sites. **50 of these have been installed, 41 remain to be installed by end of September. Equipment library have funded a further 25 very high-risk cushions to be distributed across other inpatient areas (aim to achieve this by end of October)**
- The TVN team have commenced a thematic review for Category 3 & 4 pressure ulcers reported during Jan 2026, to identify recurring trends and themes which will inform targeted improvement actions. **Completion date set for end of October**
- Datix dashboard established for Matrons to identify the Category 2 incidents requiring validation & mandatory validation field to complete before final approval.

Quality & Safety
Scorecard (1)

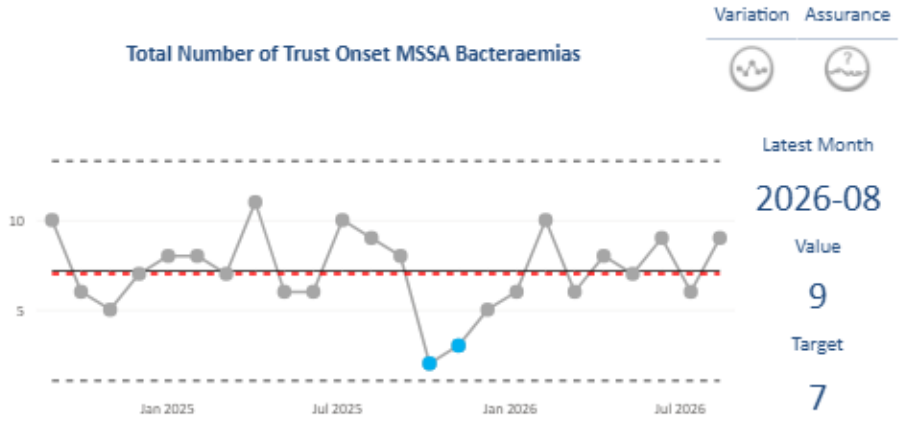
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2026-08			9	7	7
Total Number of Trust Onset MRSA Bacteraemias	2026-08			1		0
Total Number of Trust Onset C. difficile Infections	2026-08			11	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-08			10	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-08			2	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-08			3	2	2
Pressure Ulcers per thousand Bed Days	2026-08			3.3		4
Patient Falls per thousand Bed Days	2026-08			8.3		8.7
Medication incidents per thousand bed days	2026-08			4.8		6

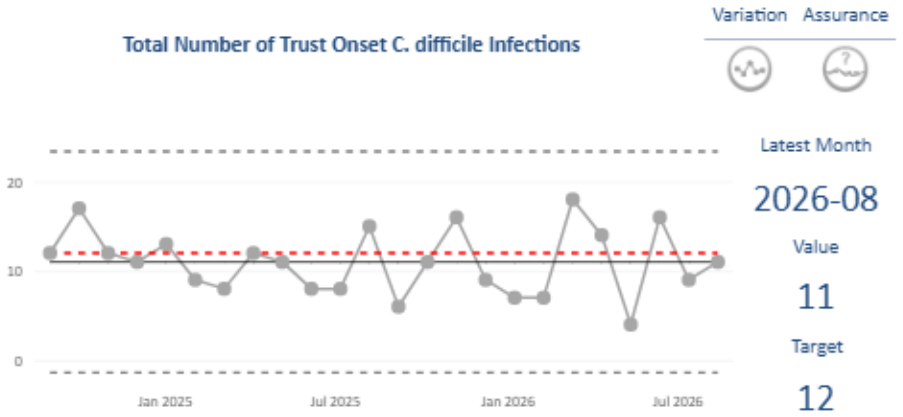
Executive Owner: Joe Hague

Operational Lead: Sue Peckitt



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

The latest months value has **deteriorated** from the previous month, with a difference of **3.0**.



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

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

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

Target: National thresholds for 2026/27 released in July. Threshold reduced by 28 cases for CDI, reduced by 2 cases for E.coli bacteraemia and remained the same for Pseudomonas and klebsiella bacteraemia. **MSSA is a True North Metric, with an internal 5% reduction target.**

Key Risks:

- C.difficile **4 cases over** the year-to-date threshold
- MSSA bacteraemia **5 cases over** year-to-date threshold.
- MRSA bacteraemia 1 case reported in August against a zero tolerence
- E.coli bacteraemia - **4 cases over** the year-to-date threshold
- Pseudomonas bacteraemia – **8 cases over** the year-to-date threshold.
- 2 cases of highly resistant CPE were identified on ward 11, the ward was closed whilst all patients screened, HPV decontamination and changing of sink traps and taps undertaken. No further cases identified and ward reopened.

Key assurances/brilliances

- Klebsiella bacteraemia **4 cases under** the year-to-date threshold
- There is a Hospital Acquired Infection review process in place led by the Corporate IPC lead nurses and the Care Group senior team to identify key learning opportunities and key actions.
- The Deputy Director of Infection Prevention & Control (DIPC) reports against the agreed strategic IPC improvement plan to the Infection Prevention Strategic Advisory Group and to Quality Committee.
- The IPC improvement plan is being refreshed following the meeting with the Chief Nurse on 25th August.
- Improvement plan and support programme is in place with ward 36 due to rates of CDI

Next Key Improvements:

- The priority improvement objective around the management of both urinary and venous catheters is continuing. This is based around the findings of a local audit undertaken in Q3 with an agreed Care Group improvement objective of achieving 90% of all care delivery outcomes for invasive devices.
- Active work moving towards water lite (water safe care) is progressing.
- MRSA decolonisation protocol for timely administration is in development with involvement from Pharmacy and Consultant Microbiologist
- September and October are the months of quality for IPC, a series of walk rounds, awareness sessions, and fun activities for raising IPC awareness and compliance are planned.

Quality & Safety
Scorecard (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patient Safety Incidents per thousand Bed Days	2026-08			50.7		57
Harmful Incidents per thousand bed days	2026-08			16.8		18
Total Number of Never Events Reported	2026-08			0		0
In-Hospital Deaths	2026-08			150		
Quarterly SHMI	2026-03			88.4		100
Monthly SHMI	2025-08			77.3		100
Quarterly HSMR	2025-09			105.7		100
Monthly HSMR	2025-09			108.9		100
Trust Complaints	2026-08	H		146		
Antepartum Stillbirths	2026-07			1		
Intrapartum Stillbirths	2026-07			0		
Early neonatal deaths (0-7 days)	2026-07			1		
PPH > 1.5L as % of all women - York	2026-07			2.7%		
PPH > 1.5L as % of all women - Scarborough	2026-07			7.6%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-07			39.3%		

Executive Owner: Adele Coulthard/ Joe Hague /Karen Stone

Operational Lead: /Alice Hunter



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

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

The rate of harmful incidents per 1,000 bed days has remained stable within expected control limits over the reporting period.

Venous thromboembolism thematic (VTE) reviews

Two VTE thematic reviews, led by Pharmacy and Care Group Surgery, identified recurring system weaknesses in VTE assessment, prescribing, administration and peri-operative care. The Pharmacy review highlighted Trust-wide anticoagulation risks, including omitted prophylaxis, prescribing errors, missed doses, discharge issues and limitations within electronic prescribing safeguards. The Surgical review identified unclear ownership of post-operative VTE prescribing, resulting in delays and omissions of prophylaxis. Both reviews concluded that risks arise from process reliability and governance gaps rather than individual performance. A combined action plan is being developed, including strengthened theatre pathways, clearer prescribing accountability, enhanced audit and governance oversight, improved electronic system controls and routine monitoring through Care Group Boards and the VTE Group. The learning from these reviews will also be shared within the care groups governance meetings.

Great-ix

There were 54 Great-ix submissions in August. Some highlights taken from the month's submissions are below. August Great-ix Highlights:

"On her last day in our rotation, she has worked even harder to teach the new FY1 doctors everything she was able to handover. She showed passion and she acknowledged how they would feel – possibly overwhelmed on their first day – and she was very supportive to them."

"The patient recalled this entire event and was very appreciative of X for the level of advocacy he demonstrated that day and reported "X saved my life"."

"The relatives recognised how busy the staff were and yet still they took the time to provide compassion and empathy to them, ensuring their needs were met alongside the patient's needs. The family wished for me to pass on their thanks – they felt you made a difficult process much easier to deal with."

Executive Owner: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy



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

The latest months value has **improved** from the previous month, with a difference of **23.0**.

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

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

Complaints

Factors impacting performance:

The SPC chart continues to show common cause variation in relation to the number of complaints received. There has been a decrease in complaints in the month of August 2026 with 146 new complaints across the Trust (in contrast to 169 in July 2026).

71% of complaints were closed in 30 days (compared to 74% in July 2026) and 61% of complex complaints were closed in 45 days (compared to 57% in July 2026). Performance continues to remain below the expected compliance rate of 90%.

Emergency Medicine has the highest number of complaints (57) reflecting the operational pressures and exceptionally high demand the service has been under in both York and Scarborough hospitals.

Key risks and emerging risks

- The new Concern and Complaints Officer will not join the PALS team until September puts pressure on the team due to the vacancy.
- Continued operational pressures in emergency medicine departments which results in an increase in complaints.

Key assurances

- The Trust wide plan for coming off corridors that will be implemented in September is anticipated to assist the pressures in ED and improve patient flow which should in turn help reduce numbers of complaints to the department.
- Care Groups will be working towards achieving the 90% target for complaints/complex complaints responses by the end of August 2026.
- Over the forthcoming financial year there will be an expansion of the "What Matters to You" training and the launch of an internally delivered customer-support skills programme to equip staff with the confidence and capability to communicate effectively and help improve patient and carer communication

Next key improvement actions

The following priorities have been identified to improve complaints performance alongside continuing to provide timely resolution of complaints within policy timescales:

- Continue the embedding of bed side handovers to improve communications.
- An Investigating Officer development sessions have been planned for Q3 to reinforce roles, responsibilities and expectations in relation to complaint investigations, quality of responses and response timescales. This has been delayed from June due to other Trust activities in relation to eliminating corridor care.
- Following the delivery of complaint letter writing training in 2025/26, the focus for 2026/27 is on completion of Ombudsman complaints handling training by all Investigating Officers to support improvements in both quality and timeliness by the end of Q2.

Quality & Safety
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone

Operational Lead: Lydia Harris

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Percentage of studies opened to patient recruitment within in our hospitals within 60 days of regulatory approval	2026-08			100%		100%
Percentage of studies recruiting their first participant in our hospitals within 30 days of opening to recruitment	2026-08			100%		100%
Percentage of commercial studies that are on target to recruit the set number of patients within our hospitals the study requires	2026-08			62.5%		100%
Percentage of non commercial studies that are on target to recruit the set number of patients within our hospitals the study requires	2026-08			69.6%		100%
Total number of participants recruited into research studies this year within our hospitals	2026-08			1024		3500

Executive Owner: Karen Stone

Operational Lead: Lydia Harris

Rationale: To monitor the National Research Delivery Network targets
Target: To meet the National Research Delivery Network targets

Percentage of studies opened to patient recruitment within in our hospitals within 60 days of regulatory approval

Variation Assurance



The indicator is **equal to the target** for the latest month and **is not** within the control limits.

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

Percentage of studies recruiting their first participant in our hospitals within 30 days of opening to recruitment

Variation Assurance



The indicator is **equal to the target** for the latest month and **is not** within the control limits.

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

Study Set-Up Performance (60 days and 30 days)

At 100% The Trust continues to deliver strong study set-up performance and is currently top in the region for the 60-day metric, with average study set-up time under one month (28 days).

In August, a commercial drug trial was opened and recruited its first participant within 30 days, reflecting effective collaboration between R&I, clinical teams and support services.

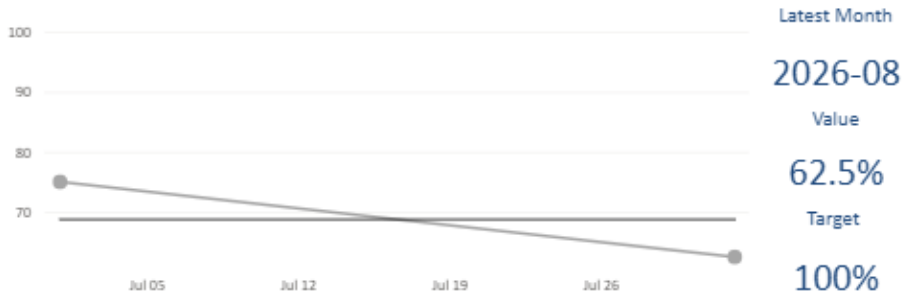
Additional information
Recruitment to NIHR Portfolio Studies
The Trust currently supports 79 active research studies and has recruited 1,024 participants during 2026/27. This includes 7 commercial and 72 non-commercial studies. Interventional research activity, including higher-income commercial research, continues to grow which is encouraging as these are important metrics for our RDN income.

Executive Owner: Karen Stone

Operational Lead: Lydia Harris

Variation Assurance

Percentage of commercial studies that are on target to recruit the set number of patients within our hospitals the study requires



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

The latest months value has **deteriorated** from the previous month, with a difference of **12.5**.

Variation Assurance

Percentage of non commercial studies that are on target to recruit the set number of patients within our hospitals the study requires



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

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

Rationale: To monitor the National Research Delivery Network targets
Target: To meet the National Research Delivery Network targets

Commercial Research target

With only a small number of commercial studies open at any one time (approx. 7 -10 studies) we expect fluctuation over time . Comparing this metric month on month isn't the best way to view this metric as performance can be disproportionately affected by recruitment challenges within a single study. Research teams continue to monitor closely where studies are at risk of not achieving agreed recruitment targets.

Non Commercial Research target

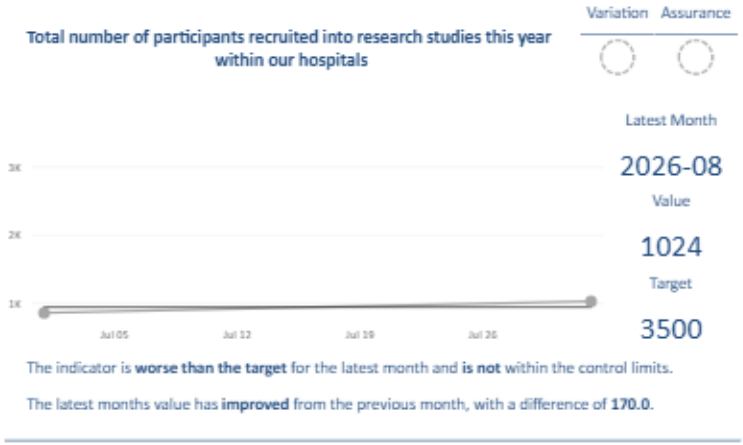
Non-commercial performance has improved slightly since the previous reporting period. Recruitment performance is monitored through monthly Portfolio Review Meetings where performance RAG ratings are reviewed, studies at risk of under recruitment are discussed, and actions are agreed to support delivery against recruitment targets.

Additional information
Commercial Research Income

Commercial research generated £157.7k income during Quarter 1 2026/27. Income performance is monitored monthly, with outstanding payments actively managed and escalated where required. Capacity-building income is being reinvested to expand commercial research delivery capacity and support continued portfolio growth within our care groups. The commercial pipeline remains strong, with new studies in set-up including a maternal vaccine study and an early-phase ophthalmology trial.

Executive Owner: Karen Stone

Operational Lead: Lydia Harris



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Rationale: To monitor the National Research Delivery Network targets
Target: To meet the National Research Delivery Network targets

Accruals
Although this is no longer a metric we continue to make good progress – our highest recruiting study if Born and bread In (BaBi) run by our maternity teams

Additional information
NIHR Grants and Awards
We have submitted 2 grants this month:

- Dr Phil Dickinson has submitted to National Institute for Health Research for a Programme Grant for Applied Research with University of York that will investigate Integrated Neighbourhood Frailty Services in Rural Areas £3,081,725.75
- Lydia Harris, Cate Laven, Dr Fran Butler and Trevor Mahon have submitted a proposal to support the Leeds Biomedical Research Centre (BRC) re bid £624,743.90

Professor James Turvill has been successfully awarded Humber and North Yorkshire Cancer Alliance Cancer Research and Innovation Funding Award 2026/27 £50,010.85

York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

September 2026

Executive Owner: Karen Stone and Sascha Wells-Munro

Please note that Maternity Services provide a dedicated report to Trust Board against a range of quality and safety metrics. The metrics in this TPR are currently under review.

Highlights:
Special Care Baby Unit.

Concerns / Risks :
Special Care Baby Unit had a period of reaching full capacity in December 2025. This has now resolved and is managed through the business continuity plan in place to support that pathway of care.

Next Steps:.
Maternity and Neonatal services are working with the local Operational Delivery Network (ODN) to review the current service delivery pathway for SCBU in Scarborough.

Highlights:
Home birth service suspensions in Scarborough and the East Coast

Concerns/ Risks:
Due to significant shortfalls in the budgeted establishment because of maternity leave and LTS as well as no headroom applied to the service the ability to safely staff on-calls consistently for homebirth overnight has been increasingly harder to achieve. This has also been impacted by the HM Coroners Prevention of future deaths letter to NHS England and other key stakeholders around the commissioning and safety of homebirth service particularly related to midwives working hours. The service has undertaken a review and has temporarily implemented and on-call system that ensures midwives have reasonable compensatory rest to support safer care to women. Due to the afore mentioned staff shortages this safe practice has further impacted on the ability to provide the service overnight which has seen more suspensions due to maintaining safety for all women and staff.

Next Steps:
A full consultation for community Midwifery service across York and Scarbrough is planned following an increase in budgeted estabalishement in line with BR+ on the first of April and after publication of new guidance for homebirth service form NHS England and the Royal colleges of Midwives and Obstetrics and Gynaecology

Highlights:
Increase in Caesarean births at York

Concerns/Risks:
There has been a significant increase in the demand for maternity theatre time at York due to an increase in Caesarean births, particularly category 3 births. This is due to clinical guidance that means more women are being induced earlier in pregnancy for multiple reasons that then results in failed induction leading to the need for a caesarean birth

Next Steps:
A further review of demand V capacity is underway for planned caesarean births as well as the demand for acute activity that includes other clinical procedures as well as unplanned caesarean births.

Summary MATRIX
Maternity Scarborough

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* L/W Co-ordinator supernumerary % - Scarborough	
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough	* No. of women delivered - Scarborough * Births - Scarborough * Induction of labour - Scarborough * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * BBA - Scarborough * Neonatal Death - Scarborough * Breastfeeding Initiation rate - Scarborough	* Homebirth service suspended - Scarborough
SPECIAL CAUSE CONCERN		* Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2026-07		P	128		169	Target
No. of women delivered - Scarborough	2026-07		?	105		112	Target
Births - Scarborough	2026-07		?	105		113	Target
Induction of labour - Scarborough	2026-07		?	42.9%		43.1%	Baseline
Elective caesarean - Scarborough	2026-07		?	19.1%		16.8%	Baseline
Emergency caesarean - Scarborough	2026-07		?	34.3%		29%	Baseline
BBA - Scarborough	2026-07		?	0		2	Target
Total number of Stillbirths - Scarborough	2026-07			0			No Target
Neonatal Death - Scarborough	2026-07		?	0		0	Target
Number of maternity diverts/unit closures - Scarborough	2026-07			1			No Target
Homebirth service suspended - Scarborough	2026-07		F	21		3	Target
SCBU at capacity - Scarborough	2026-02			0		0	Baseline
% of 3rd and 4th degree tears - Scarborough	2026-07			0%			No Target
L/W Co-ordinator supernumerary % - Scarborough	2026-07	H	?	100%		100%	Target
Breastfeeding Initiation rate - Scarborough	2026-07		?	81.9%		75%	Target

Maternity Scarborough
Scorecard (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	2026-07	H	?	1		0	Target
% of women seen within 15 minutes in triage - Scarborough	2026-07			96.8%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - Scarborough	2026-07			1			No Target
Number of babies transferred out for cooling - Scarborough	2026-07			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - Scarborough	2026-07			7			No Target
Number of babies born with an Apgar of 7 at 5 mins - Scarborough	2026-07			11			No Target
Number of maternal deaths - Scarborough	2026-07			0			No Target
Number of midwifery red flags - Scarborough	2026-07			2			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - Scarborough	2026-07			1			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - Scarborough	2026-07			0			No Target
Number of planned caesarean sections > 24 hours - Scarborough	2026-07			1			No Target

Summary MATRIX
Maternity York

MATRIX KEY
- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* SCBU at capacity - York * L/W Co-ordinator supernumerary % - York	* Bookings - York * No. of women delivered - York * Births - York * Induction of labour - York * Elective caesarean - York * Emergency caesarean - York * BBA - York * Neonatal Death - York * Breastfeeding Initiation rate - York * Number of Maternity and Newborn Safety Investigations (MNSI) referrals - York	
SPECIAL CAUSE CONCERN			* Homebirth service suspended - York

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - York	2026-07			271		295	Target
No. of women delivered - York	2026-07			214		242	Target
Births - York	2026-07			217		245	Target
Induction of labour - York	2026-07			43.5%		41.2%	Baseline
Elective caesarean - York	2026-07			16.6%		16.7%	Baseline
Emergency caesarean - York	2026-07			22.6%		24.1%	Baseline
BBA - York	2026-07			4		2	Target
Total number of Stillbirths - York	2026-07			1			No Target
Neonatal Death - York	2026-07			1		0	Target
Number of maternity diverts/unit closures - York	2026-07			0			No Target
Homebirth service suspended - York	2026-07	H	F	31		3	Target
SCBU at capacity - York	2026-02		P	0		0	Baseline
% of 3rd and 4th degree tears - York	2026-07			1.4%			No Target
L/W Co-ordinator supernumerary % - York	2026-07		P	100%		100%	Target
Breastfeeding Initiation rate - York	2026-07			88.4%		75%	Target

Maternity York
Scorecard (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - York	2026-07			1		0	Target
% of women seen within 15 minutes in triage - York	2026-07			94.3%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - York	2026-07			1			No Target
Number of babies transferred out for cooling - York	2026-07			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - York	2026-07			10			No Target
Number of babies born with an Apgar of 7 at 5 mins - York	2026-07			3			No Target
Number of maternal deaths - York	2026-07			0			No Target
Number of midwifery red flags - York	2026-07			0			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - York	2026-07			1			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - York	2026-07			0			No Target
Number of planned caesarean sections > 24 hours - York	2026-07			1			No Target

York and Scarborough Teaching Hospitals NHS Foundation Trust

WORKFORCE

September 2026

Executive Owner: Lydia Larcum

1. Highlights

- The workforce remained broadly stable in July, with a net reduction of -3 WTE since June and -56 fewer WTE than the same period last year.
- Recruitment activity continued in priority clinical areas, including the appointment of new consultants, onboarding of resident doctors, and a pipeline of pre-registered nurses and healthcare support workers.
- Temporary staffing controls continue to strengthen, with reductions in administrative bank activity, lower levels of medical bank rate escalations, and successful transition from some long-term agency usage to substantive employment.

2. Concerns

- Sickness absence increased for the third consecutive month, reaching 5.5% over the previous 12 months and remaining above the planned trajectory.
- Stress and anxiety remained the most common reason for sickness absence, accounting for more than a quarter of all absences.
- Workforce WTE remained above plan, reflecting lower-than-expected turnover and assumptions linked to the continued operation of Bridlington Care Unit, creating additional challenge in achieving the March 2027 workforce target.

3. Future

- The Supporting Staff Health and Wellbeing Attendance Policy review and Autumn ‘flu vaccination campaign will support continued efforts to reduce sickness absence and maintain workforce resilience over winter.
- Strengthened vacancy controls and medical approval panels are being implemented to support workforce affordability and reduce reliance on bank and agency utilisation.
- Analysis of feedback from the Big Conversation is underway, with a refreshed values and behaviours framework planned, alongside the launch of the 2026 NHS Staff Survey in October.

Summary MATRIX

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

MATRIX KEY

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

VARIATION

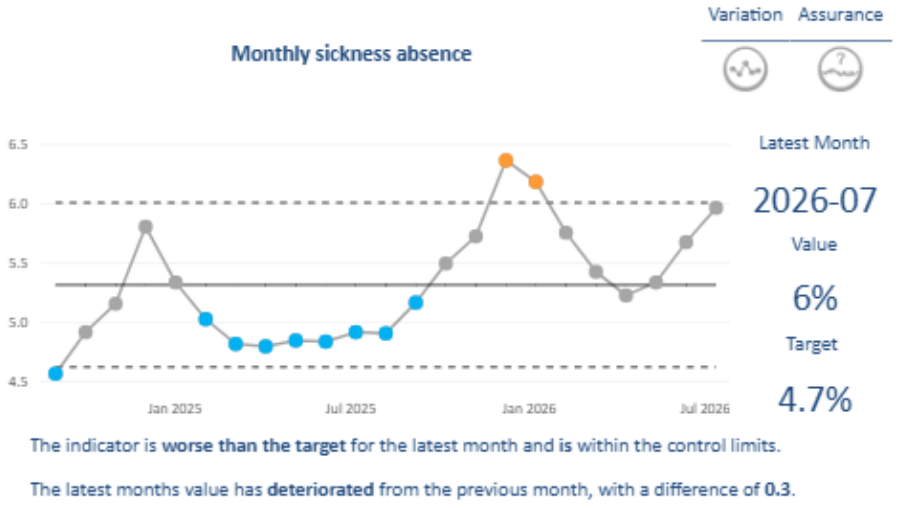
	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* 12 month rolling turnover rate Trust (FTE) * Overall corporate induction compliance * A4C staff corporate induction compliance	* Registered Nursing vacancy rate * Medical & dental staff corporate induction compliance	* Total Agency Whole Time Equivalent Filled * Overall stat/mand training compliance
COMMON CAUSE / NATURAL VARIATION		* Monthly sickness absence * Overall vacancy rate * Medical and dental vacancy rate * AHP vacancy rate * Total Bank Whole Time Equivalent Filled * A4C staff stat/mand training compliance * Appraisal Activity	* Medical & dental staff stat/mand training compliance
SPECIAL CAUSE CONCERN		* HCSW vacancy rate * Midwifery vacancy rate	* Annual absence rate

Executive Owner: Lydia Larcum **Operational Lead:** Amy Messenger/Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-07			6%	4.7%	4.7%
Annual absence rate	2026-07			5.5%	5.2%	4.9%
Total Agency Whole Time Equivalent Filled	2026-07			54.2	52	52
Total Bank Whole Time Equivalent Filled	2026-07			531.9	565	536
12 month rolling turnover rate Trust (FTE)	2026-08			6.9%		8.5%
Overall vacancy rate	2026-08			8.3%		7.7%
HCSW vacancy rate	2026-08			13.9%		8%
Midwifery vacancy rate	2026-08			6.2%		0%
Medical and dental vacancy rate	2026-08			5%		6%
Registered Nursing vacancy rate	2026-08			3.9%		5%
AHP vacancy rate	2026-08			6.6%		7%

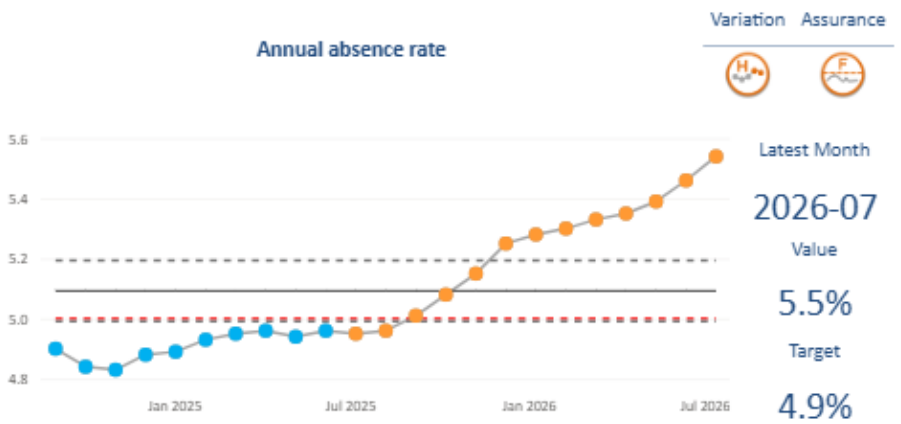
Executive Owner: Lydia Larcum

Operational Lead: Nic English



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

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



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

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

Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.9% annual absence rate (March 2027)

Factors impacting performance and actions:

The July sickness absence rate represented the third successive month in which absences increased, following a sustained reduction from the winter peak in December 2025.

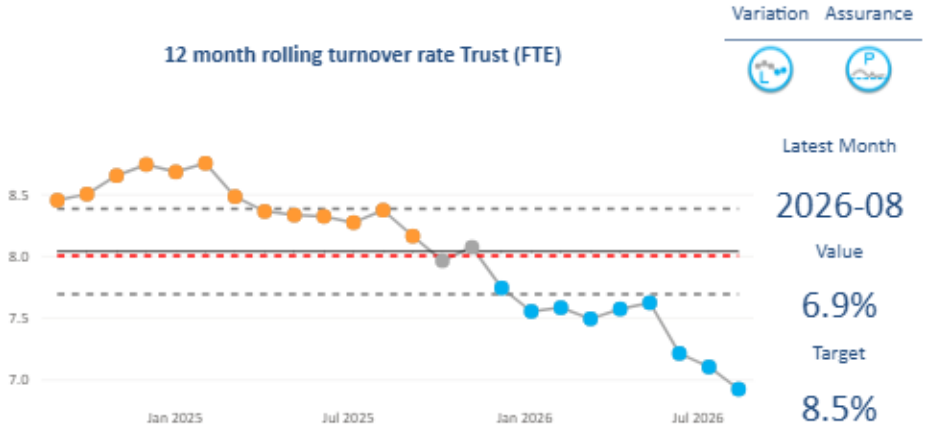
Absences were 30 WTE greater than in June, going from 529 to 559 WTE. Stress and anxiety remains the top reason for sickness absence and the proportion of these absences increased slightly from 26% to 27% in July. The share of absences resulting from musculoskeletal and gastrointestinal issues reduced by 1% each in July, dropping to 11% and 9% respectively.

The July rate contributed to an annual absence rate of 5.5% across the Group. This is 0.3% higher than the trajectory in the workforce plan. The Group has planned for a 4.9% absence rate in the 12-months up to and including March 2027.

Work is continuing to review the Trust's Supporting Staff Health and Wellbeing Attendance Policy, while plans for the 2026-27 'flu vaccination campaign are being finalised. Vaccination will be available to colleagues from 1 October via drop-in clinics. As in previous years, the clinics will be complimented by a team of trained peer vaccinators who will provide vaccinations in colleagues' place of work. The campaign aims to maximise vaccination uptake amongst eligible colleagues, supporting workforce resilience and helping to reduce the risk of winter illness-related absence.

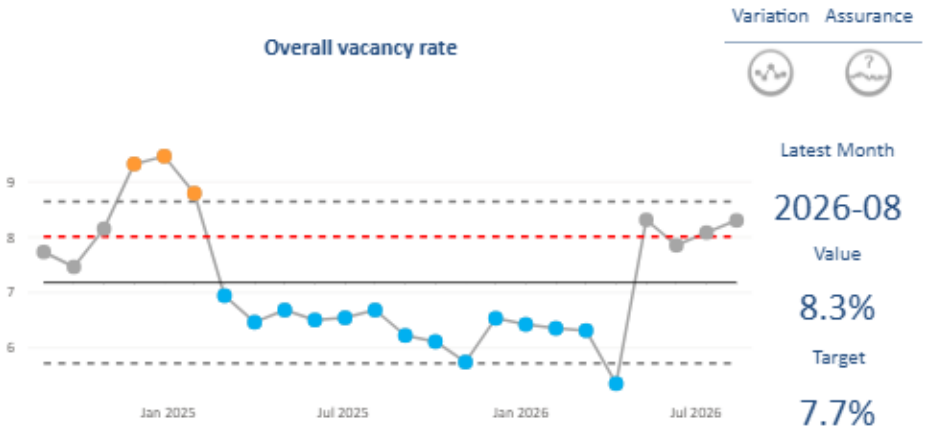
Executive Owner: Lydia Larcum

Operational Lead: Will Thornton



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

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



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

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

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 8.5% Vacancy Rate 7.7%

Factors impacting performance and actions:

In July 2026, the Group's total workforce WTE was 9,981, which was +31 above plan. This variance relates in part to assumptions that were made about the decommissioning of Bridlington Care Unit (which remains operational at the present time), while turnover of colleagues has also been lower than planned.

The Group's WTE ceiling target for March 2027 is 9,886 WTE. This represents a -1.7% reduction from total WTE in March 2026.

The breakdown of the workforce at the end of July was as follows:

Type	Jul-26 WTE plan	Jul-26 WTE actual	WTE Variance with plan	Jul-25 WTE actual for comparison
Substantive	9334	9395	+61	9312
Bank	565	532	-33	630
Agency	52	54	+2	95

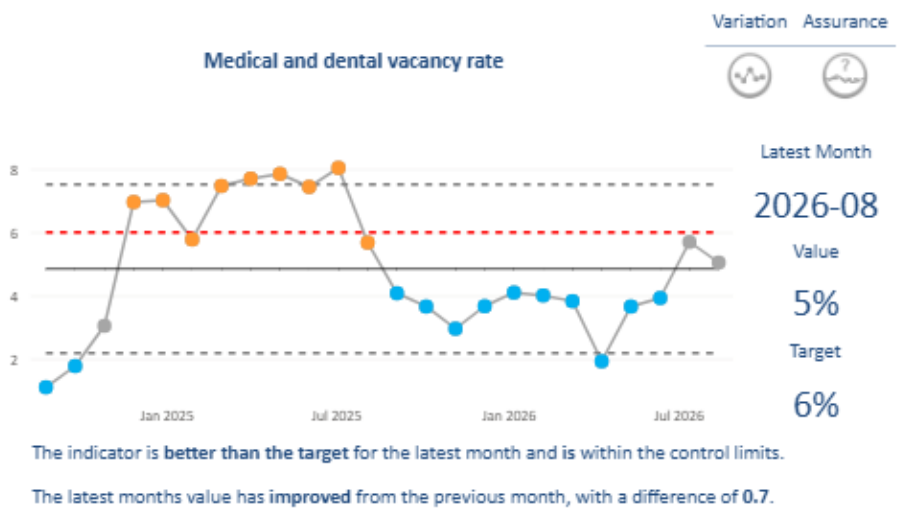
The net change in workforce size between June and July 2026 was -3 WTE.

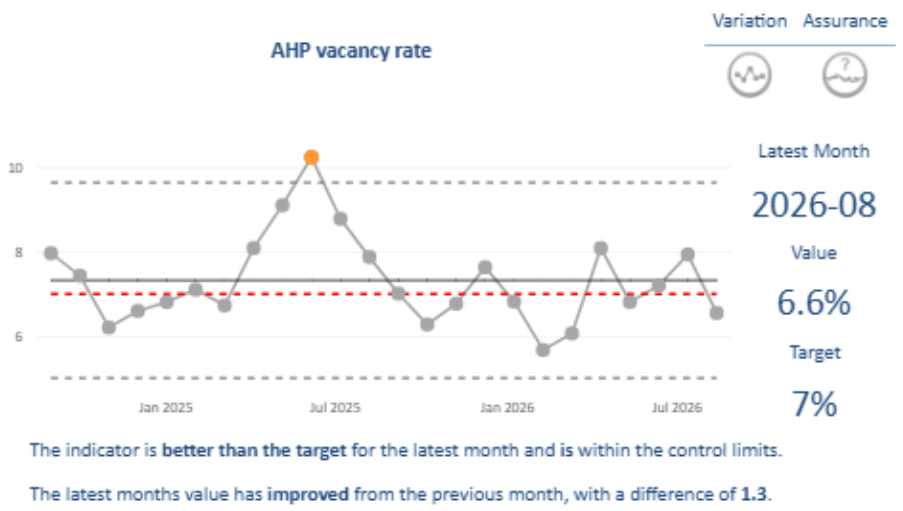
WTE in July was -56 less than in the same month in 2025.

The Trust has strengthened its vacancy control process which will reduce levels of recruitment activity, though roles which are critical to clinical safety will continue to progress.

Executive Owner: Lydia Larcum

Operational Lead: Amy Messenger





Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 7%

Factors impacting performance and actions:

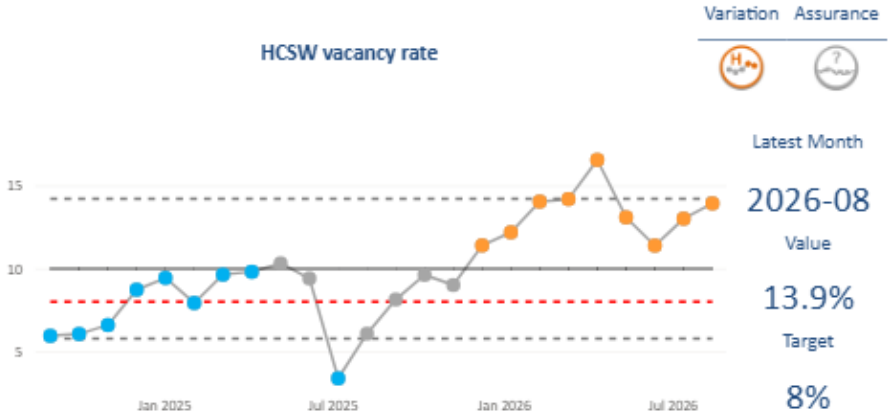
In addition to August changeover where the organisation onboarded 186 Resident Doctors, the Trust also welcomed 33 new medical colleagues, including six permanent Consultants within Respiratory, Rheumatology and Ophthalmology. In addition, 11 offers of employment for medical posts were made, including four permanent Consultant posts in Diabetes & Endocrinology, Emergency Medicine and Paediatrics.

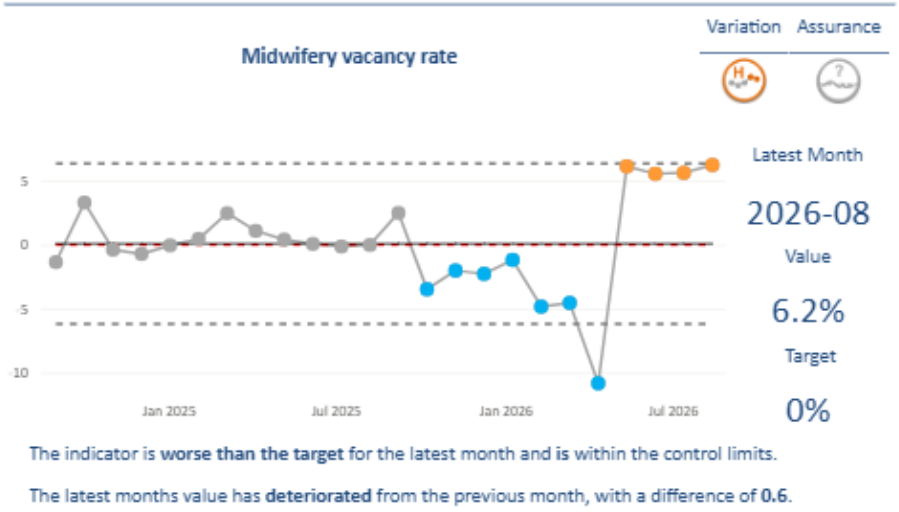
A further changeover in September saw 39 Resident Doctors join the organisation.

Ahead of the Autumn, 49 pre-registered nurses (46 WTE) are currently undergoing pre-employment checks with the Trust.

Executive Owner: Lydia Larcum

Operational Lead: Amy Messenger





Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 8%, Midwifery vacancy rate 0%

Factors impacting performance and actions:

In August, there was a small regression in the HCSW vacancy position with several colleagues leaving roles in inpatient settings.

The Trust is relaunching information sessions for HCSWs to support recruitment to this role. This approach supports better quality applications and retention, as candidates must attend a session to learn about the role before they can apply for a position with the Trust. Sessions took place in Scarborough (14th August) and York (20th August) where 163 individuals were registered to attend. Participants have been applying for posts, with interviews scheduled to take place in September.

The current pipeline includes 21 candidates (17 WTE) undertaking pre-employment checks, with a further two candidates (2 WTE) booked onto the October Academy.

The number of Nursing Associates within the Trust has increased slightly in August, from 49 to 53.

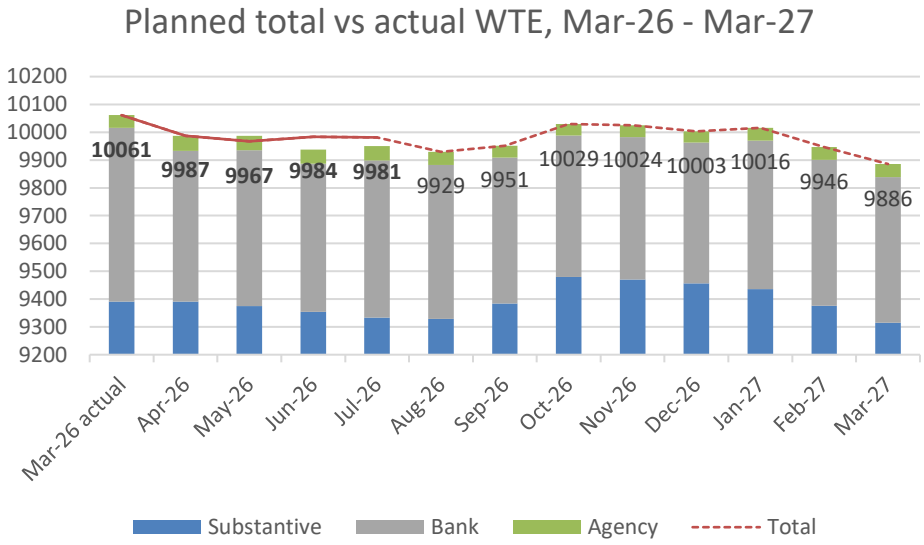
(When interpreting the vacancy charts, please note that in May the Health Care Support Worker establishment in the Trust decreased by 68 WTE following adjustments to the roster. At the same time, the Midwifery establishment increased by 33 WTE, linked to the programme of work to improve the quality and safety of Maternity services).

Workforce Table

Workforce (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Lydia Larcum **Operational Lead:** Amy Messenger



The table below shows planned and actual WTE totals for each staff group. These totals include substantive, bank and agency WTE.

Staff Group	Jul-26 WTE plan	Jul-26 WTE actual	Variance
Medical and Dental	1158	1146	12
Nursing and Midwifery	2692	2711	-20
Support Workers	2753	2765	-12
NHS Infrastructure	2002	2017	-15
Scientific Therapeutic & Technical	1334	1330	5
Misc (Ambulance roles, Non-Executives)	12	12	0
Total	**9950**	**9981**	**-31**

Factors impacting performance and actions:

Reducing bank and agency spend remains a key focus for the Group, with the organisation required to reduce agency spend by at least 30% and bank spend by 10% in the financial year 2026-27. A specific area of focus is medical bank and agency use, with the Trust implementing a Waste Reduction and Productivity (WRAP) scheme to oversee targeted reduction in this area. To support this, the Trust has put in place Medical Approval Panels (MAPs) to authorise all medical bank and agency shifts. The first panel convened on 10th September to review shifts from 1st October onwards. Additionally, the Trust continues to monitor the number of rate escalations for medical bank shifts after changes to the rate escalation process were implemented in August 2025. For context, in the final week prior to the change of process, 432 shifts had escalated rates. The number of rate escalations requested in August decreased to an average of 30 shifts a week, down from 42 a week on average in July. It is anticipated that holidays may have contributed to a dip in the number of requests, with bank workers on pre-agreed escalated rates taking time off.

The Trust continues to negotiate with agency providers to reduce rates and convert agency workers on block bookings into bank or substantive positions. The Trust has recently ended its last remaining administrative agency booking as well as ending its longest serving medical agency worker following successful substantive recruitment.

Administrative bank activity in August decreased to 578 shifts worked, compared to the 744 shifts recorded in July. System permissions for managing bank shifts have recently been adjusted to support stronger controls in this area.

Workforce
Scorecard (2)

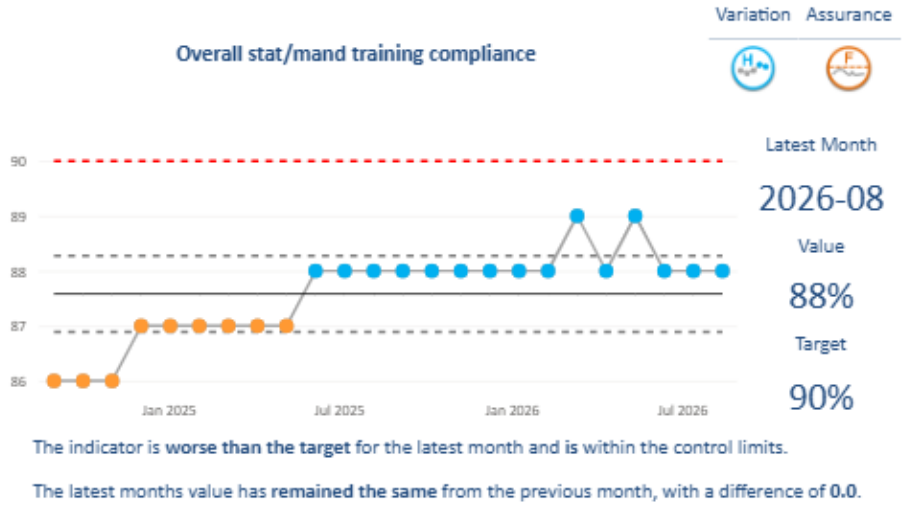
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Executive Owner: Lydia Larcum **Operational Lead:** Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2026-08	H	F	88%		90%
Overall corporate induction compliance	2026-08	H	P	97%		95%
A4C staff stat/mand training compliance	2026-08		?	89%		90%
A4C staff corporate induction compliance	2026-08	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2026-08		F	75%		90%
Medical & dental staff corporate induction compliance	2026-08	H	?	96%		95%
Appraisal Activity	2026-08		?	19.4%		95%
I would recommend my organisation as a place to work	2026-03			48.7%		50%
If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation	2026-03			46.7%		49%
If I spoke up about something that concerned me I am confident my organisation would address my concern	2026-03			37.3%		40%
I am able to make improvements happen in my area of work	2026-03			51.4%		53%

Executive Owner: Lydia Larcum

Operational Lead: Will Thornton





Rationale: Trained workforce delivering consistently safe care
Target: Mandatory Training 90% and Corporate Induction 95%

Factors impacting performance and actions:

Last year, the Group adopted a new target for statutory and mandatory training compliance. The 90% target strives for a 3% increase in the level of completions compared with our previous aim for 87% compliance. In August, mandatory training compliance maintained at 88%.

The Group's Big Conversation, designed to review and refresh our organisational values and standards of behaviour, closed at the end of August. Over a three-week period, 14% of colleagues logged-onto the Safe Spaces platform used to host the conversation and contributed more than 12,500 ideas, comments and votes. A deep analysis has begun to identify common themes and priorities, ahead of the development of an enhanced values and behaviours framework which will be rolled-out later in the year.

Building on the momentum created through the Big Conversation, the Group will launch its 2026 NHS Staff Survey on 1st October, providing another important opportunity for colleagues to share their experiences and views. The survey is a key component of the Group's commitment to developing a strong listening culture, helping us to understand what is working well, where improvements are needed, and whether actions taken in response to previous feedback are making a difference. Colleagues will be encouraged to participate throughout the survey period, which closes on 27 November, ensuring that the views of as many staff as possible help to shape future improvements in colleague experience, organisational culture and patient care.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

Executive Owner: James Hawkins

Highlights

EPR implementation:

- Nervecentre Tranche 2 went live successfully across York, Scarborough, Bridlington, Selby, Easingwold and Malton.
- The implementation went very smoothly with no major issues to report. As with all EPR implementations there were minor issues raised and addressed as users became familiar with the new business processes.
- The second Tranche included full order communications for Pathology and Radiology within areas that are already live with Nervecentre.
- The Trust and Nervecentre are working through the baselined plan for Tranche 3.

Wider Digital Portfolio delivery continues with key focus on:

- Multi-year programme of paper records scanning and storage consolidation continues, with the initial metrics resulting from Nervecentre EPR encouraging.
- Supporting AI products in both diagnostics and Ambient Voice Technology in outpatients, alongside widespread trial of Microsoft Copilot across the organisation with focus on efficiency and productivity opportunities.
- Supporting the launch of the new Sexual Health EPR system, due to go-live this month

Concerns / Risks

- Ability to manage Y&S Digital business as usual work, whilst delivering the new EPR.
- Data Security and Protection Toolkit 2026 audit is finalised and highlights known gaps that will require multi-year investment and remediation.

Executive Owner: James Hawkins

Future / Next Steps

EPR implementation:

- Finalise revised Tranche 3 plan with Nervecentre.
- Progress implementation plan for Patientcentre, alongside Tranche 3.
- Progress technical and commercial discussions with Nervecentre on their AVT solutions.
- Progress transition of OPCS codes in current EPR in advance of Tranche 3.

Wider Digital Portfolio:

- Overall cyber security posture: Finalise Data Security and Protection Toolkit 2026 improvement plan.
- Progress rollout of AVT in outpatients.
- Progress rollout of electronic ordering for image diagnostics in primary care.
- Invest in addressing the increasing amount of Subject Access Requests.

Summary MATRIX

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

MATRIX KEY

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

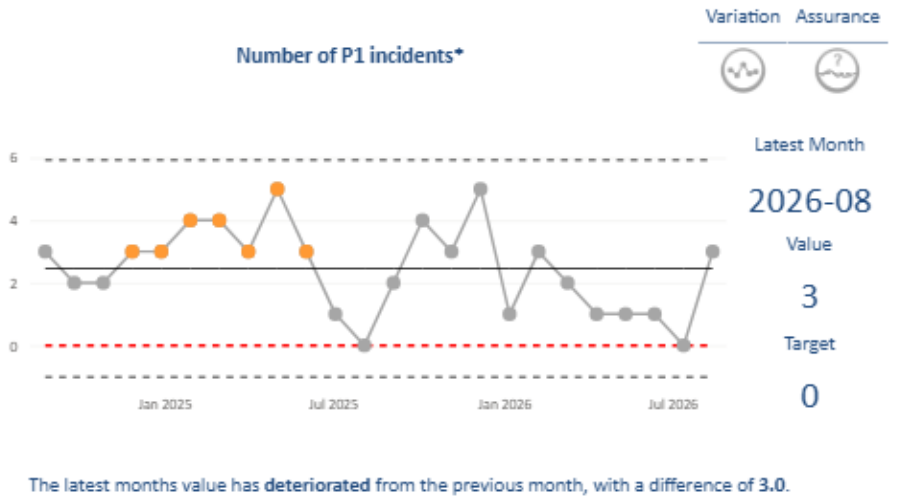
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* Percentage of FOIs and EIRs responded to within 20 working days (monthly)	* Number of P1 incidents* * Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	
SPECIAL CAUSE CONCERN			

Executive Owner: James Hawkins

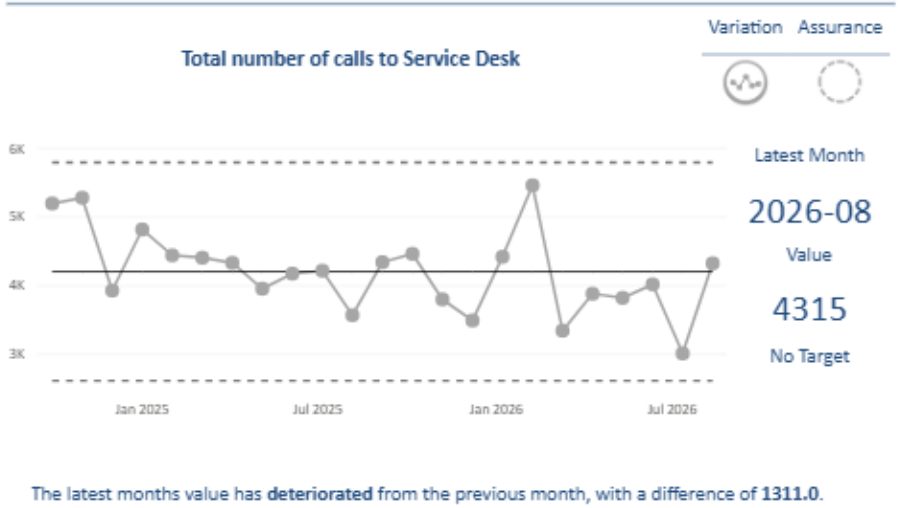
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-08		?	3		0
Total number of calls to Service Desk	2026-08			4315		
Total number of calls abandoned	2026-08			1491		
Number of information security incidents reported and investigated	2026-08			54		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-08			373		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-08			199		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-08		?	71%		80%
Number of FOIs and EIRs received (monthly)	2026-08			52		
Number of FOIs and EIRs completed (monthly)	2026-08			64		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-08		P	92%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



The latest months value has **deteriorated** from the previous month, with a difference of **3.0**.



The latest months value has **deteriorated** from the previous month, with a difference of **1311.0**.

Rationale: Reduction in P1 Incidents and Service Desk Calls are a proxy for better digital service

Target: 0 P1 Incidents

Factors impacting performance:

3x P1 incidents occurred in August.

13/8 Nervecentre performed a planned upgrade which took slightly longer than the agreed window resulting in a 30-minute period of unplanned unavailability between 0138 and 0208

27/8 Nervecentre performed a planned update which had unexpected impact on availability of printing services for sample label printing. The teams were able to continue to use CPD as their business continuity solutions and we are working with Nervecentre teams to ensure we have greater resilience within the print systems used for label printing.

27/8 Nervecentre intermittent performance / availability issues for a short period, which the root cause has been rectified.

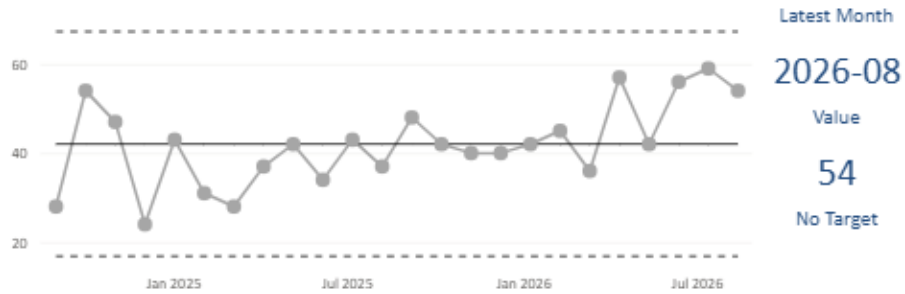
Note: Telephone statistics may not be directly comparable to previous periods, following changes to using new call queue system, and introduction of new “request a call back” option. However, calls remain below their peak due to the additional use of the self-service feature.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2026-08
Value
54
No Target

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

Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

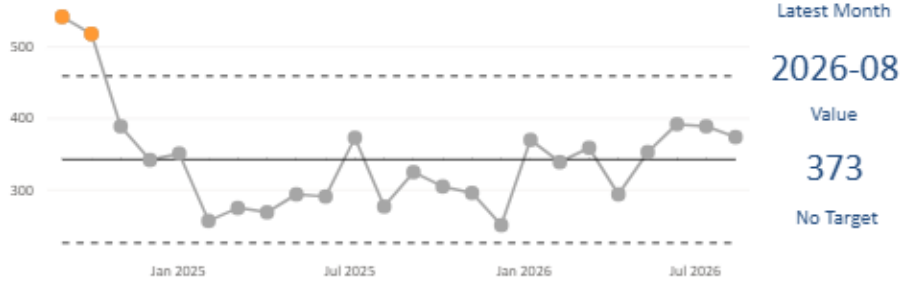
Factors impacting performance:

Information security incidents have decreased slightly since July; there has been an increase in misfiles, likely due to change in August. The team are seeing a lot of incidents misattributed to use the new system.

Actions: Trends will be communicated to staff and root cause analysis will be completed on all incident investigations.

Variation Assurance

Number of patient Subject Access Requests (SAR) received (monthly)



Latest Month
2026-08
Value
373
No Target

The latest months value has **improved** from the previous month, with a difference of **15.0**.

Rationale: Monitoring of Subject Access Requests received to ensure the Trust is managing its statutory obligations under the UK GDPR.

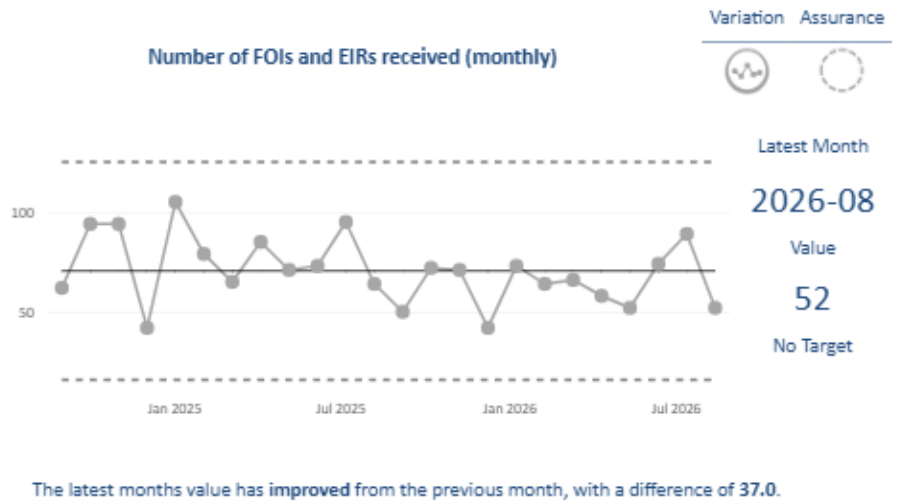
Number of Subject Access Requests (SAR) submitted by patients

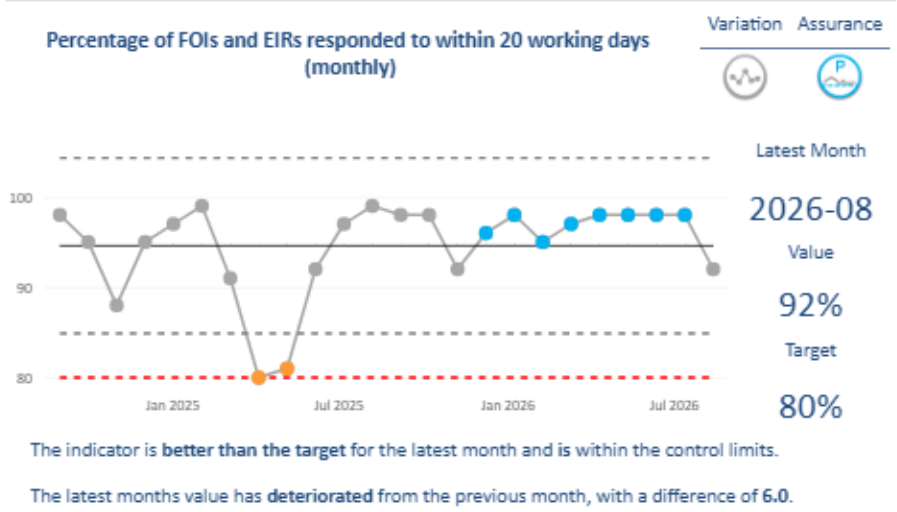
Factors impacting performance:
The reporting for SARs has changed to only include patient access requests. Previous reports have also included police requests, access to health records (deceased patients) and ad hoc external requests which are no longer included in this count.

Volumes received have increased; we are still seeing high volumes with other types of information requests. The Trust is currently experiencing a backlog and response times have been impacted. This is being communicated to requesters. We are investing to try and address the significant backlog.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley





Rationale: Ensuring the Trust responds to % Freedom of Information (FoI) request and Environmental Information Regulation (EIR) requests in line with legislation
Target: 80% Freedom of Information (FoI) request and Environmental Information Regulation (EIR) requests responded to within 20 days

Factors impacting performance:.

Number of FOIs Received

The number of FoIs the Trust received has recently decreased above the mean.

Actions: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has decreased; but is above the target of 80%.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

September 2026

Executive Owner: Andrew Bertram

Highlights

At the end of August 2026, the adjusted year-to-date deficit is **£14.1m** against a planned **£7.8m**, an adverse variance of **£6.3m**. August was **£1.8m adverse**. The main impact on the August position is the improvement to an **£18.5m deficit plan**, which required a further **£4m stretch WRAP target**, of which 5/12ths of the additional £4m is within the M5 YTD plan and has resulted in a **£6.6m** delivery gap. There is however evidence in month 5 of a more stable run rate position with both pay and non pay having lower in month costs than June & July.

The 2026/27 plan has now been agreed with NHSE at a year-end deficit of **£18.5m before deficit support funding**. The associated **£18.5m of deficit support funding** will be subject to conditions, is not automatic and **must be earned** through delivery of the agreed plan and its recovery, productivity and control requirements. Delivery of the deficit plan and receipt of the support in full would produce a balanced I&E.

Forecasting illustrates the scale of the risk. The best case assumes full WRAP delivery, effective recovery action and full payment for activity above plan, producing an **£18.5m deficit**. The most likely scenario is **£31.5m** and the worst case **£46.8m**. NHSE's Provider Assurance Model gives a most likely deficit of **£25.1m** the difference between the two forecast models is due to profiling differences, assumptions relating to additional activity and delivery of the expenditure recovery programme. The Executive Committee has agreed recovery actions assessed as capable of delivering up to **£7.8m**, supported by the Challenged Provider Programme.

Cash closed at **£6.9m** against a **£6.4m** plan, but the position was supported by holding **£4.0m** of supplier payments. A cash-support request is expected in October for a November draw although approval is not guaranteed. Variable activity is provisionally **£6.6m above plan**, including high-cost excluded drugs, but remains subject to final coding, costing and commissioner agreement.

Capital is **£5.0m behind plan** at Month 5, mainly from RAAC slippage, although the forecast is **£62.8m** against a **£63.4m** plan.

Concerns

WRAP remains the principal risk. Month 5 year-to-date delivery is **£19.7m** against a target of **£26.4m**, a **£6.6m shortfall**; full-year delivery is **£30.4m** against **£65.7m**. The gap has been managed through non-recurrent measures, including deferred investment and contract overtrade. These measures do not reduce the underlying cost base and increase the delivery required later in the year, placing both the £18.5m deficit plan and the ability to earn the full support funding at risk.

Workforce expenditure also remains a material pressure. Agency spend is **£2.4m** against a **£2.7m** plan, but bank spend is **£15.6m** against **£10.8m**, **£4.8m adverse**. Medical and dental staffing, premium cover and industrial action remain key drivers. Vacancy controls, rota management, substantive recruitment and tighter temporary staffing approvals must now reduce the underlying pay run rate.

Income above plan cannot be assumed until agreed with commissioners. The overall priority is to replace temporary mitigations with evidenced recurrent delivery and maintain clear compliance with the conditions attached to the **£18.5m support**.

Executive Owner: Andrew Bertram

Future

The agreed 2026/27 plan is an outturn deficit of £18.5m before deficit support funding. The associated £18.5m support will be conditional and must be earned; it is not guaranteed income. Full receipt, together with delivery of the plan, would enable a balanced reported position including the support.

The year-end outcome will depend on sustained run-rate improvement through recurrent WRAP, recovery-plan delivery, workforce control and commissioner-backed income, with clear ownership and transparent Board reporting.

OPERATIONAL FINANCIAL MEDIUM TERM FINANCIAL PLAN - 2026/27 TO 2028/29	Year 1 2026/27 £'000	Year 2 2027/28 £'000	Year 3 2028/29 £'000
Income	887,777	906,450	925,320
Gross Operating Expenditure	-967,732	-944,134	-950,353
Less: WRAP	65,640	36,122	39,929
OPERATING SURPLUS / (DEFICIT)	**-14,315**	**-1,563**	**14,896**
Finance Costs	-12,677	-13,171	-13,564
SURPLUS / (DEFICIT) FOR THE YEAR	**-26,992**	**-14,734**	**1,332**
Technical Adjustments	8,346	-1,124	-1,079
ADJUSTED FINANCIAL SURPLUS / (DEFICIT)	**-18,646**	**-15,858**	**253**

The immediate priority is to convert the WRAP pipeline into delivered, recurrent savings. The Month 5 shortfall is £6.6m and full-year delivery of £30.4m remains below the £65.7m target. Financial Improvement Boards must maintain scheme-level ownership, credible phasing and rapid mitigation of slippage. The Executive recovery plan and NHSE's Challenged Provider Programme should accelerate delivery, with progress judged by sustained improvement in the monthly run rate rather than one-off actions or rephasing.

Workforce requires the same level of control. Agency remains within plan, but bank usage is £4.8m above plan and medical and dental staffing is the main operational pay pressure. Tighter rota management, vacancy controls, substantive recruitment and oversight of premium cover must deliver measurable monthly reductions. Where temporary staffing is necessary to protect services, the cost must be forecast explicitly and mitigated elsewhere.

Income recovery remains uncertain. The provisional £6.6m variable activity overtrade must be coded, costed and agreed with commissioners before it can be relied upon. Contract management should distinguish pay-award funding, delegated commissioning, high-cost pass-through items and genuine activity growth. Material activity outside the Indicative Activity Plan will require an agreed response that protects patient access and system affordability.

Cash management will become more important as the year progresses. August cash was supported by delayed supplier payments, and the expected November support request remains subject to approval. Capital delivery must also recover from the Month 5 phasing shortfall, particularly across RAAC and other reprofiled schemes.

Over the next two months, the Board should expect evidence of recurrent WRAP and recovery delivery, a lower workforce run rate, commissioner-backed income assumptions and less reliance on non-recurrent measures. Reporting should show performance against each funding condition. This is central both to achieving the £18.5m deficit plan and to earning the associated £18.5m deficit support funding.

Key Financial Risks

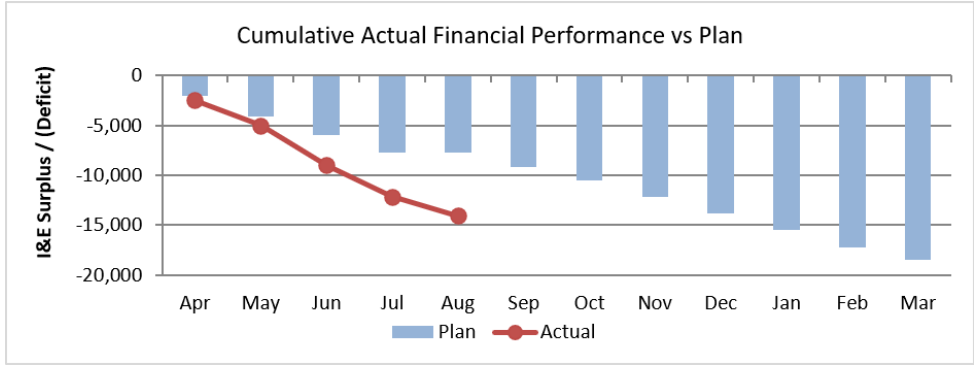
Key Risk Area	Board Level Risk Statement	Mitigations
Waste Reduction & Productivity (WRAP)	Risk that the WRAP is not delivered in full and / or schemes are not delivered recurrently	• Weekly/Monthly tracking of WRAP delivery (£ and %) with variance analysis & weekly progress from scheme leads. • Formal review and accountability meetings through Financial Improvement Boards (FIB) • Rolling review of recurrent vs non-recurrent delivery to ensure sustainability
Workforce sustainability	Risk that pay and temporary staffing costs exceed plan assumptions, impacting delivery of the financial plan	• Monthly monitoring of bank and agency spend against plan and trajectory • Active vacancy management – internal triple lock process still in place as established by NHSE. • Bank fill rate monitoring to reduce agency reliance • Premium pay controls (agency caps / approval thresholds) with exception reporting
Drugs and devices	Risk that growth in drugs and devices exceeds contract for 'in-tariff' drugs	• Monthly tracking of drugs and devices spend against plan and activity growth • Monitoring of key cost drivers (top spend lines) with targeted mitigation plans • Review of high-cost drugs against contract assumptions (in-tariff vs excluded)
System affordability	Risk that system plans remain unaffordable, increasing delivery expectations at Trust level	• Monthly tracking of delivery against control total and system efficiency requirements • Monitoring of contract performance (over/under-performance vs plan) • Contract Management Boards in place monthly
Cash Position	Risk that the Trust will run out of cash by November 2027	• Weekly Cash Committee to track cash position and escalate key issues • Increased engagement with NHS providers and other debtors to improve cash collection • Extending creditor payment terms whilst prioritising critical suppliers to protect patient services

BAF

BAF Principal Risk	How this report provides assurance	Outlook
Financial sustainability	Month-end I&E, forecast outturn, key variance analysis and cash position.	Current WRAP delivery and workforce costs continue to indicate a risk to delivering the plan over the next quarter, although run rate has slowed.
Delivery of recovery plans	WRAP delivery, high-risk schemes, slippage and recovery actions	Slippage in high-value schemes is increasing reliance on recovery actions, with a risk to achieving recurrent savings.
External financial compliance	Agency and bank controls, capital and cash management, system reporting	No immediate compliance issues identified; risk remains if spend and system assumptions are not brought back on plan.

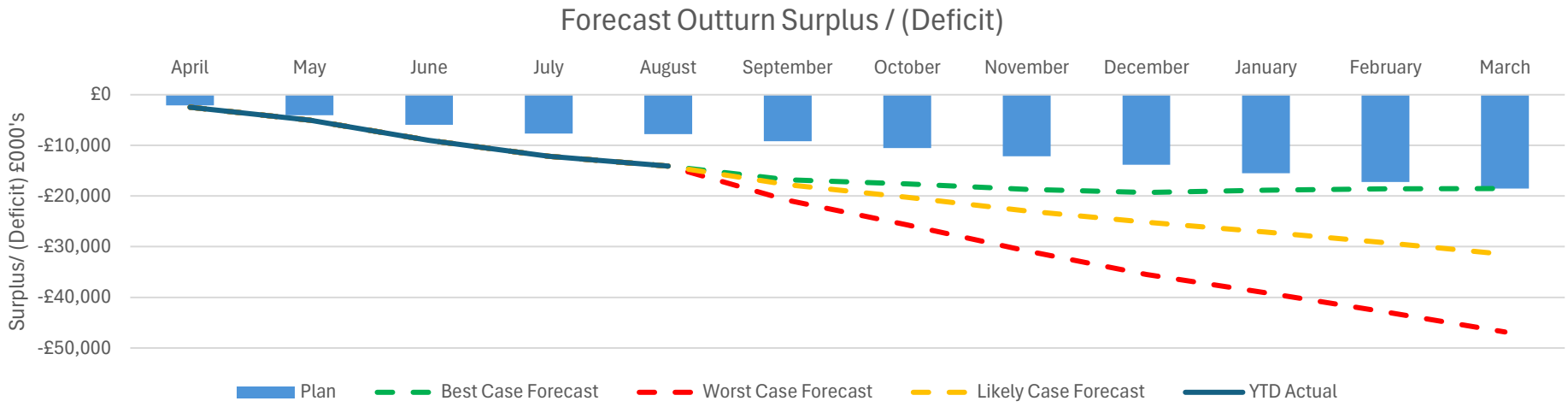
	Plan	In Month Plan	In Month Actual	In Month Variance	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000	£000	£000	£000
Clinical Income	826,291	75,099	70,012	-5,087	344,288	346,437	2,150
Other Income	84,561	7,446	6,490	-955	35,259	37,531	2,272
Total Income	910,852	82,544	76,502	-6,042	379,547	383,969	4,422
Pay Expenditure	-623,367	-52,475	-51,469	1,006	-254,322	-258,473	-4,151
Drugs	-72,058	-7,511	-6,510	1,001	-30,042	-33,484	-3,441
Supplies & Services	-97,846	-8,083	-7,804	279	-40,548	-40,856	-309
Other Expenditure	-148,621	-8,495	-11,276	-2,781	-54,688	-57,392	-2,704
Outstanding WRAP	35,371	2,954	0	-2,954	6,616	0	-6,616
Total Expenditure	-906,521	-73,610	-77,059	-3,449	-372,984	-390,205	-17,221
Operating Surplus/(Deficit)	4,331	8,934	-557	-9,491	6,563	-6,237	-12,799
Other Finance Costs	-12,677	-1,056	-1,075	-18	-5,282	-5,244	38
Surplus/(Deficit)	-8,346	7,878	-1,632	-9,509	1,281	-11,481	-12,762
NHSE Normalisation Adj	8,346	-271	-288	-17	-1,359	-2,601	-1,242
Adjusted Surplus/(Deficit)	0	7,607	-1,920	-9,527	-78	-14,082	-14,004
Remove DSF	-18,500	-7,706	0	7,706	-7,706	0	7,706
NHSE DSF Adjusted Position	-18,500	-99	-1,920	-1,821	-7,784	-14,082	-6,298

The I&E table confirms an actual adjusted year to date deficit of £14.1m against a planned deficit of £7.8m, leaving the Trust with an adverse variance to plan of £6.3m. The in-month position for August is an adverse variance of £1.8m.



The income and expenditure plan profile (excluding deficit support funding) shows an expected cumulative deficit throughout the year with an outturn deficit of £18.5m at the end of March 2027. The plan has now been approved by NHSE.

The actual adjusted I&E performance at the end of August 2026 is an adverse variance to plan of £6.3m

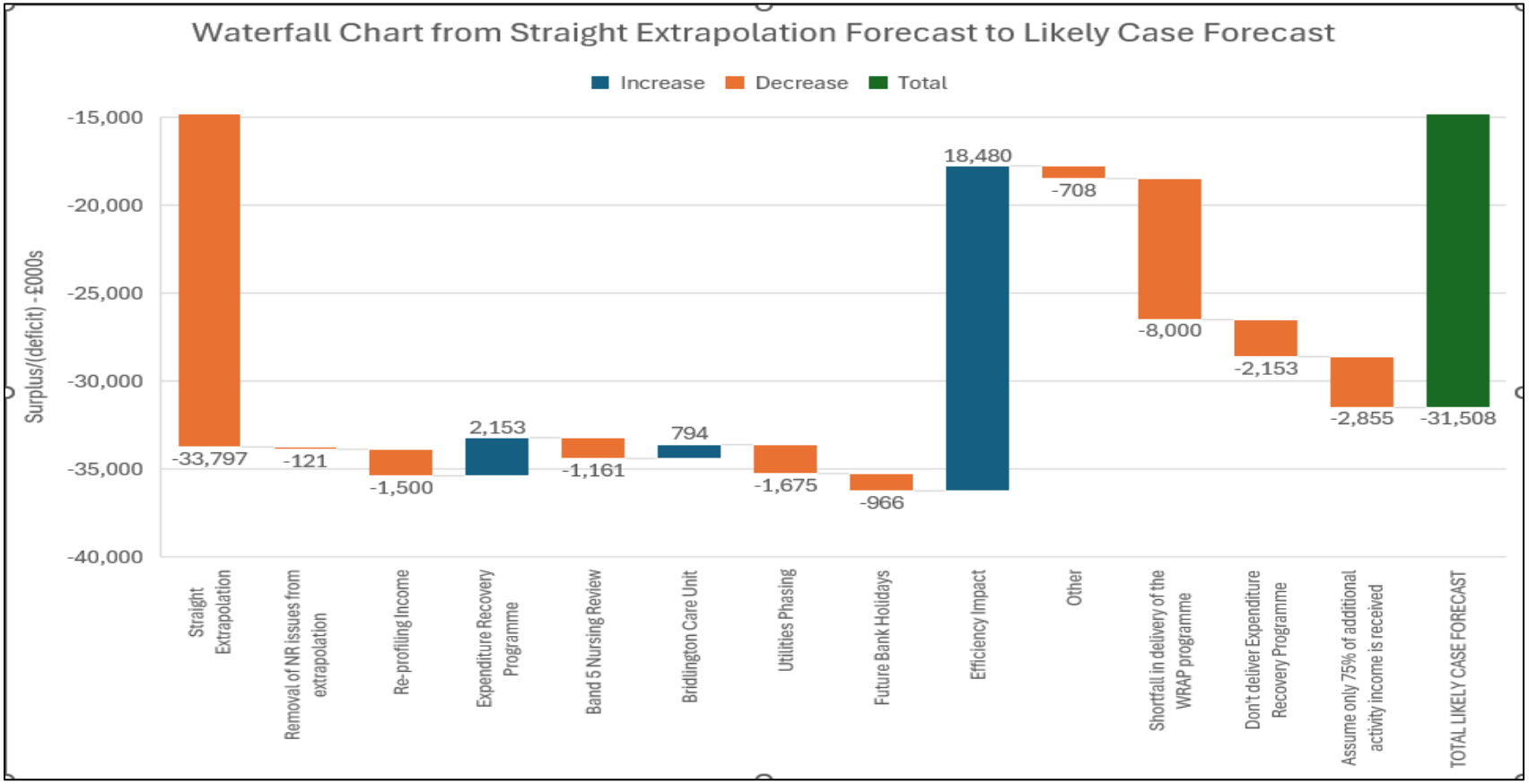


The graph above presents the forecast outturn deficit compared with the planned deficit (excluding DSF) of £18.5m. It presents the following 3 scenarios:

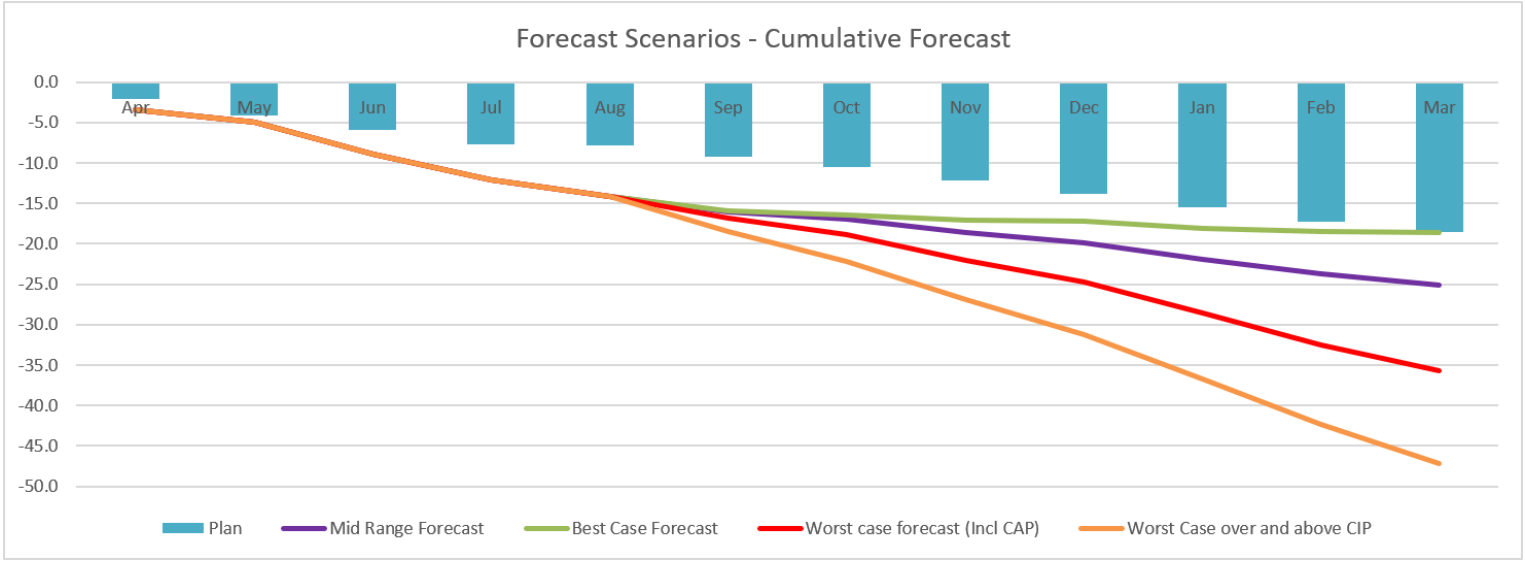
The best-case scenario assumes that the Trust recovers its financial position and delivers an outturn deficit of £18.5m, in line with plan. This assumes full delivery of the WRAP programme, achievement of financial recovery plans that deliver a further £2.2m of savings compared with the current run rate and payment in full for activity delivered ahead of plan (estimated at £11.5m in full year terms).

The most likely scenario is an outturn deficit of £31.5m, which is £13m worse than plan. This assumes a shortfall in the delivery of the WRAP programme of £8m, non delivery of the additional £2.1m financial recovery plan and failure to secure 25% of the income linked to activity ahead of plan.

The worst-case scenario assumes that the Trust continues its current run rate trajectory, with no further run rate savings over current levels or additional income for activity ahead of plan. Under this scenario, the outturn position would be a deficit of £46.8m which is £28.3m worse than plan.



The chart summarises the assumptions behind the most likely forecast, moving from the extrapolated month 5 position (£33.797m deficit) to the most likely position (£31.508m deficit). Blue bars demonstrate assumptions that improve the position; orange bars show assumptions that make the position worse.



To support the delivery of financial plans in 2026/27, NHSE have introduced an In-Year Provider Assurance Model. The model generates a forecast risk range that will be used as part of the regional assurance process. It is not designed to replace the Trust's formal forecast, rather it identifies the risk to delivering the formal forecast.

The model takes a similar approach to the Trust's existing forecast in that it is based on the underlying run rate but takes a risk adjusted approach to the assessment of WRAP scheme delivery. The model produces four forecast scenarios described as mid-case which is the most likely forecast, the worst case which is as per the mid-case but assumes no further WRAP delivery, the best case which reflects full delivery of identified opportunities and a worst case over and above CIP which is as per the worst case but assumes reduced income recovery.

The mid case scenario is an outturn deficit of £25.1m compared to the planned deficit of £18.5m. The worst-case scenario is a deficit of £35.7m, the best case is a deficit of £18.5m and the worst case over and above CIP is a deficit of £35.7m

This model focuses primarily on WRAP delivery risk and limits the risk modelling for issues such as commissioner overtrades. For this reason, the forecasts produced differ from our own modelling. We will work with NHSE to refine and improve our understanding and use of this model.

Recovery Plan – Version 1

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Action	Comments	Target Savings Level	Target Action Date	Actioned Date	Actioned by Who	Progress to Date
		£000				
Asset Revaluation Exercise - MEA Review	A Bertram evaluating proposal for external support	1,750	Sep26	Sep26	A Bertram	The contract has been signed. Audit paper shared. Benefit expected to be realised in latter months this FY. This is a cash releasing scheme.
Enhanced Vacancy Control Process	CEO-led review process. All posts. Safety critical only. A&C internal only. L Larcum/C Hansen preparing proposal with Care Groups	2,000	Aug26	Aug26	L Larcum/C Hansen	Process now in place.
Reduction in medical bank premium rates/WLI reductions/Insourcing/Outsoourcing Reductions	Establishment of MAPS review meetings for all bank/agency shifts - with senior Care Group leadership. F Gunebakan preparing ToR and Process.	1,000	Sep26	Sep26	F Gunebakan	ToR and process shared and agreed. Medical and Dental Unpaid breaks approved by execs. c£639k risk adjusted in-year benefit expected starting mid-Oct 26. Unadjusted benefit is c£852k. This will be governed in the MAPs process and process change at point of request. The additional benefit yet to be captured is re WLI requests where HoF have been asked to check and challenge CG submissions to payroll to ensure accurate reporting of discounted breaks. MAPs panel go live on 10/09 - based on requests to cover 1st October - 11th October - 25% rejected & 50% clarification required, 25% approved
Community Bed Reduction Programme	Exec Cttee agreement to progress programme. Considering wider community prortfolio and opportunity from ESD.	1,000	Nov26		J Hague	
Prepare and evaluate withdrawel from Whitby - Maternity and Radiology and potential clinic offering	Outreach support to cease. Resource stretching and poor VFM	200	Nov26		J Hague / C Hansen	
Requirement for GP requested diagnostics to come from GP	Protocol requirement to be communicated to GPs to ensure request for imaging diagnostics originate from a GP and not other practice staff	250	Sep26		K Stone	In progress, paper to be presented to the Executive Committee in October
In-hours diagnostics from Consultant only (CT, MRI)	Protocol requirement to be communicated to all medical staff to ensure request for CT and MRI originate from a Consultant only	250	Sep26		K Stone	
Consider reduction in UTC opening hours	Review usage data to consider VFM	200	Oct26		C Hansen	
Consider opportunity for Cancer scheme funding Slippage	K Hinton to review	N/A	Sep26		K Hinton	Any slippage on SDF schemes support alternative improvement plans.
Defer study leave which is not considered stat/mand/essential	Defer until April, where temporary staffing backfill is required	TBC			K Stone (Medical Staff) plus other Directors	
Consider the release of unspent/not yet committed CPD funding	Chief Nurse Team to evaluate opportunity	TBC	Sep26		J Hague	
Consider the release of unspent/not yet committed MIS non-recurrent funding	Board-level commitments made. Consider timing of recruitment, slippage availability whilst still meeting obligations.	TBC	Sep26		J Hague	
Discretionary expenditure review panel	At present all non-pay spend above £5k is reviewed. Reduce this to £500 with Exec Panel.	500	Sep26	Sep26	F Gunebakan / A Bertram	This panel went live on 03/09 where process refinements agreed. Next panel on 10/09. Delivery tracking route yet to be identified, however the grip and control is now in place.
Further First Class Post Restrictions	Consider senior approval only	TBC	Sep26		C Norman	
Further Taxi Restrictions	Consider senior approval only	TBC	Sep26		C Norman	
Bank shift Break Review	Early evaluation underway of potential opportunity	400	Sep26		F Gunebakan / J Hague / K Stone	Nurses breaks are being discounted at source for B&A (no direct opportunity here). However, all AfC staff are being paid breaks through the ECP route. Opportunity of RR reduction switching AfC WLI/ECP payments to bank. This would result in a premium saving and break deduction (currently exec paper being drafted with HRD linking in with Hempsons etc).
Roster Policy Review - rules application	Recheck best practice and policy adherence	250	Sep26		F Gunebakan / J Hague	Headroom tool to be built and an extra level of executive scrutiny will be incorporated to ensure headroom compliance, better roster planning to reduce unavailability resulting in a reduction of reliance on temporary backfill. Delivery will be tracked through monthly run rate post month end hardclose.
Sickness absence policy and process review	LNC & URG letters sent from CEO 11.8.26 to commence review work	N/A	Sep26		L Larcum	Embedded within existing WRAP scheme
Audio Typing Reduction	Exec Cttee agreement to progress programme	N/A	Oct26		J Hawkins	Embedded within existing Admin optimisation WRAP scheme
TOTAL		7,800				

The Executive Committee has prepared and agreed a draft financial recovery plan. Initial assessments suggest that an impact of up to £8m is achievable through this work. This is summarised here.

Actions have been developed from the Board discussion at the July meeting and have incorporated initiatives picked up through the challenged provider programme work.

The Executive Committee is now working on implementation of these actions. Monthly progress reporting will be implemented. These actions are all designed to reduce run rate expenditure and support delivery of the WRAP programme.

Key Subjective Variances: Trust

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHSE income	-£16.0m	NHSE under trade linked to services which have been delegated to ICBs to commission. There is a corresponding over trade on the ICB line below.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27.
ICB Income	£18.3m	ICB over trade linked to services which have been delegated from NHSE to ICBs to commission. The position also includes additional income to fund the increased agenda for change and medical staffing pay awards and overtrade on high-cost drugs and variable activity.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27. Contract Management Board engagement re overtrade.
Other Income	£2.1m	£1.5 income brought forward (£2.1m at m4) to partially compensate shortfall in delivery of WRAP. This approach has been discussed with NHSE. Research and Development and Education and Training income also ahead of plan.	Shortfall in WRAP delivery needs to be recovered, this may be delivered through delay / avoidance of investments included in plan.
Employee Expenses	-£4.2m	Pay awards have been agreed and paid at a higher rate than originally funded in the plan/contract. This is currently contributing £3.4m to the pay overspend but is fully offset by a corresponding income adjustment. Income and expenditure plans have not yet been uplifted because contract variations have not been confirmed by commissioners. In addition, the position includes medical bank and extra contractual costs relating to April's industrial action (£0.6m). However, while Aug Pay was marginally above the prior 11-month average due to the resident doctor pay award accrual, the underlying pay run rate was lower than recent months.	NHSE have confirmed there is no funding to cover the cost of industrial action. The Trust will continue to apply NHSE best practice controls to manage agency expenditure and continue to recruit to posts being covered through bank, agency and other premium costs. Vacancy control measures remain in place and Medical Bank and Agency Panels (MAPS) are being established to review, challenge and approve requests for temporary medical staffing.
Drugs and Devices	-£3.4m *Net of income: -£1.2m*	Drugs expenditure is £3.4m above plan. £1.7m relates to drugs funded through pass-through arrangements and is reflected within the income position. In addition, there is growth in expenditure on drugs that were formerly managed as pass through but are now funded through tariff (£0.5m). Funding for these drugs is provided within in the income linked to the activity overtrade. The remaining variance reflects costs incurred which are not offset by income recovery, resulting in a net in-year pressure. This includes increased costs linked to drugs that were previously prescribed in primary care (£0.3m). No funding has been transferred from primary care to support this change. High-cost devices are £0.3m above plan. These are commissioned on a pass-through basis and full reimbursement is assumed within the income position.	Overtrade on high-cost drugs has been shared with HNYICB and income assumed in the position. HNYICB are in the process of establishing a contract management board which will review all overtrades against the agreed plan. The Trust will seek additional income from HNYICB to recover costs relating to drugs that were previously prescribed in primary care.
WRAP	-£6.6m	Year to date savings of £19.7m have been delivered compared to a target of £26.4m. This is a shortfall of £6.6m. In full year terms, £30.4m has been delivered against the target of £65.7m.	Continued focus on delivery of the WRAP overseen through the Finance Improvement Boards. The shortfall has been managed to date through the deferral of planned investments. A recovery director has been engaged in conjunction with NHSE to support improved delivery of WRAP.
Other Non Pay	-£3.0m	Cost pressures relating to outsourcing costs particularly in CSCS in Radiology and Surgery in Head and Neck and Theatres.	A reduction in outsourcing costs is being managed through the financial recovery programme.

Care Group Forecast
Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Year to Date 2026/27 Care Group Financial Position							
Care Group	Annual Adjusted Budget	YTD Budget	YTD Actual	YTD Variance	YTD Adjusted Budget	YTD Adjusted Variance	Key Drivers of YTD Adjusted Variance
	£000	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	246,727	101,570	104,537	-2,968	104,475	-62	Overspend position currently driven by large £3.6m Drug Overspend and £0.7m Radiology Reporting Overspend offset by vacancies, underspends on CDC and WRAP delivery £0.2m ahead of Plan, Radiology Usage currently £0.85m ahead of plan driving increased reporting requirement.
Family Health Care Group	91,378	37,745	39,564	-1,819	38,251	-1,313	£223k relates to the premium cost of covering medical vacancies, £84k Community Nursing overspend, £119k Sexual Health underspend, £42k Drugs Overspend, £1198k unachieved CIP / VF.
Medicine	194,222	81,232	85,929	-4,697	82,081	-3,849	£906k overspend on drugs, primarily Gastro; £435k relates to cover of Industrial Action; £3.146m pressure due to shortfall on delivery of WRAP schemes
Surgery	161,298	67,185	74,455	-7,270	67,752	-6,703	Year-to-date pressures include a £2.2m shortfall against the WRAP target, a £694k overspend on Clinical Services and Supplies (primarily within T&O and Theatres), £629k of insourcing expenditure across H&N and Theatres, and a £591k overspend on Resident Doctor budgets, driven by premium bank and agency staffing.
TOTAL	693,625	287,732	304,486	-16,754	292,558	-11,927	

Full Year 2026/27 Care Group Forecast Financial Position						
Care Group	Annual Adjusted Budget	Forecast Prior to Mitigating Actions	Mitigating Actions	Forecast Post Mitigating Actions	Forecast Variance	Key Drivers of Forecast Variance
	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	246,727	246,911	0	246,911	-184	Vacancies projected to continue and Run Rate impacts of WRAP savings along with drug run rate to mirror previous financial years to reduce run rate before year end, work ongoing to close gap further including Headcount reductions.
Family Health Care Group	91,378	95,424	0	95,424	-4,046	£385k relates to the premium cost of covering medical vacancies, £201k Community Nursing overspend, £101k Drugs Overspend, £3291k unplanned CIP.
Medicine	194,222	204,710	0	204,710	-10,488	£1.540m overspend on drugs, primarily Gastro; £435k relates to cover of Industrial Action; £7.9m pressure due to shortfall on delivery of WRAP schemes
Surgery	161,298	175,102	0	175,102	-13,804	The forecast overspend is primarily driven by a £7m shortfall against the WRAP target, a £1.7m overspend on Clinical Services and Supplies, £1m of insourcing expenditure across H&N and Theatres, and a £1.4m overspend on Resident Doctor budgets, driven by premium bank and agency staffing.
TOTAL	693,625	722,147	0	722,147	-28,522	

Activity Related Investments	Reserve	Period
Total	**11,797**	
£3m plan adjustment	- 3,000	
Shortfall of WRAP - M3 YTD	- 1,500	
Revised Reserve	**7,297**	
Approved to date by specialty:		
Acute Medical Model	639	Q1-Q2
Audiology	312	Q1-Q2
Dermatology	115	Q3
Colorectal Surgery	570	Q1-Q3
ENT	286	Q1-Q2
Gynaecology	107	Q1-Q2
Neurology	37	Q2
Oral Surgery	87	Q1-Q2
Paediatric SaLT	507	Full Year
Pain Management	241	Q2
Renal	45	Q2
Respiratory	54	Q2-Q4
Urology	77	Q1-Q2
Total approved as at 31st August 2026	**3,077**	
Remaining reserve	**4,220**	

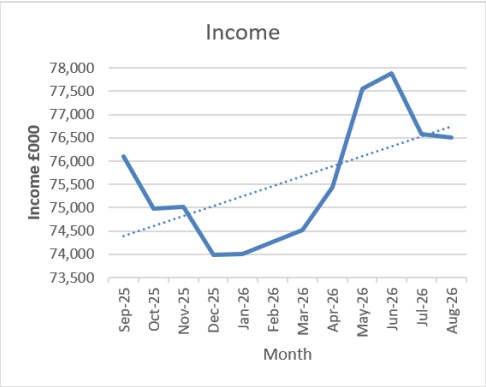
Within the plan, the activity-related investment provision was £11.7m. After the £3m plan adjustment and £1.5m WRAP shortfall, the reserve was revised to £7.3m at the end of August 2026. Approvals recorded to date amount to £3.1m, leaving £4.2m available to support further specialty investments.

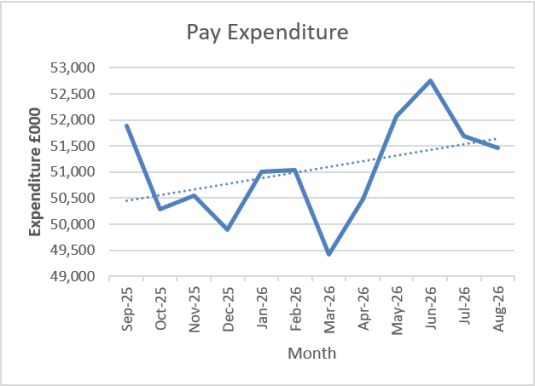
Most investments have been agreed on a non-recurrent, quarter-by-quarter basis and currently extend only to the end of Q3. The exceptions are Paediatric SaLT, which has full-year approval but requires an approved business case before funding can be drawn, and Respiratory, which is approved to year-end to recruit to a specialist nurse role.

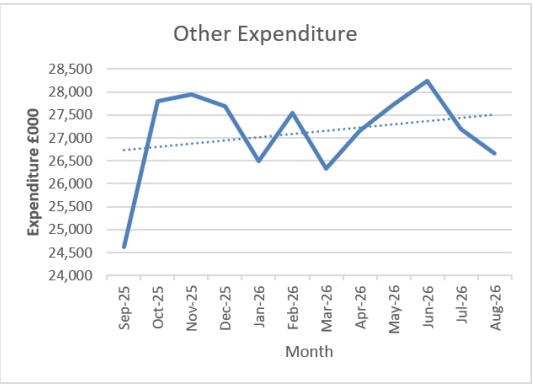
*Note: The shortfall of WRAP adjusted against the reserve is reduced to £1.5m (from £2.1m in M4) following the commitment to wind this adjustment back by the end of quarter 3, the remaining WRAP shortfall, now at £6.6m due to the amended financial plan is offset against an overtrade on the HNY ICB contract.

Income and Expenditure Run Rate

Finance







	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD Average	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	76,095	74,981	75,011	73,986	74,000	74,268	74,525	75,442	77,557	77,887	76,580	76,502	75,485	1,018
Pay Expenditure	51,884	50,282	50,548	49,895	51,005	51,041	49,416	50,484	52,073	52,761	51,684	51,470	51,007	-463
Other Expenditure	24,629	27,807	27,945	27,683	26,486	27,538	26,333	27,156	27,718	28,248	27,190	26,666	27,158	492

The graph and table above show the monthly run rate for income, pay and other expenditure. The figures for 2025/26 have been normalised through the removal of one – off items including increased pension contributions, impairment, ERF overtrade from 2024/25 write off and sparsity funding.

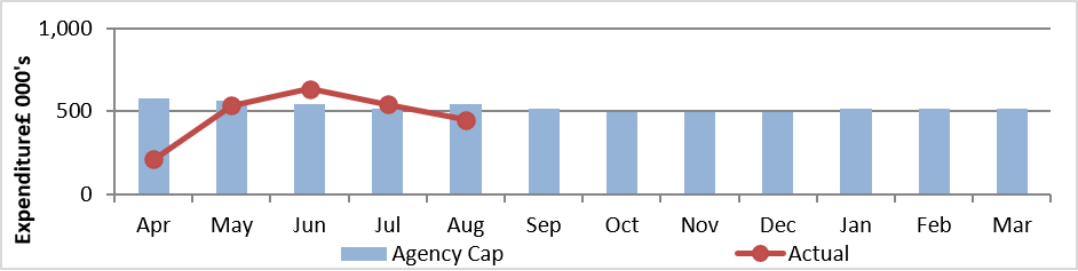
Income in August 2026 was £76.5m, which was £1.0m above the average monthly income for September 2025 to July 2026. This includes additional funding for 2026/27 pay awards and £4.3m of overtrade with HNYICB relating to pass through costs and tariff-funded activity.

Pay expenditure in August 2026 was £51.5m which was £0.5m above the average monthly pay expenditure for September 2025 to July 2026. The increase in August relates to accrued costs relating to the resident doctor pay award expected in September. This approach has been mandated by NHSE and has been offset by accrued income.

Other expenditure was £26.7m in August 2026, which was £0.5m lower than the average monthly expenditure for September 2025 to July 2026. The reduction is across several expenditure groups including clinical supplies and services and provisions .

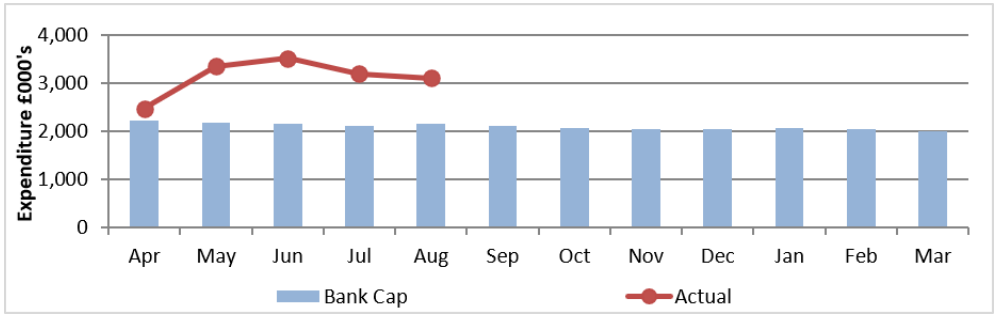
Agency, Bank and Workforce

Finance



Agency Controls

The Trust has an agency staffing spend limit of £6.3m in 2026/27. This represents a reduction of 4% on the 2025/26 expenditure level. The year-to-date expenditure on agency staff at the end of August 2026 is £2.4m, compared to a plan of £2.7m, representing a favourable variance of £0.3m.



Bank Controls

The Trust has a bank staffing spend limit of £25.2m in 2026/27. This represents a reduction of 45% on the 2025/26 expenditure level. The year-to date expenditure on bank staff at the end of August 2026 is £15.6m, compared to a plan of £10.8m, representing an adverse variance of £4.8m.

	Year to Date Expenditure		
	Budget	Actual	Variance
	£000	£000	£000
Registered Nurses	65,378	66,361	-983
Scientific, Therapeutic and Technical	33,190	33,394	-203
Support To Clinical Staff	29,884	25,480	4,403
Medical and Dental	71,095	74,455	-3,359
Non-Medical - Non-Clinical	57,077	57,760	-683
Reserves	-3,187	0	-3,187
Other	885	1,023	-138
TOTAL	254,322	258,473	-4,151

Workforce

This table presents a breakdown, by staff group, of the budget and actual expenditure for the year to date. The table illustrates that the key driver for the operational pay overspend is on Medical and Dental staffing. This includes £0.6m of cost linked to covering Industrial Action. Note the point that pay awards have been agreed and paid at a higher rate than originally funded with a corresponding favourable income variance. This is represented as £3.2m overspend on the Reserves line. Income has been accrued to offset this cost. Formal contract variations will follow.

Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Trust Variable Activity Performance Report vs Commissioner Values in Contract.

Commissioner	Value VAPR scope Indicative Weighted Values at 26/27 prices	VAPR Month 5 Phase (Av %)	Weighted Activity to Month 5 Actual	Variance - (Clawback Risk) M4
Humber and North Yorks	£198,878,373	£82,262,799	£87,020,743	£4,757,943
West Yorkshire	£1,579,629	£799,217	£969,036	£169,819
Cumbria and North East	£413,808	£170,950	£228,928	£57,978
South Yorkshire	£190,159	£77,934	£141,794	£63,860
All ICBs	***£201,061,969***	***£83,310,901***	***£88,360,501***	**£5,049,600**
NHSE Specialist Commissioning	£41,389,000	£17,500,782	£19,081,787	£1,581,005
NHSE Other	£285,266	£118,858	£132,941	£14,083
All Commissioners Total	**£242,736,235**	**£100,930,541**	**£107,575,228**	**£6,644,687**

Note:- Position Includes High Cost Exclude Drugs/ Devices, Unbundled Radiology and Estimated adjustment for Blended Payment variation

Variable Activity Performance Report

The Trust is monitoring the weighted financial value of activity that falls within the scope of the variable elements of the contract. This is in line with the 2026/27 National Payment Scheme Guidance. The weighted value of activity is calculated on an early 'heads-up' approach using partially coded data and extrapolating this for the year-to-date position. The scope of variable activity includes, Elective IP, Day case, Unbundled Radiology, First Outpatient and Outpatient attendances with a Procedure. It also includes High Cost Excluded Drugs and an estimated impact of the variance for Urgent and Emergency Care activity which is re-imbursed as part of the blended element at 20% marginal rates.

Although the funding for the variable activity is now reimbursed on a cost per case arrangement. HNY ICB has introduced a new Contract Management Framework (CMF) designed to support the delivery of the agreed activity, performance, quality and financial plans and to strengthen collaboration between the ICB and providers. This approach will also enable timely identification, escalation and resolution of risks and issues.

Any identified "material" variance to the Indicative Activity Plan (IAP) in year may then require a joint Activity Management Plan (AMP) to manage activity levels back within system resource where possible.

At Month 5, across all commissioners, the weighted activity position is above the planned weighted value by circa £6.6m. This includes expected additional income for High Cost Excluded drugs (£1.66m) and current overtrades in Activity, mainly in Day case & Unbundled Diagnostics Points of Delivery (PoD). The position included a corporate adjustment for SDEC inpatient activity, which is currently counted under Type 5 ED activity within Nervecentre, This adjustment reallocates the activity and finance, to the original PoDs (Daycase and Non-Elective) that were submitted as part of the Annual Plan. This position, includes provisional data and estimates so the reported variable position is subject to change when the final Month 5 activity is fully coded, costed and reconciled with the ICB. As this is provisional data and is currently higher than plan as part of the New Contract management Framework, the Trust is required to work with the HNY ICB and identify the key drivers of the current activity variance.

Waste Reduction and Productivity Dashboard — All Care Groups | August 2026

26/27 position • Reset: select All Care Groups

Care Group	All Care Groups	Directorate*	All Directorates

Executive Summary

Programme Summary Position

	Full Year	YTD Position
Target	£65,785,699	£26,327,064
Delivered	£30,414,661	£19,710,785
Variance	**-£35,371,038**	**-£6,616,279**
Additional Plans to be delivered		
Planned Low Risk	£12,626,834	£542,060
Planned Medium Risk	£9,847,997	£2,149,023
Planned High Risk	£4,887,046	£183,334
Total Additional Plans	**£27,361,877**	**£2,874,417**
(Planning Gap)/Over delivery	**-£8,009,161**	**-£3,741,862**

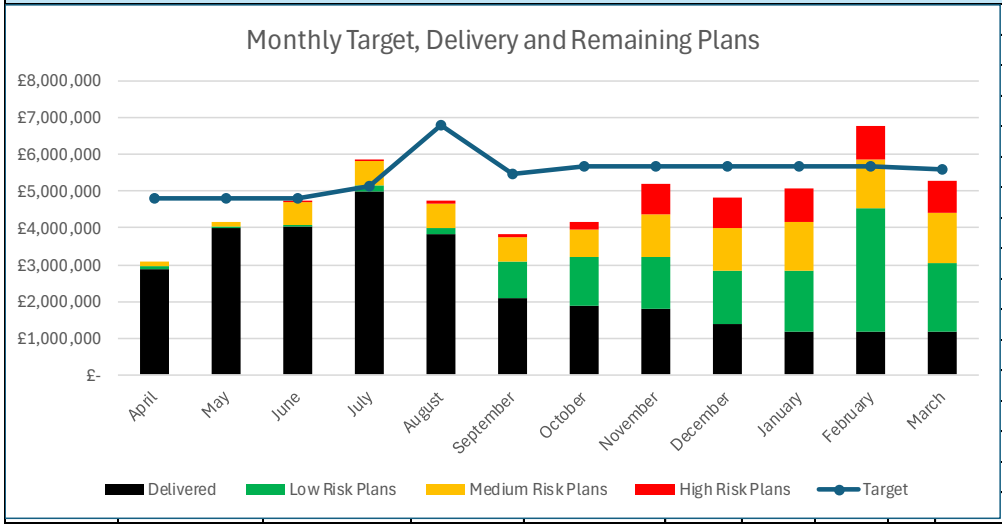
WTE Plan	238.34	**WTE Delivered**	47.91

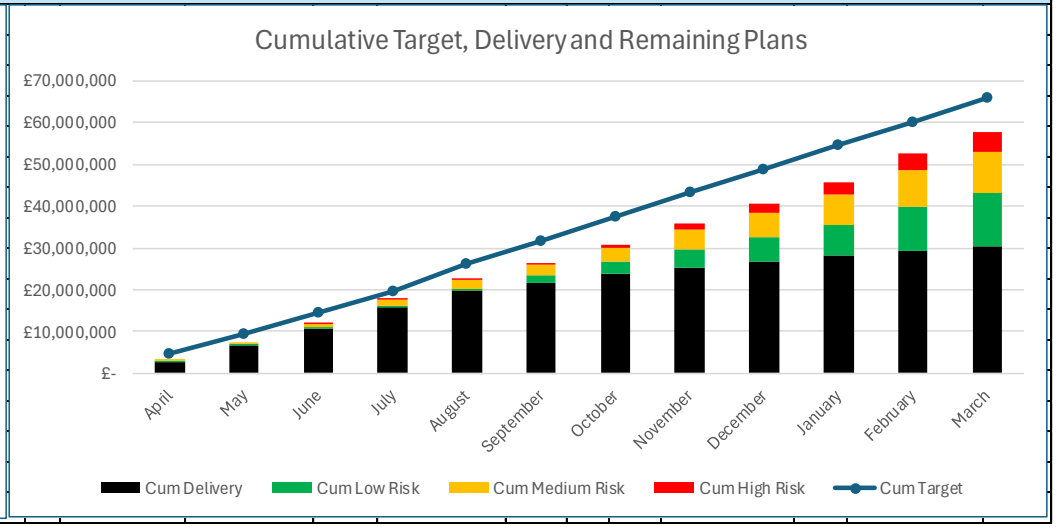
Scheme Governance

Total Number of Live Schemes						**152**				
EQIA Outstanding						51	34%			
Pre-Pipeline						7	5%			
Opportunity						33	22%			
Plan in Progress						10	7%			
Fully Developed						102	67%			
	Plans	**%**	**Delivered**	**%**		**Plans**	**%**	**Delivered**	**%**
Recurrent	£37,730,842	57%	£18,496,163	28%	**Pay**	£25,680,749	39%	£12,380,960	19%
Non Recurrent	£20,045,695	30%	£11,918,498	18%	**Non Pay**	£31,780,426	48%	£17,814,338	27%
Total	**£57,776,538**	88%	**£30,414,661**	46%	**Income**	£315,363	0%	£219,363	0%
					Total	**£57,776,538**		**£30,414,661**	

YTD Period Name	Aug-26

In Year Plan Profile





WRAP Programme – 27/28 Planning

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

27/28 Indicative Waste Reduction and Productivity Programme Position

The 27/28 programme has £29.3m of plans against a £68.2m indicative Trust target, leaving a £38.8m planning gap and 43% coverage. Corporate Functions holds the largest Care Group plan value at £8.6m. Workforce & Pay is the largest TPR category at £14.4m.

TRUST ESTIMATED TARGET	PLANS IDENTIFIED	PLANNING GAP	TARGET COVERAGE
£68,176,585	£29,331,017	-£38,845,568	43.0%

CARE GROUP POSITIONS

Care Group	27/28 Target	Plans	Planning Gap	Coverage	Share of Plans
CSCS	£14,827,264	£3,858,484	-£10,968,780	26.0%	13.2%
Family Health	£7,405,606	£3,863,384	-£3,542,223	52.2%	13.2%
Medicine	£16,828,706	£8,077,850	-£8,750,856	48.0%	27.5%
Surgery	£17,473,457	£4,941,319	-£12,532,138	28.3%	16.8%
Corporate Functions	£11,641,551	£8,589,980	-£3,051,571	73.8%	29.3%
Trust Total	**£68,176,585**	**£29,331,017**	**-£38,845,568**	**43.0%**	**100.0%**

Note: 27/28 Care Group targets are indicative based on Carry forward (26/27 Target less recurrent planned delivery) plus 27/28 indicative additional target apportioned as per 26/27.

WRAP CATEGORY POSITIONS

Category	27/28 Plans	Share of Plans
Workforce & Pay	£14,408,530	49.1%
Procurement, Medicines & Non-Pay	£5,867,592	20.0%
Clinical Productivity & Pathways	£4,889,000	16.7%
Digital & Technology	£2,768,120	9.4%
Estates, Facilities & Energy	£1,286,582	4.4%
Income & Commercial	£91,000	0.3%
Corporate Services & Administration	£20,193	0.1%
Trust Total	**£29,331,017**	**100.0%**

TOP 5 SCHEMES BY 27/28 PLAN VALUE

Rank	Scheme Ref	Scheme Name	WRAP Category	27/28 Plan	Share of Plans
1	CIP1	NON RECURRENT PAY SAVINGS	Workforce & Pay	£12,000,430	40.9%
2	CIP2	NON RECURRENT NON PAY SAVINGS	Procurement, Medicines & Non-Pay	£3,360,498	11.5%
3	CIP203	ACUTE MODEL OF CARE	Clinical Productivity & Pathways	£3,066,000	10.5%
4	CIP166	EPR CASH RELEASING BENEFITS - REDUCTION IN ADMIN SUPPORT RESOURCES REQUIRED	Digital & Technology	£1,527,500	5.2%
5	CIP4	PROCUREMENT SAVINGS	Procurement, Medicines & Non-Pay	£927,630	3.2%
Top 5 Total				**£20,882,058**	**71.2%**

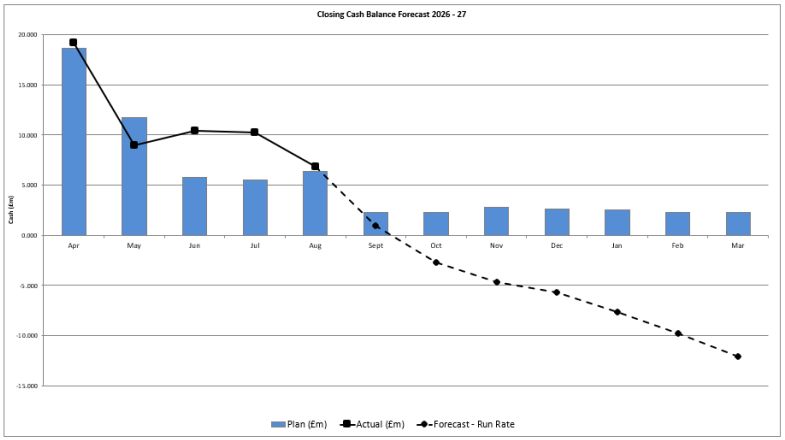
Current Cash Position and Better Payment Practice Code (BPPC)

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Group's cash plan for 2026/27 is for the cash balance to reduce through the year resulting in a closing balance of £2.3m at the end of March 2027. The table below summarises the planned and actual month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	18,649	11,726	5,776	5,486	6,358	2,286	2,318	2,784	2,581	2,552	2,309	2,309
Actual	19,199	9,017	10,304	10,290	6,903							



Closing cash was **£6.9m**, compared with a planned balance of **£6.4m**, resulting in a positive variance of **£0.5m**.

Similarly to the previous months, due to the uncertainty of cash receipts approaching month end & the timing of the final supplier payment run, £4m of invoices due for payment were held to ensure sufficient cash resources were available before payment could be released. In the final days of the month, the £2m reclaimable VAT was received alongside large value key receipt of £1.9m from HUTH increasing the closing cash position.

The favourable variance due to timing of supplier payments described above is offset by the adverse I&E variance and other working capital movements.

The run rate forecast, is based on continuation of cash receipts & payment run rates in line with current levels and any known adjustments. The run rates are extrapolated to give an indication of emerging cash pressures which continue to indicate a cash shortfall. With increased working capital management, we expect to manage the pressure until November.

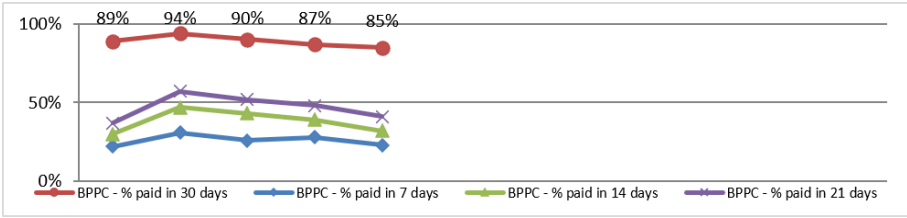
The expectation it to submit a cash support request in October to receive cash support in November. Approval of this support is not guaranteed. An update will be presented to the September Resources Committee & September Board of Director's for approval.

<u>Better Payment Practice Code</u>

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

The graph illustrates that in August, the Group managed to pay 85% of its suppliers within 30 days, reducing from the previous month.

This reduction is partially due to holding supplier payments to navigate cashflow uncertainties over the month end.



Current and Forecast Capital Position

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

The board approved capital plan for 2026/27 is £63.4m. RAAC eradication & pathology build on the Scarborough site are the largest value schemes in the plan.

The forecast has reduced by £0.6m to £62.8m. This is due to a £1.9m decrease from the RAAC pathology scheme, with expenditure and PDC funding reprofiled between financial years. There is a £1.3m increase due to the Macmillan cancer care centre not completing in the previous financial year. This scheme is charitably funded and therefore does not impact on the overall capital program funding.

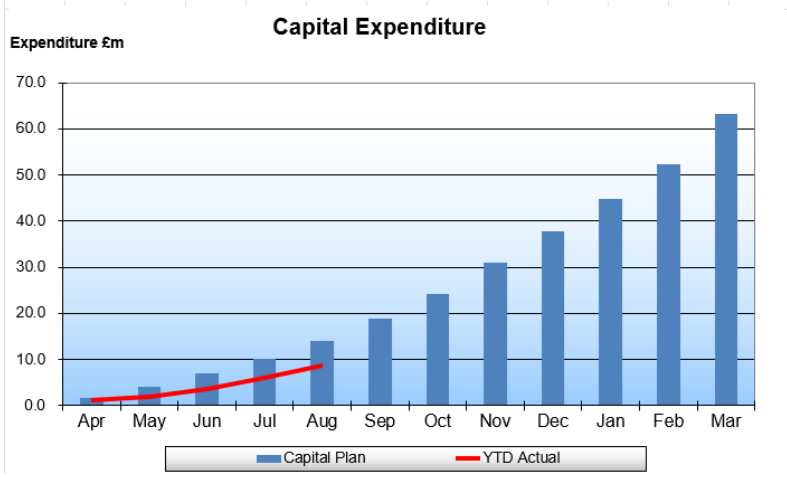
Capital Position	Plan	Forecast Outturn	YTD Plan	Actual YTD Expenditure	Variance to YTD Plan
	£000's	£000's	£000's	£000's	£000's
Internally Funded Schemes					
Electronic Patient Record (EPR)	7,200	7,200	549	1,141	592
York - PACU / Hybrid Theatre	2,850	1,700	650	1,145	495
Histopathology Refurb Completion	1,800	600	600	-	- 600
Salix Decarbonisation - Trust Contribution	1,459	1,459	-	-	-
Minor Works Schemes	559	589	-	62	62
Estates Backlog Maintenance & EDI	1,150	1,150	300	811	511
Y&S Digital Capital Projects	1,000	1,000	300	236	- 64
Medical Equipment Purchase/Lease	5,600	5,600	275	1,534	1,259
Capitalised Staff / Project Fees	2,100	2,100	745	841	96
Other Capital Projects	499	- 61	-	558	558
CIR - Refurb & Extension of SCBU York	-	1,080	-	157	157
Upgrade of CT (CT3) - York	-	700	-	476	476
Renal Ward York - Water ring upgrade	-	300	-	-	-
MRI 4 Relocatable	-	400	-	30	30
Ward 16 York	-	400	-	-	-
Total Internally Funding Schemes	**24,217**	**24,217**	**3,419**	**6,992**	**3,573**
PDC, Charitable and Grant Funded Schemes					
RAAC - Scarborough Pathology - PDC	16,458	14,604	7,357	-	- 7,357
RAAC - Scarborough Theatres - PDC	8,737	8,737	2,007	160	- 1,847
Constitutional Standards Schemes - PDC	6,150	6,150	-	-	-
Safer Estates Schemes - PDC	3,655	3,655	155	25	- 130
Charitable & Grant Schemes	4,160	5,460	1,195	1,521	326
Total Externally Funded Schemes	**39,160**	**38,606**	**10,714**	**1,706**	**- 9,008**
Total Capital Programme	**63,377**	**62,823**	**14,133**	**8,698**	**- 5,435**

Due to slippage and reprofiling of schemes including histopathology refurbishment scheme & York hybrid theatre scheme, several schemes that were presented from the capital prioritisation work as an overcommitment are now funded within the forecast.

These include York SCBU, completion of CT3, renal water ring main upgrade, MRI 4 relocatable and commencement of Ward 16 towards the end of the financial year.

The M5 position is £5m behind plan.

This is mainly due to the RAAC schemes running behind the original planned phasing (£9m), offset by several schemes running ahead of the monthly planned phasing but within the total annual agreed allocations. These include EPR, York - PACU / Hybrid Theatre, Estates Backlog Maintenance, Medical Equipment Purchase/Lease & CT3.



M5 System position – Humber and North Yorkshire (inc. and excl. DSF)

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

HNY Finance Summary - M5

Code	Name	ICB / Provider	Surplus / (Deficit) Including DSF					
			YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	0	0	0	0	0	0
RCD	Harrogate and District NHS Foundation Trust	Provider	(2,408)	(18,816)	(16,408)	0	0	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	(21,578)	(36,124)	(14,546)	(39,400)	(39,400)	0
RV9	Humber Teaching NHS Foundation Trust	Provider	0	0	0	0	0	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	(12,491)	(14,328)	(1,837)	(23,665)	(23,665)	0
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	(78)	(14,082)	(14,004)	0	0	0
Humber and North Yorkshire Provider Total		QOQ	**(36,555)**	**(83,350)**	**(46,795)**	**(63,065)**	**(63,065)**	**0**
Humber and North Yorkshire Total		QOQ	**(36,555)**	**(83,350)**	**(46,795)**	**(63,065)**	**(63,065)**	**0**

Code	Name	ICB / Provider	Surplus / (Deficit) Including DSF					
			YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	(4,535)	(4,535)	0	(10,883)	(10,883)	0
RCD	Harrogate and District NHS Foundation Trust	Provider	(8,033)	(18,816)	(10,783)	(13,500)	(13,500)	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	(21,578)	(36,124)	(14,546)	(39,400)	(39,400)	0
RV9	Humber Teaching NHS Foundation Trust	Provider	0	0	0	0	0	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	(12,491)	(14,328)	(1,837)	(23,665)	(23,665)	0
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	(7,784)	(14,082)	(6,298)	(18,500)	(18,500)	0
Humber and North Yorkshire Provider Total		QOQ	**(49,886)**	**(83,350)**	**(33,464)**	**(95,065)**	**(95,065)**	**0**
Humber and North Yorkshire Total		QOQ	**(54,421)**	**(87,885)**	**(33,464)**	**(105,948)**	**(105,948)**	**0**

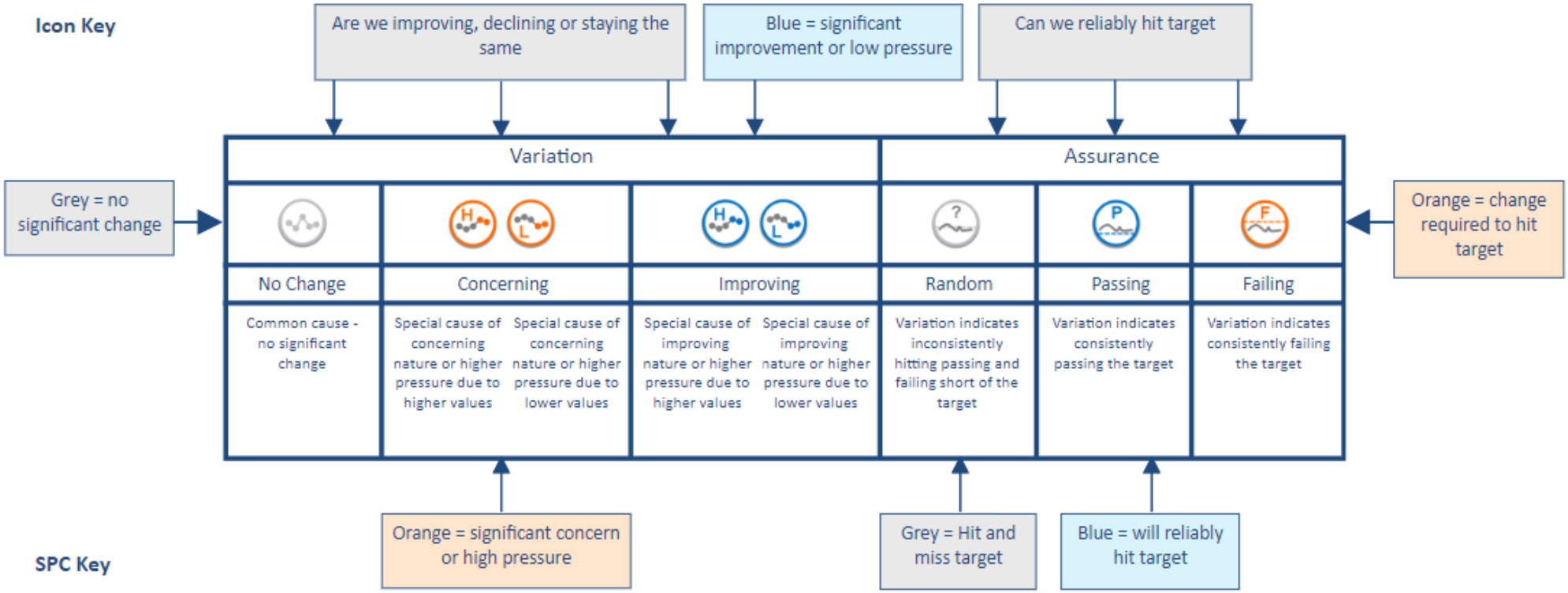
HNY Efficiency Summary - M5

			Total Efficiencies					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	30,231	29,869	(362)	81,468	81,467	(1)
RCD	Harrogate and District NHS Foundation Trust	Provider	11,994	5,897	(6,097)	32,000	32,000	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	25,792	10,540	(15,252)	72,881	72,881	(0)
RV9	Humber Teaching NHS Foundation Trust	Provider	5,876	6,037	161	14,353	14,353	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	15,633	7,920	(7,713)	46,223	46,223	(0)
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	26,329	19,711	(6,618)	65,787	65,786	(1)
Humber and North Yorkshire Provider Total		**QOQ**	**85,624**	**50,105**	**(35,518)**	**231,244**	**231,242**	**(2)**
Humber and North Yorkshire Total		**QOQ**	**115,855**	**79,974**	**(35,881)**	**312,712**	**312,709**	**(2)**

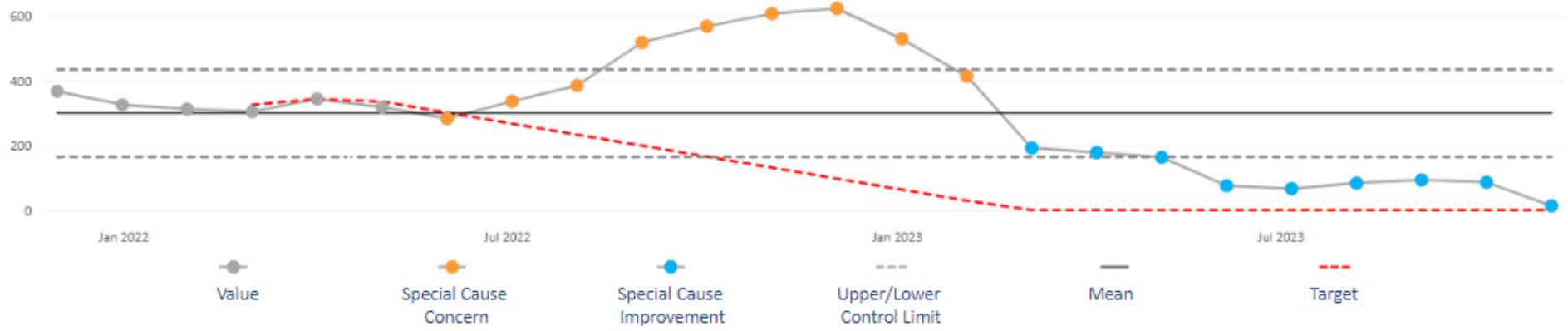
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3 are near the upper or lower control limit. The target can be either static or moving.

Icon Descriptions

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

			
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.

Report to:	Trust Board
Date of Meeting:	30 September 2026
Subject:	NHS Patient Standards
Director Sponsor:	Claire Hansen, Chief Operating Officer
Authors:	Kim Hinton, Deputy Chief Operating Officer Amber Lee, Professional Lead Patient Administration

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

Approve ☒ Discuss ☒ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

NHS England has issued minimum standards of patient experience for elective care. These standards set out what patients should expect after referral to hospital for planned care, including timely communication of referral outcomes, regular waiting list updates, clear appointment information, support for additional needs and confirmation when care is complete.

Trust Boards are expected to assess current performance against each standard, identify how they will improve where standards are not being met, and publish a statement in 2026/27 setting out the Trust's approach to compliance.

Alert

- NHS England has introduced eight minimum patient experience standards for elective care, with a requirement for Trust Boards to assess compliance and publish a formal compliance statement during 2026/27.
- The Trust's initial assessment identifies 2 standards rated Green and 6 rated Amber. No standards are currently rated Red; however, significant assurance gaps exist in the ability to consistently evidence compliance through routine data, reporting and audit arrangements.
- The principal risk is the inability to demonstrate compliance consistently across all specialties and patient groups due to fragmented recording systems, multiple communication methods and limited reporting capability. Proxy measures have had to be used to provide evidence against some of the standards.

Assure

- The Trust already has several processes in place that support delivery of the standards, including referral communication processes, 12-week waiting list validation through Envoy, recording of reasonable adjustments within CPD, standard correspondence templates and discharge recording through outpatient clinic outcomes.
- There are opportunities to strengthen future assurance through digital developments, including Nervecentre, outpatient transformation programmes and Single Point of Access initiatives.

Advise

- Approve the proposed Trust response, including establishing executive ownership, developing a Trust-wide patient standards dashboard, defining measurable indicators and commissioning baseline audits where routine measures do not currently exist.
- Prioritise development of robust reporting and assurance mechanisms to support evidence of compliance, reduce variation and prepare for publication of the Trust's mandatory patient standards compliance statement.
- Receive a further progress report within six months setting out updated compliance assessments, audit findings, key risks, mitigations and readiness for the 2026/27 compliance statement

Recommendation:

1. **Note** the NHS England minimum patient experience standards and the requirement for Trust Boards to assess compliance and publish a formal patient standards statement during 2026/27.
2. **Note** the current baseline assessment, gaps in compliance and evidence reporting limitations.
3. **Note and approve** the proposed Trust response and assurance statement**.**

4. **Receive** a further progress update within six months, including revised compliance assessments, audit findings, key risks, mitigating actions and readiness for publication of the Trust's 2026/27 patient standards compliance statement.

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

Meeting/Engagement	Date	Outcome/Recommendation

Patient Standards

1. Executive Summary

NHS England has issued minimum standards of patient experience for elective care. These standards set out what patients should expect after referral to hospital for planned care, including timely communication of referral outcomes, regular waiting list updates, clear appointment information, support for additional needs and confirmation when care is complete.

Trust Boards are expected to assess current performance against each standard, identify how they will improve where standards are not being met, and publish a statement in 2026/27 setting out the Trust's approach to compliance. NHS England has also stated that an annual statement will be required thereafter, reflecting progress against the standards.

The standards are linked to the wider NHS elective reform plan, which aims to return elective care to the 18-week referral to treatment standard by March 2029. The reform plan places emphasis on improving patient experience, increasing patient choice and control, expanding digital access, improving productivity, reforming outpatient care and ensuring patients receive care in the right setting

The Trust has completed an initial gap analysis against the eight standards. The current internal assessment identifies two standards rated green and six standards rated amber. No standard is currently rated red in the submitted gap analysis.

The main assurance gap is the Trust's ability to evidence compliance consistently. For several standards, processes exist, but there is no single routine data source or agreed metric to confirm that the standard is being met across all specialties and patient groups. This results in reporting gaps both to evidence compliance but also to provide an operational management tool to support delivery.

Several mitigation measures and recommendations are made in the paper, these needs to be scoped to understand timescales for delivery, noting that more accurate recording and reporting may not be available until Nervecentre tranche 3. It is proposed that further progress update within six months, including revised compliance assessments, audit findings, key risks, mitigating actions and readiness for publication of the Trust's 2026/27 patient standards compliance statement.

2. Background and National Context

On 3 July 2026, NHS England wrote to NHS trust chief executives and chief operating officers setting out the minimum standards of patient experience for elective care. The letter stated that patients waiting for elective care have too often not known whether their referral has been accepted or whether they remain on a waiting list and described this as a basic issue of patient communication and experience.

The standards apply to elective pathways and are structured around three stages of the patient journey:

- When a patient is referred.
- While a patient is on the waiting list and throughout care.
- Planning and understanding appointments.

NHS England expects Trust Boards to assess current performance against each standard and set out how they will improve where they are not meeting a standard. Trust Boards are

also expected to publish a statement in 2026/27 setting out their approach to compliance, followed by an annual statement reflecting progress.

NHS England has stated that a national stocktake will be undertaken after six months to assess progress across England, alongside ongoing monitoring of patient experience through national surveys.

3. NHS Elective Reform Ambitions

The minimum patient experience standards form part of the wider national elective reform programme. NHS England's elective reform plan sets out the ambition to return to the constitutional standard that 92% of patients should wait no longer than 18 weeks from referral to treatment by March 2029.

The elective reform plan states that elective care should become increasingly personalised and digital, with a focus on improving patient experience and convenience, and giving people more choice and control over when and where they are treated.

The plan identifies four areas of focus:

- Empowering patients through more choice, control and clear standards of experience.
- Reforming delivery to improve productivity and consistency.
- Delivering care in the right place.
- Aligning funding, performance oversight and delivery standards.

The Trust's internal gap analysis shows that several current and planned developments are relevant to these ambitions, including use of e-RS (electronic referral system), Patients Know Best (PKB), waiting list validation through Envoy (text messaging platform), CPD recording of reasonable adjustments, Synertec (hybrid mail supplier) letter production and future Nervecentre functionality.

The Trust's current position is therefore linked to elective reform but is not yet fully supported by consistent data, reporting and assurance processes for all eight patient experience standards.

4. National Minimum Standards

The eight minimum standards are:

1. Patients will know within 28 days whether their referral has been accepted or what the next steps are.
2. Communication will be clear and easy to understand, and patients with specific communication needs will have the opportunity to tell the provider.
3. When the referral is accepted, patients will receive information to help them while they wait.
4. Patients will receive regular updates on their wait, at least every 12 weeks.
5. Before appointments, patients will be able to tell the provider of any additional needs and reasonable adjustments required.
6. Patients will receive clear information about appointments at least 21 days in advance.
7. If an appointment is cancelled by either the patient or provider, a new date will be communicated within 28 days.
8. Patients will be told when their care is complete and what happens next.

5. Trust Current Position

The Trust has undertaken an initial gap analysis against the eight standards. The current assessment is as follows:

<table>
<tr><th>Standard</th><th>Current Trust Assessment</th><th>Summary Position</th><th>Evidence and Reporting Gaps</th></tr>
<tr>
<td>1. Referral outcome within 28 days - Patients will know within 28 days whether their referral has been accepted or what the next steps are.</td>
<td>Amber</td>
<td>Referral outcome is communicated through partial booking letters, text, telephone, appointment booking and e-RS updates, there is no single data item to automate assurance that communication has occurred within 28 days.

When the referral is added to an outpatient waiting list it changes the referral status so that we can see when the outpatient waiting list letter was generated. This gives an indication of the proportion of patients that were communicated the outcome of their referral within 28 days. For patients added to the waiting list 92.9% of these letters are initiated within 28 days.
*Sample data is for Q1 2026/27
<table>
<tr><th>Referral Status</th><th>Within 28 Days</th><th>Total</th><th>Proportion</th></tr>
<tr><td>Accepted</td><td>10961</td><td>11934</td><td>91.8%</td></tr>
<tr><td>Accepted (P)</td><td>13481</td><td>14516</td><td>92.9%</td></tr>
<tr><td>Appt.Made</td><td>59704</td><td>61141</td><td>97.6%</td></tr>
<tr><td>Oth.Service</td><td>6</td><td>7</td><td>85.7%</td></tr>
<tr><td>Rejected</td><td>4016</td><td>4282</td><td>93.8%</td></tr>
<tr><td>Total</td><td>88168</td><td>91880</td><td>96.0%</td></tr>
</table>
This is retrospective reporting, with no prospective reporting to flag when patients are approaching or have breached 28 days for operational action.</td>
<td>The Trust gap analysis notes that there is no single data item to confirm whether a referral outcome was communicated within 28 days.

Suggested actions / mitigations:
The Business Intelligence Team are Developing a minimum patient standards dataset covering standards 1& 4 & 6-8, with agreed indicators, data source, reporting frequency and executive owner.
Proxy assessment measures have been used for standards 2, 3 & 5 where direct measures are not currently available, ie;
Accessible and understandable Information
Waiting Well Information
Additional Needs and Reasonable Adjustments
Prioritise Nervecentre reporting requirements so future functionality supports compliance reporting where existing systems cannot.</td>
</tr>
</table>

2. Accessible and understandable communication – Communication will be clear and easy to understand, and patients with specific communication needs will have the opportunity to tell the provider.	Amber	We have worked with patient groups to agree the new wording for the Nerve Centre standard letter wording. We have added a standard footer to all standard letters sent via our Hybrid mail supplier to encourage any patient who needs help to access our services to log on to the accessibility hub on the web site. Standard letters also provide phone and email contacts for patients who need alternative communication methods. Large print can be supported for letters generated from CPD via Synertec (hybrid mail supplier), but risks remain in relation to accessible information and inserts not automatically produced in large print.	Large print can be generated for letters printed from CPD via Synertec, but this does not include inserts produced in standard font. The gap analysis also references risks identified through the Accessible Information Standard gap analysis. The Trust lead for accessible information is overseeing the project to ensure compliance with the accessible information standard
3. Waiting well information - When the referral is accepted, patients will receive information to help them while they wait	Amber	Some teams include waiting well information in referral acknowledgement letters, but there is no consistent Trust-wide measure and information is often condition-specific. Therefore, it is only appropriate where the condition group is very specific. Eg Pelvic Health include several resources to manage the condition within the letter. We do not have safety netting signposting in standard letters, following previous discussions and agreements with the Local Medical Committee (primary care).	**Waiting well information is not standardised** Waiting well information is provided by some teams, but there is no Trust-wide approach or consistent measurement, and this may not be appropriate. We do not have outpatient coding to facilitate condition specific information to be given in general services, and indeed it may be difficult to understand the appropriateness of this information prior to diagnosis. The gap analysis notes that generic waiting well information is difficult because information is often condition-specific. Suggested actions / mitigations:

			• Develop a Trust-wide waiting well resource on the Trust Web site that patients can access for different conditions or client groups. • Include reference to NHS App, Trust website and patient advice routes where relevant. • Measure compliance through website usage
4. Waiting list updates every 12 weeks - Patients will receive regular updates on their wait, at least every 12 weeks.	Green	Patients with an open RTT clock and no booked appointment receive waiting list validation text messages every 12 weeks, with evidence available through the Envoy text message system. Work is currently underway with the BI team to initiate text messages for patients with no clock (patients not on an RTT pathway/clock). The costs associated with this will need to be examined in conjunction with the technical solution.	
5. Additional needs and reasonable adjustments - Before appointments, patients will be able to tell the provider of any additional needs and reasonable adjustments required.	Green	CPD can record additional needs and reasonable adjustments, and appointment letters sent via hybrid mail include accessibility hub information, but other appointment systems (eg. Soliton or system 1) do not hold this information.	Scope and understand the operational use of Nervecentre as the master patient record as part of Tranche 3 alongside the third party systems such as Soliton.
6. Appointment information at least	Amber	Compliance is difficult to measure because appointments can be communicated by letter, text or telephone. We have used the date that the appointment was booked as a proxy measure for this	Appointment communication cannot currently be measured through one source

<table>
<tr>
<td>21 days in advance - Patients will receive clear information about appointments at least 21 days in advance.</td>
<td></td>
<td>standard and it assumes that we send communication on the date that the appointment is booked.

We have limited the data set to non-cancer referrals as suspected cancer referrals are required to be booked within 14 days.

<table>
<tr><th>Urgency</th><th>More Than 21 Days</th><th>Total</th><th>Proportion</th></tr>
<tr><td>Non-Cancer</td><td>94249</td><td>274252</td><td>34.37%</td></tr>
</table>

This indicates that we are booking high numbers of patients at less than 3 weeks’ notice. This measure will require more analysis as the scope needs to be defined.</td>
<td>Appointments may be communicated by letter, telephone or text. The gap analysis concludes that there is no single measure of whether appointment information has been communicated at least 21 days in advance.</td>
</tr>
<tr>
<td>7. New appointment date within 28 days of cancellation - If an appointment is cancelled by either the patient or provider, a new date will be communicated within 28 days.</td>
<td>Amber</td>
<td>Compliance is difficult to measure as not all cancellations require a further appointment. A data extract may identify cancelled appointments with a further appointment booked, but there is no data link to the cancellation if the appointment is cancelled without immediate rebooking. Therefore, we have looked at appointments on the same referral, which may not be directly linked.

We have used cancellation date and compared to the next appointment date, where a further booking has been made. An assessment of whether this is 28 days or less.</td>
<td>The gap analysis identifies that an extract could be used to measure the time between hospital cancellation and rebooking where a further appointment exists, but there is no link to the cancellation if the appointment is cancelled without immediate rebooking. It is also not possible to confirm if the future booking directly relates to the cancellation.

Suggested actions / mitigations:
• Assess if this functionality will be available in Nerve centre.</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>Sample data includes position on current OP PTL at 11-09-2026

<table>
<tr><th>Appointment Cancellation – OP PTL</th><th>Within 28 Days</th><th>Total</th><th>Proportion</th></tr>
<tr><td>Days to re-booked appt</td><td>3946</td><td>14531</td><td>27.2%</td></tr>
</table>

To note this is focused on appointment date for outpatients within 28 days. This is in place for patients on the admitted waiting list, when cancelled on the day, and the Trust reports against patients who wait longer than 28 days for a new procedure date.</td>
<td></td>
</tr>
<tr>
<td>8. Clear discharge/completion and next steps - Patients will be told when their care is complete and what happens next.</td>
<td>Amber</td>
<td>Discharges are recorded through clinic outcomes and clinic letters, but the position is less clear where patients are discharged outside an outpatient appointment context. We have used the completion of outcomes to estimate how many patients leave clinic with a discharge plan an understanding of the next steps, which will be explained at the appointment.

32.5% of all patients in Quarter 1 left clinic with a discharge plan.

Sample data is for Q1 2026/27

<table>
<tr><th>Clinic Outcome</th><th>Discharged</th><th>Total</th><th>Proportion</th></tr>
<tr><td>Completed</td><td>59660</td><td>183488</td><td>32.5%</td></tr>
</table>
</td>
<td>Discharges are recorded through clinic outcomes and clinic letters, but there is less clarity for discharges outside an outpatient appointment context. The gap analysis also identifies high numbers of open referrals not discharged following completion of care as a possible indicator of process failure.

It is difficult to assess if the patient has been told that their care is complete and what happens next. Although a letter may be sent, we cannot identify the purpose of the letter from the data; ie, we cannot identify a ‘discharge’ letter.

Suggested actions / mitigations; Assess if this functionality will be available in Nerve centre.</td>
</tr>
</table>

6. Proposed Trust Response

The Trust response should include the following actions:

1. Confirm executive ownership for the patient experience standards and reporting route to Executive Committee and Trust Board.
2. Develop a Trust compliance statement for publication during 2026/27, as required by NHS England.
3. Approve the definition of measurable indicators for each standard, including where proxy measures are implemented.
4. Commission baseline audits for standards where routine performance metrics do not currently exist, specifically:
    1. Referral outcome communication within 28 days.
    2. Appointment communication at least 21 days in advance.
    3. Rebooking following cancellation within 28 days.
    4. Confirmation of pathway completion and discharge communication.
5. Develop a Trust-wide approach to publishing waiting well information.
6. Align patient standards work with elective reform programmes, including outpatient transformation, digital access, referral management, Nervecentre development and Single Point of Access work.
7. Review accessible communication arrangement as part of the Accessible Information Standard compliance work.
8. Develop a Trust-wide patient standards dashboard, including agreed indicators, proxy measures, audit requirements, executive ownership and reporting frequencies for all eight standards.
9. Develop a Trust-wide "waiting well" framework, incorporating core information for all patients alongside specialty-specific content where clinically appropriate.
10. Complete a review of accessible communication arrangements to ensure compliance with the Accessible Information Standard, including alternative formats, inserts accompanying correspondence and the recording and use of reasonable adjustment information.
11. Ensure that patient standards requirements are incorporated into relevant transformation programmes, including outpatient reform, Single Point of Access, digital developments, patient communication initiatives and Nervecentre implementation plans.

Assurance Statement

The Trust has completed an initial assessment against the NHS England minimum standards of patient experience for elective care. Current initial assessment shows two standards rated Green and four rated Amber. The Trust has processes in place that support delivery of all standards, including referral communication routes, 12-week waiting list validation, CPD recording of reasonable adjustments, standard letter templates and discharge recording through clinic outcomes.

However, assurance is limited by gaps in data, reporting and audit capability. For several standards, the Trust cannot currently demonstrate compliance through a single routine metric. Further work is required to establish baseline measurement, reduce specialty variation, address accessibility risks and prepare the required 2026/27 Trust compliance statement.

12. Conclusion

The introduction of the NHS England minimum patient experience standards represents a significant shift in the expectations placed on providers to demonstrate not only that appropriate processes exist, but that compliance can be evidenced consistently through reliable measures and governance arrangements. The Trust's initial assessment indicates that elements of all eight standards are already in place, with particular strengths in waiting list validation processes and the recording of reasonable adjustments. However, six of the eight standards are currently rated amber due to limitations in assurance, measurement and the consistency of implementation across services.

The principal risk to the Trust is not the absence of patient communication processes, but the inability to consistently evidence that standards are being achieved across all specialties and patient groups. Variations in pathways, multiple communication methods, inconsistent recording practices and limited reporting functionality reduce the Trust's ability to provide assurance to the Board, patients and regulators. The forthcoming requirement to publish a formal compliance statement during 2026/27 further increases the need for robust measurement, audit and governance arrangements.

Addressing these gaps will require a coordinated approach across outpatient transformation, elective reform, digital programmes, patient administration and specialty services. Establishing a clear framework of metrics, audits and accountability will provide a stronger basis for demonstrating compliance, reducing variation and improving the overall patient experience throughout the elective pathway.

7. Recommendations

The Board is asked to:

5. **Note** the NHS England minimum patient experience standards and the requirement for Trust Boards to assess compliance and publish a formal patient standards statement during 2026/27.
6. **Note** the current baseline assessment, gaps in compliance and evidence reporting limitations.
7. **Note and approve** the proposed Trust response and assurance statement**.**
8. **Receive** a further progress update within six months, including revised compliance assessments, audit findings, key risks, mitigating actions and readiness for publication of the Trust's 2026/27 patient standards compliance statement.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 14

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Care Quality Commission (CQC) Update
Director Sponsor:	Joseph Hague, Chief Nurse Adele Coulthard, Director of Quality, Improvement and Patient Safety
Author:	Emma Shippey, Head of Compliance and Assurance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The Trust has undergone significant CQC activity across multiple services since October 2025. This includes the recent unannounced inspection at the Harrogate Renal Unit in September 2026. The inspection reports for Maternity Services were published on 3 September 2026.

Recommendation:

- Note the current position regarding the recent CQC inspection activity.
- Note the current position of the open CQC cases

CQC Update

1. CQC Activity - Updates

1.1 York and Scarborough Hospital Inspection of Harrogate Renal Unit (September 2026)

A Care Quality Commission (CQC) team inspected the Harrogate Renal Unit on Tuesday 1 September 2026. This was part of the CQC's routine inspection programme and was not undertaken in response to specific concerns.

At the time of writing the report, a request for supporting evidence is expected shortly.

1.2 York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER) Inspection : Breast Screening Programme (June 2026)

The CQC conducted an onsite inspection of the Breast Screening Programme at York Hospital on 24 June 2026 as part of its Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) programme.

There were no enforcement actions but three recommendations included in the report for which an action plan was requested by 27 August 2026. The IRMER inspector reviewed the plan and asked for additional detail to be provided by 16 September 2026.

1.3 York and Scarborough Hospital Inspection of Easingwold Renal Unit (May 2026)

A CQC inspection team inspected the Easingwold Renal Unit on Tuesday 19 May 2026. This was part of the CQC's routine inspection programme and was not undertaken in response to specific concerns.

The draft CQC inspection report has been received and a factual accuracy response was provided by the deadline of 27 August 2026.

1.4 York and Scarborough Hospital Inspection of Maternity Services (April 2026)

The CQC inspection team attended York Hospital on 14 and 15 April, and Scarborough Hospital on 16 and 17 April. The inspection formed part of a planned re-assessment following the 2023 inspection, during which services were rated as inadequate.

The final reports were published on 3 September 2026 with a rating of good provided for the York and Scarborough Hospital Maternity services. The reports can be viewed using the following links Scarborough Hospital and York Hospital

A response to the breaches in regulation identified in the report must be provided to the CQC by 18 September 2026.

2. CQC Activity - Ongoing

2.1 York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER) Inspection : Nuclear Medicine (January 2026)

The CQC conducted an onsite inspection of Nuclear Medicine at York Hospital on 28 January 2026 as part of its proactive Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) programme.

No breaches of IR(ME)R 2017 were identified that met the threshold for regulatory action; however, two recommendations were made. IRMER reports are not published on the CQC website.

2.2 Scarborough Hospital Inspection of Urgent and Emergency Care and Medical Care (October 2025)

There was an unannounced CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital between 7 and 9 October 2025. The final report was published on 20 March 2026 click here to view.

An update on progress with the agreed actions was considered at the Executive Committee on 19th August 2026. It was agreed that a quarterly paper will be presented going forwards.

2.3 York Hospital Inspection of Urgent and Emergency Care and Medical Care (January 2025)

In response to the CQC inspection report published on 2 July 2025 (click here to view), the CQC have asked for quarterly updates on progress with actions to be provided, the first of which was sent in November 2025.

There were six breaches to regulation identified in the report. Updates on progress are made at the quarterly engagement meetings.

An update on progress with the agreed actions was considered at the Executive Committee on 19th August 2026. It was agreed that a quarterly paper will be presented going forwards.

2.4 Section 31: Care and Assessment of Patients with Mental Health Needs in the Emergency Department

An application to remove the conditions has been drafted with approval scheduled through the Executive Committee on 5 August 2026. This has been submitted to the CQC.

3. Ongoing CQC Engagement

Quarterly engagement meetings are planned with our CQC colleagues and a workplan for 2026 has been developed.

The onsite visit for Surgery has been rearranged for 20 October 2026. The visit will focus of the fractured neck of femur pathway. An engagement meeting will also take place on the same day along with an update on the introduction of Nervecentre.

4. CQC Cases / Enquiries

The CQC receive information from a variety of sources in relation to the quality of care provided at the Trust. This information can be related to known events, for example patient safety incidents (PSI's), formal complaints and Datix incidents, or unknown events, such as concerns submitted directly to the CQC from either patients, staff, members of the public, or other organisations. Following receipt of such information, the CQC share the concerns with the Trust for review, investigation, and response. The CQC monitor themes and trends of enquiries received, and these can inform inspection and other regulatory activity.

As of 28 August 2026, there are 22 open CQC cases. Nine cases have had responses submitted, and we are awaiting feedback from the CQC. Two further cases have been partly responded to. One further case has been closed / put on hold by the CQC pending receipt of the structured judgement case review investigation.

5. CQC Updates / Local Inspections

5.1 Local Inspections

- **Calderdale Royal Hospital published 11th August 2026 – Urgent and Emergency Care – Requires Improvement**

  The Care Quality Commission (CQC) has downgraded the rating of urgent and emergency at Calderdale Royal Hospital, run by Calderdale and Huddersfield NHS Foundation Trust, from good to requires improvement. The report can be found here: Calderdale Royal Hospital - Care Quality Commission

  The CQC found that staff in urgent and emergency care at Calderdale Royal Hospital were compassionate and working hard under significant pressure, but staffing shortages were affecting the service's ability to provide consistently safe and timely care. Patients experienced long waits, including delays in receiving pain relief, basic care needs, and specialist reviews, with some waiting more than 24 hours in A&E. The inspection identified concerns around patient flow, delays in medical reviews, and inconsistent completion of falls and bed rail risk assessments, creating potential safety risks. Positively leaders recognised the need to strengthen responses to deteriorating patients and were working on an electronic monitoring system which reminds staff when observations are required.

  Inspectors found:

- Leaders must ensure rooms used for people experiencing mental health difficulties are safer. Some had ligature risks and contained fixtures or items which could be used for self-harm.
- Inspectors observed visitors being allowed into the paediatric emergency department without security checks about their reason for attending. This meant people could enter inappropriately, increasing the risk to children and their families.
- Several staff raised concerns about the remoteness of the SDEC (same day emergency care) unit because there were no emergency call bells and staff said they felt isolated from the main department.

- Staff did not always ensure people were given their medicines at the right time. This included time critical medicines such as those for the treatment of Parkinson's Disease.
- Staff did not always ensure infection prevention measures were followed in the department.
- Managers ensured support was available to staff after a difficult event or incident, and staff said they felt supported by leaders and colleagues.
- Staff identified and recorded people's cultural needs, such as language and dietary requirements, and aimed to meet these needs.

Tees, Esk and Wear Valley published 7th August 2026 - Specialist community mental health services for children and young people - Good

The report can be found here**:** **Tees, Esk and Wear Valleys NHS Foundation Trust - Care Quality Commission**

The CQC found significant improvements in children and young people's mental health services, with staff going above and beyond to ensure children and young people were receiving a good level of care and making young people feel listened to, supported and safe. Families and carers reported positive experiences, and improvements to referral pathways and continuity of care meant young people were being seen more quickly by the most appropriate teams. Waiting times remained high but were better than the national average, with staff actively monitoring and responding to escalating risks. However, concerns remained regarding the quality of some risk assessments, which did not always include clear risk management or contingency plans. Overall, the CQC recognised the positive progress made by leaders and staff while highlighting the need for further improvements to ensure safety and sustain the gains achieved.

Inspectors found:

- The service managed safety incidents well and carried out thorough investigations to identify any learning and improvements.
- Staff understood how to protect young people from abuse and the service worked well with other agencies to do so.
- Clinicians had a good understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA) meaning they could support people well.
- Managers were supportive of staff and valued their teams and the work they were doing.
- Leaders used feedback to make improvements to services to meet the needs of people in their local communities.
- The trust had Getting Help teams, Getting More Help teams and a CAMHS (Children and Adolescent Mental Health Services) Crisis Team which were closely interlinked to ensure young people were directed to the most appropriate service to meet their needs and level of risk.
- Some staff felt that service pressures had a negative effect on staff well-being, however this did not affect the care given to young people.

5.2 Updates from the CQC

- **CQC Inpatient Survey 2025 Published 26th August 2026**

An update on this report is being considered at the Patient Experience Committee on 9th September. The report is available here Adult inpatient survey 2025 - Care Quality Commission

The CQC have advised that the annual adult inpatient survey shows encouraging improvements in patients' experiences of hospital care, with many people reporting more positive interactions with staff and greater involvement in decisions about their treatment. Most respondents said they were treated with dignity, kindness and compassion, while confidence and trust in doctors and nurses remained high. More patients also felt able to discuss worries and fears with staff and reported that sufficient nursing support was available.

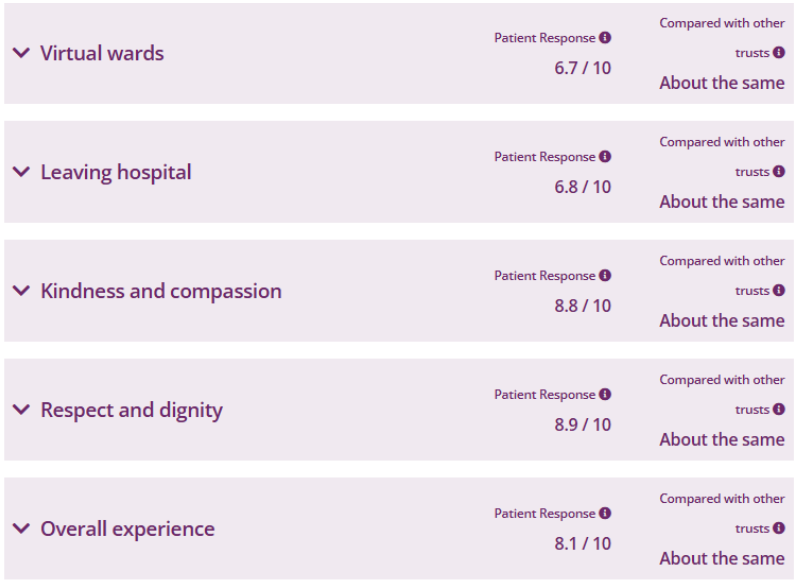
However, the findings also highlight areas where improvement is still needed. Delays to admission remain a concern, with many patients reporting long waits and a deterioration in their health while waiting for treatment. Discharge planning and post-hospital support continue to be challenging, with around a quarter of respondents saying they did not receive enough support after leaving hospital. People living with frailty, disabilities and certain long-term conditions consistently reported poorer experiences, underlining the need for more personalised and equitable care.

York and Scarborough Teaching Hospitals NHS Foundation Trust

Specific figures for York and Scarborough Teaching hospitals NHS Foundation Trust are available here.

Responses were received from 503 people at York and Scarborough Teaching Hospitals NHS Foundation Trust. The key findings are below:

	Patient Response	Compared with other trusts
Admission to hospital	6.9 / 10	About the same
The hospital and ward	7.3 / 10	About the same
Basic needs	8.2 / 10	About the same
Doctors	9.0 / 10	About the same
Nurses	8.4 / 10	About the same
Care and treatment	8.2 / 10	About the same
Individual needs	7.7 / 10	About the same



Date: 1 September 2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board of Directors
Date of Meeting:	30 September 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Joseph Hague Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

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Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team. The report provided oversight of the performance and quality metrics for the months of June and July 2026, and data for August 2026 for workforce, unit diverts and homebirth service provision. There was no Trust Board in August 2026.

Key Assurance

- Three of five perinatal mortality reviews considered in July were completed and closed; outstanding reviews are progressing through approval, alignment and family-sharing processes.
- Investment and recruitment continue to strengthen the workforce, including £200,000 of non-recurrent funding to support 20 newly qualified midwives.
- Both August maternity unit diverts were followed up to confirm outcomes and appropriate ongoing care arrangements.

Key Risks

- Maternity Incentive Scheme training requirements are forecast to be achieved, supported by monthly training opportunities and targeted follow-up of outstanding staff, however some risks to achieving 90% in anaesthetic and neonatal doctors. PROMPT training compliance for anaesthetic colleagues at York is below target and depends on validation of the labour ward rota and prioritised attendance by the remaining staff.
- Twenty incidents were graded moderate harm or above in August 2026 and require continued thematic review, action tracking and assurance through governance routes.

Key Concerns

- Homebirth provision remained constrained in August: no area achieved continuous 24-hour cover, three homebirths were not supported because of staffing, and independent midwifery support was required for one case.
- Although active recruitment is underway, substantive and roster gaps, sickness, maternity leave and supernumerary requirements continue to create reliance on temporary staffing and pressure on service resilience.

Recommendation:
The Board is asked to receive the updates from the Maternity and Neonatal Service.

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation

Introduction

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, to inform the Trust Board of key areas of improvement to enhance safe maternity care and identify any present or emerging safety concerns and actions required or taken to address them.

The Maternity and Neonatal Services continue to review and monitor improvements in key quality and safety metrics, and this paper provides the Trust Board with the performance and quality metrics for the months of June and July 2026, and data for August 2026 for workforce, unit diverts and homebirth service provision.

Annex 1 provides the current delivery position for the service against the core national safety metrics.

Perinatal Quality Oversight Model

The introduction of the Perinatal Quality Oversight Model (PQOM) provides enhanced oversight of key performance indicators, patient outcomes, safety concerns, and improvement actions, enabling earlier identification of risks and more robust escalation processes. In line with PQOM, the Service is required to report the information outlined in the data measures monthly to the Trust Board and to NHS England quarterly (a national return was submitted to NHSE in July 2026, with the last reported position to Trust Board in June 2026).

Perinatal Deaths

There were two Trust reported neonatal deaths in June 2026 (meeting MBRRACE-UK reporting criteria). There were no trust reportable cases for July 2026.

There were no neonatal deaths in June and three in July that delivered at York and Scarborough but were subsequently transferred to another hospital.

The Perinatal Mortality Review Tool (PMRT) applies a standardised grade to each relevant phase of care. Grade A indicates that there were no issues with care; Grade B identifies issues that would have made no difference to the outcome; Grade C identifies issues that may have made a difference to the outcome; and Grade D identifies issues that were likely to have made a difference to the outcome. Grading is agreed through multidisciplinary review and supports transparent reporting, identification of learning and development of proportionate improvement actions.

There were five reviews of perinatal deaths undertaken at the perinatal mortality meeting in July 2026. Three reviews were completed and closed. The other two reviews continue.

Annual rolling mortality data is shown in Appendix 1

Maternity and Newborn Safety Investigations (MNSI)

There was one case referred to MNSI in June 2026. There is currently one ongoing MNSI case being investigated.

A finalised MNSI investigation report has been received. A full review will now take place with the relevant multidisciplinary teams to implement the actions required. The agreed actions and delivery arrangements will be shared through Directorate and Care Group governance in October 2026.

Moderate Harm Incidents and above

There were 7 incidents graded moderate or above in June 2026 and 21 incidents graded moderate harm or above in July 2026

Red flags

There were 0 red flags as per NICE guidance reported in June and 6 reported in July 2026. All red flag incidents are reviewed for learning. Themes were:

- 2 were delays to planned Caesarean birth due to issues with transfusion samples,
- 2 were delays in induction of labour due to ward acuity,
- 1 delay in epidural due to anaesthetic availability.
- 1 for delay in LSCS due to acuity.

Maternity Unit diverts/ closures and suspension of services

In August there was one divert from Scarborough and one from York. 5 women were affected in the period of divert and all women were followed up to ascertain outcome and ensure appropriate follow up plans were in place.

Provision of the homebirth service is shown in the table below:

August 2026	East Coast	York and Selby
24hours Homebirth Service Provision Partial night cover either Team A or Team B Day service	0 6 13 (at least 3 PNV working)	0 2 3 (at least 3 Earlies)
Number Homebirth completed by Community midwives	0	0
Number of attendances at home with transfer in (with reason)	0	0
Number of homebirths not supported due to staffing	2	1
Number of Homebirths where independent midwives have been engaged to provide service	0	1
Born Before Arrival (booked homebirth only)	0	0
Free Labour/Birth due to Homebirth services not available	0	0

Triage Audit Compliance

Continue to monitor compliance on a weekly basis for triage assessment and wait times. All cases where waiting is longer than 30mins are Datix and investigated with learning shared. Twilight shifts now rostered and good pick up from staff enhancing the workforce. There has been introduction of 2nd midwife shift on a long day in SGH along with Night shift to provide 24/7 telephone triage cover.

A dedicated Triage OPEL score is being developed to support timely escalation and operational oversight. The triage telephone system is also being upgraded to improve monitoring of access times and strengthen documentation through call recording capabilities.

Benchmarking exercise has taken place using the new National Maternity Triage Specification and NHS England assessment tool.

Red Flags at SGH have significantly decreased to 2.80%

Red Flags at York have significantly decreased to 5%

Midwifery Workforce

The midwifery and maternity support workforce continue to grow with active recruitment underway to fill the roles vacant following the investment on the 1st April 2026.

NHS England has approved the Trust's Expression of Interest under the Midwifery Graduate Support Offer 2026/27, providing £200,000 of non-recurrent funding to support the recruitment and early-career development of 20 newly qualified midwives. The national team will issue further information on the Memorandum of Understanding, purchase orders and funding arrangements, with regional reporting requirements and timelines to follow.

The table below shows the funded establishment vacancy variance to staff in post (substantive vacancy) for roles Band 3 to 6, which is predominantly frontline roles. The recruitment vacancy takes account of maternity leave cover that is agreed to be backfilled at 100% and recruited to on top of the establishment budget. The table also shows other unavailability of staff due sickness and supernumerary hours, including the maternity leave and substantive vacancy position (roster vacancy) to give a true reflection of the unavailable cover. Other unavailability is covered using bank shifts first and then if unable to meet safe staffing levels midwives from an agency. Due to an increase in investment and following recruitment, we expect to see a reduction in bank/agency use.

August 2026 Band 6 to 3 midwifery vacancy and recruitment position:

	Band 5/6	Band 3/4
Establishment budget	174.61 WTE	42.96 WTE
Staff in post	161.96 WTE (of which 25.53 WTE are band 5)	42.25WTE
Substantive Vacancy	12.65 WTE	0.71 WTE
Maternity Leave	8.08 WTE (4.76 WTE York & 3.32 WTE Scarborough)	1.59 WTE (0.59 WTE York & 1.00 WTE Scarborough)
Recruitment vacancy	20.73	2.30
Supernumerary	5.21 WTE	
Sickness	9.44 WTE	
Roster vacancy	35.38	

Training and development

Compliance with training requirements for MIS is on track to be met. All staff who are yet to complete training are booked to attend, and there are monthly training opportunities across both sites. The following shows a breakdown of training compliance as of July 2026. Whilst some staff groups are currently short of the required 90% requirement, projections for August and September are showing compliance will be met across maternity. This is subject to planned attendance and follow through and is being closely monitored.

Neonatal resuscitation training for medical staff is above required compliance at York, with final figures to be confirmed for Scarborough. Projections show that nurses and midwives will likely meet the 90% target.

The main risk is for anesthetic colleagues training on PROMPT. Work has been taking place to obtain an up-to-date register of those doctors working on the Labour Ward Rota so that compliance data can be validated. For York compliance is below target, but the numbers of staff to be trained are relatively low and work is ongoing to priortise these individuals.

Fetal Monitoring

Staff Group	Jul-26
Midwives	87% (233/269)
Obstetric Consultants/SAS Doctors	96% (25/26)
Obstetric Tier 2 (Reg/ST)	95% (20/21)

MDT Emergency Training

Staff Group	Jul-26
Midwives	93% (249/267)
Obstetric Consultants/SAS Doctors	88% (23/26)
Obstetric Tier 2 (Reg/ST)	81% (21
Obstetric Tier 1 (F2/GP Trainees/SHO)	81% (13/16)
Anaesthetic Consultants	TBC
Obstetric Anaesthetic Doctors	TBC
MSWs (24)	85% (53/62)

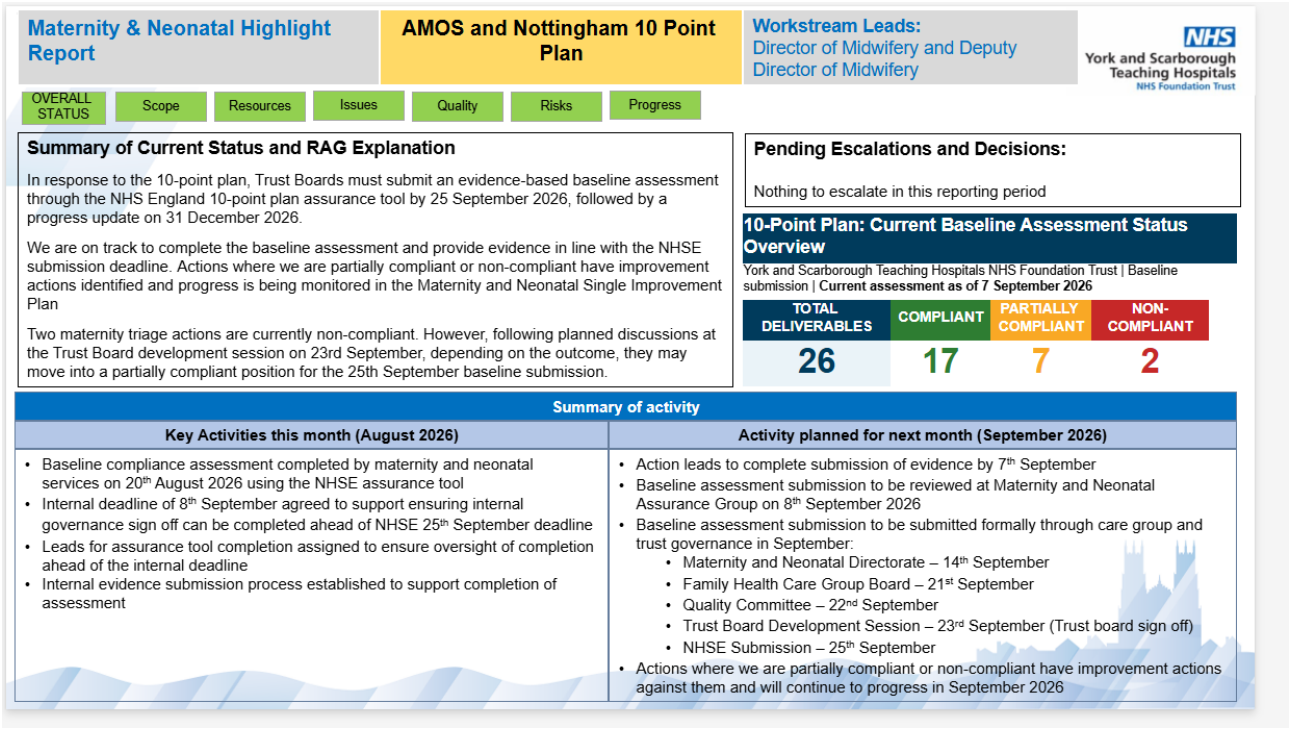
Neonatal Resuscitation Training

Staff Group	Jul-26
Midwives	87% (233/267)
Neonatal/Paediatric Consultants/SAS Doctors	TBC
Neonatal Tier 2 (Resident Doctors who attend any births)	TBC
Neonatal Tier 1 (who attend any births)	TBC
Neonatal Nurses (Band 5+)	85%

Improvement and Transformation

Following agreement of the Board, the Single Improvement Plan work has been paused with the Maternity and Neonatal Oversight Group having a specific focus on the actions which relate to the delivery of:

- The 10-Point Plan following the AMOS and Nottingham Report
- Saving Babies' Lives Care Bundle Version 3.2
- The Maternal Care Bundle requirements
- Maternity Incentive Scheme (MIS) Year 8



Maternity & Neonatal Highlight Report	AMOS and Nottingham 10 Point Plan	Workstream Leads: Director of Midwifery and Deputy Director of Midwifery

York and Scarborough Teaching Hospitals NHS Foundation Trust

OVERALL STATUS	Scope	Resources	Issues	Quality	Risks	Progress

Summary of Current Status and RAG Explanation

In response to the 10-point plan, Trust Boards must submit an evidence-based baseline assessment through the NHS England 10-point plan assurance tool by 25 September 2026, followed by a progress update on 31 December 2026.

We are on track to complete the baseline assessment and provide evidence in line with the NHSE submission deadline. Actions where we are partially compliant or non-compliant have improvement actions identified and progress is being monitored in the Maternity and Neonatal Single Improvement Plan

Two maternity triage actions are currently non-compliant. However, following planned discussions at the Trust Board development session on 23rd September, depending on the outcome, they may move into a partially compliant position for the 25th September baseline submission.

Pending Escalations and Decisions:

Nothing to escalate in this reporting period

10-Point Plan: Current Baseline Assessment Status Overview

York and Scarborough Teaching Hospitals NHS Foundation Trust | Baseline submission | **Current assessment as of 7 September 2026**

TOTAL DELIVERABLES	COMPLIANT	PARTIALLY COMPLIANT	NON-COMPLIANT
26	17	7	2

Summary of activity

Key Activities this month (August 2026)	Activity planned for next month (September 2026)
• Baseline compliance assessment completed by maternity and neonatal services on 20th August 2026 using the NHSE assurance tool • Internal deadline of 8th September agreed to support ensuring internal governance sign off can be completed ahead of NHSE 25th September deadline • Leads for assurance tool completion assigned to ensure oversight of completion ahead of the internal deadline • Internal evidence submission process established to support completion of assessment	• Action leads to complete submission of evidence by 7th September • Baseline assessment submission to be reviewed at Maternity and Neonatal Assurance Group on 8th September 2026 • Baseline assessment submission to be submitted formally through care group and trust governance in September: • Maternity and Neonatal Directorate – 14th September • Family Health Care Group Board – 21st September • Quality Committee – 22nd September • Trust Board Development Session – 23rd September (Trust board sign off) • NHSE Submission – 25th September • Actions where we are partially compliant or non-compliant have improvement actions against them and will continue to progress in September 2026

Separate updates in the board papers are provided on each of these areas.

Key Risks to Delivery of the Single Improvement Plan

The risks to delivery of the MNSIP have been reviewed and scores updated

Risk title	Risk Description	Risk score
Risk of timeline delays impacting overall programme delivery	There is a risk that key programme actions may not be completed within planned timelines due to factors such as interdependencies with other services, delayed decision-making, delayed governance processes, resource constraints, extended stakeholder reviews, or unforeseen operational pressures. These delays can cause slippage across key milestones, affecting the ability to meet overall delivery timelines.	12 *Impact: High* *Likelihood: Medium*
Insufficient investment to support programme and project delivery	There is a risk that the Maternity & Neonatal Service will not receive the required financial investment, resource uplift, or capital funding needed to progress key improvement plan actions	16 *Impact: High* *Likelihood: High*
Expansion of programme scope	There is a risk that the programme's scope expands beyond what was originally agreed, due to informal requests, evolving expectations, national context or pressure from stakeholders to include additional work.	16 *Impact: High* *Likelihood: High*
Loss of key staff impacting programme delivery	There is a risk that key members of the programme leadership team (SRO's, Workstream leads, subject matter experts, programme team, MNVP etc.) may: leave the organisation, move roles, be reallocated to support alternative programmes of work or may not have an identified recurrent funding source. Loss of key staff may lead to gaps in expertise, reduced institutional knowledge, delays in decision making and reduced programme level strategic oversight which will decrease programme momentum.	16 *Impact: High* *Likelihood: High*
Insufficient resources, skills, tools and over reliance on third parties	There is a risk that the programme will be unable to deliver key actions due to limited internal capacity, shortages of specialist skills, lack of access to required tools or systems, and a dependency on third parties (e.g. contractors, suppliers, business intelligence and partner organisations)	16 *Impact: High* *Likelihood: High*

Recommendations to Trust Board

To note the contents of this report

Date: September 2026

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

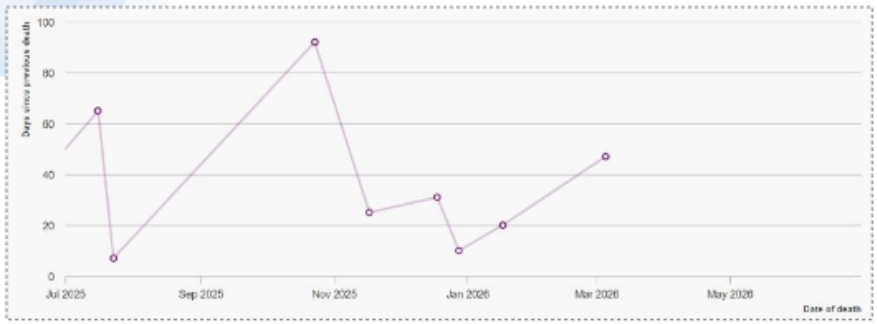
Maternity Quality and Safety Metrics

July 2026 data

(due to the earlier date of the meeting not all data sources are available.)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Stillbirths – July 2026



KEY MESSAGE

- Trust stillbirth rate – 2.84/1000 births, this is around average for similar Trusts
- Trust neonatal mortality rate –1.1 /1000 births, this average for similar Trusts
- Trust perinatal mortality rate –3.95 /1000 births, this is around average for similar Trusts

There have been no stillbirths (meeting MBRRACE-UK reporting criteria) since April 2026

ACTION

All early neonatal deaths and stillbirths are reviewed using the Perinatal Mortality Review Tool and are presented at the monthly Perinatal Mortality Meeting.

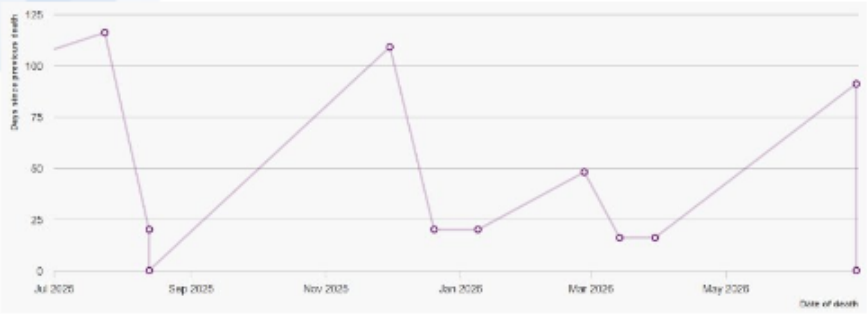
ASSURANCE

A quarterly PMRT report and action plan is presented at private Board. These will provide details of themes and trends and provide assurance around actions taken.
Where the criteria is met, all stillbirth and early neonatal deaths are reported to MNSI for external investigation.

Data: MBRRACE-UK

Neonatal Deaths – July 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust



KEY MESSAGE

- There were two neonatal deaths (meeting MBRRACE-UK reporting criteria) in June 2026. There were no trust reportable cases for July 2026.

Data: MBRRACE-UK

ACTION

All early neonatal deaths and stillbirths are reviewed using the Perinatal Mortality Review Tool and are presented at the monthly Perinatal Mortality Meeting.

ASSURANCE

A quarterly PMRT report and action plan is presented at private Board. These will provide details of themes and trends and provide assurance around actions taken.
Where the criteria is met, all stillbirth and early neonatal deaths are reported to MNSI for external investigation.

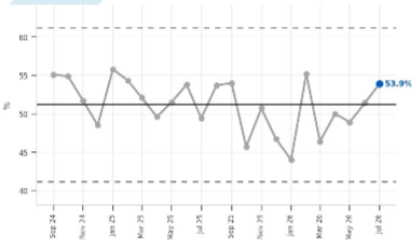
Data: MBRRACE-UK

Dashboard Summary - York

Birth mode measures | Main SPC charts

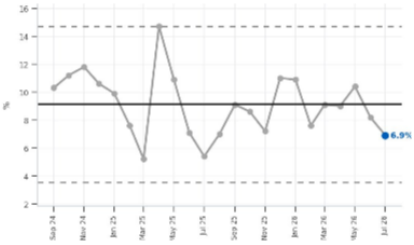
York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal Births — LATEST 53.9%



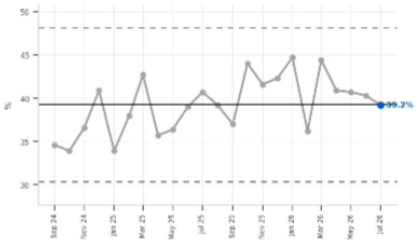
Mean 51.2% — Within Expected Variation

Assisted Vaginal Births — LATEST 6.9%



Mean 9.1% — Within Expected Variation

Caesarean Births — LATEST 39.2%



Mean 39.3% — Within Expected Variation

KEY MESSAGE

All three birth mode measures are currently within the expected process limits. Assisted vaginal births previously showed a sustained lower run during 2025, but more recent results have returned towards the process average.

ACTION

- Continue routine monthly monitoring

ASSURANCE

Normal and caesarean birth measures remain stable. The earlier assisted birth pattern should be understood in context, although the latest result remains within expected limits.

Dashboard Summary - Scarborough

Birth mode measures | Main SPC charts

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Normal Births

LATEST
41.0%



Mean 46.7%

Within Expected Variation

Assisted Vaginal Births

LATEST
5.7%



Mean 7.4%

Within Expected Variation

Caesarean Births

LATEST
53.3%



Mean 45.7%

Within Expected Variation

KEY MESSAGE

All three birth mode measures are fluctuating within the expected range. No unusual change is identified.

ACTION

- Continue routine monthly monitoring
- No immediate corrective action required
- Review if an unusual pattern emerges

ASSURANCE

Local SPC indicates stable processes across the three birth mode measures. Continue to review national benchmarking alongside local performance.

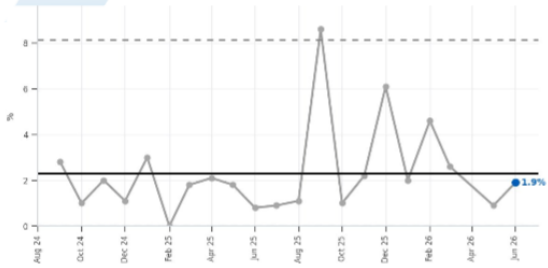
PPH ≥1500mls

Postpartum haemorrhage over 1.5 litres | Main SPC charts

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Scarborough

LATEST
1.9%

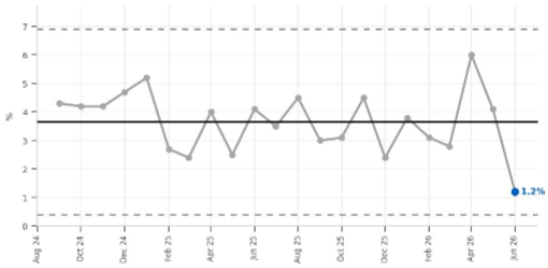


Mean 2.3%

Within Expected Variation

York

LATEST
1.2%



Mean 3.7%

Within Expected Variation

KEY MESSAGE

Latest PPH >1500ml rates are within expected variation at both sites: 1.9% in Scarborough and 1.2% in York. Scarborough recorded one unusually high point in September 2025; subsequent results returned within expected limits.

ACTION

- Continue routine monthly monitoring and reporting
- Continue review of all PPH >1500ml cases
- Review if a further unusual pattern emerges

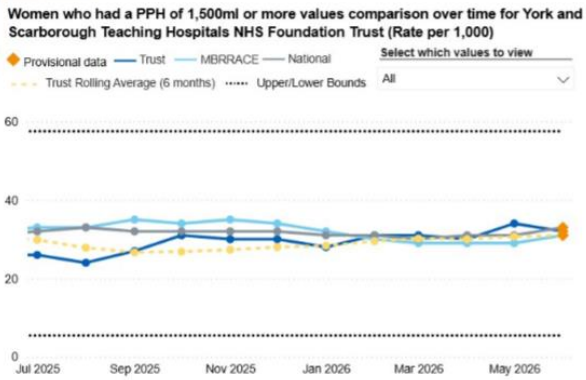
ASSURANCE

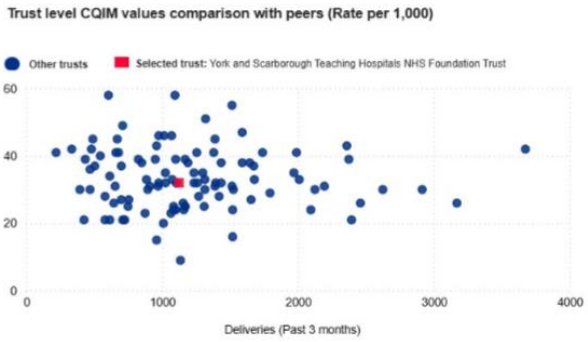
All PPH >1500ml cases are reviewed through the multidisciplinary Maternity Case Review process. Local SPC should continue to be considered alongside case-level review and national benchmarking.

PPH >1500mls National digital dashboard

The latest data available as at August is Provisional June 2026 data

York and Scarborough Teaching Hospitals NHS Foundation Trust





Summary:

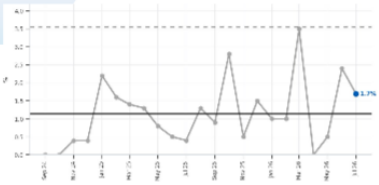
The national maternity dashboard demonstrates the Trust (rate 32/1000 births) is not an outlier compared to all Trusts in England (national rate 33/1000 births / MBRRACE rate 31/1000 births). This data is sources from the national Maternity Data Set which is published monthly and shows a comparison position against other trusts and locally held data.

3rd/4th Degree Tears - York

Severe perineal trauma | Main SPC charts

York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal births

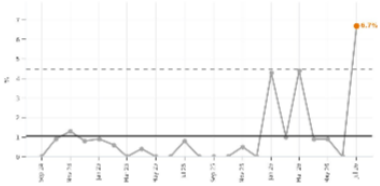


LATEST

1.7%

Mean 1.1%

Assisted births



LATEST

6.7%

Mean 1.1%

KEY MESSAGE

Normal-birth tears remain within expected variation at 1.7%. Assisted-birth tears increased to 6.7% in July 2026, above the upper process limit and indicating special-cause concern.

ACTION

- Validate the July 2026 numerator and denominator data
- Undertake multidisciplinary review of the assisted-birth tear cases
- Report findings and any actions through maternity governance

ASSURANCE

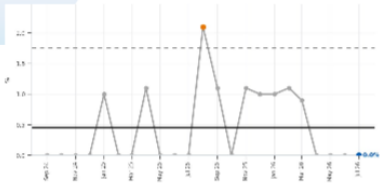
Normal-birth performance remains statistically stable. Existing case-review arrangements remain in place, and continued monthly SPC monitoring will determine whether the July assisted-birth result is isolated or sustained.

3rd/4th Degree Tears - Scarborough

Severe perineal trauma | Main SPC charts

York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal births

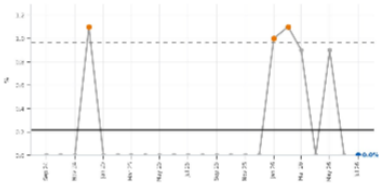


LATEST

0.0%

Mean 0.5%

Assisted births



LATEST

0.0%

Mean 0.2%

KEY MESSAGE

Latest severe perineal tear rates are 0.0% for both normal and assisted births. Both SPC charts show expected variation, with no current special-cause concern.

ACTION

- Continue routine monthly monitoring and reporting
- Continue multidisciplinary review of all 3rd/4th degree tears
- Review if a further unusual pattern emerges

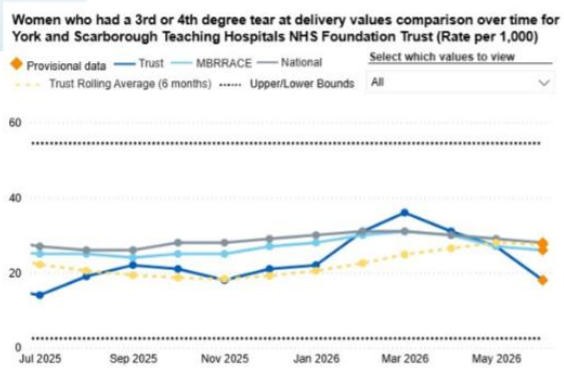
ASSURANCE

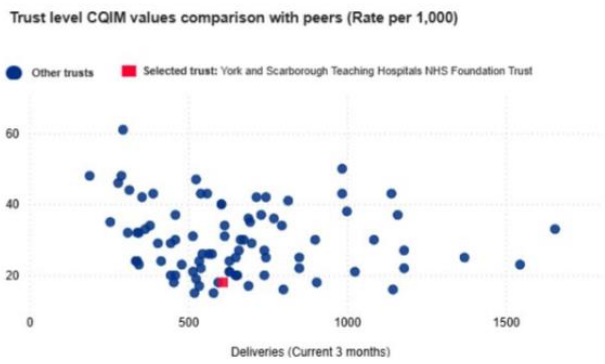
All 3rd/4th degree tear cases continue to be reviewed through established maternity governance processes. SPC should be interpreted alongside case-level review,
activity volumes and national benchmarking.

National digital dashboard 3rd/4th degree tears from all births

York and Scarborough Teaching Hospitals NHS Foundation Trust

The latest data available as at August is Provisional June 2026 data

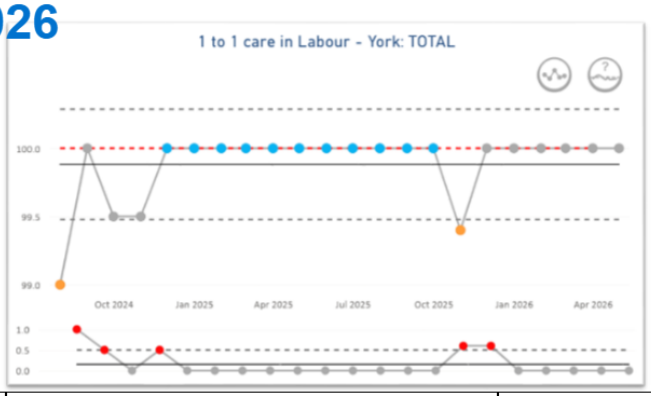




Summary:

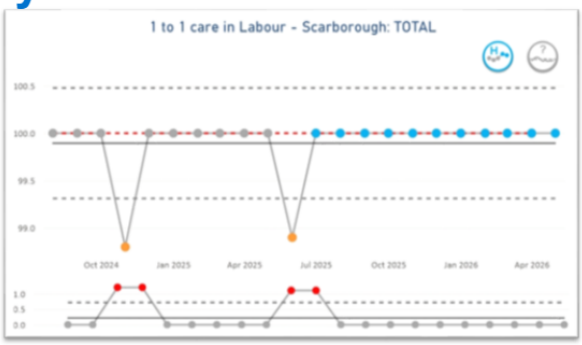
The national maternity dashboard demonstrates the Trust (monthly rate 18/1000 births – 27.5/1000 births for rolling 6 months) is not an outlier compared to all Trusts in England (national monthly rate 28/1000 births / MBRRACE rate 26/1000 births). This data is sources from the national Maternity Data Set which is published monthly and shows a comparison position against other trusts and locally held data.

Dashboard 1:1 Care in Labour – York July 2026



Summary:	Action:	Assurance:
The local SPC charts show common cause variation for births and a special cause for improvement for 1:1 care in labour. The data is extracted from Signal	There is a review of the Maternity Escalation Policy and acuity tools in place. Specialist Midwives, Managers and Matrons are deployed to work clinically when 1:1 care cannot be provided.	In the event 1:1 care cannot be maintained an incident is completed and review of the staffing and acuity is undertaken.

Dashboard 1:1 Care in Labour – Scarborough July 2026

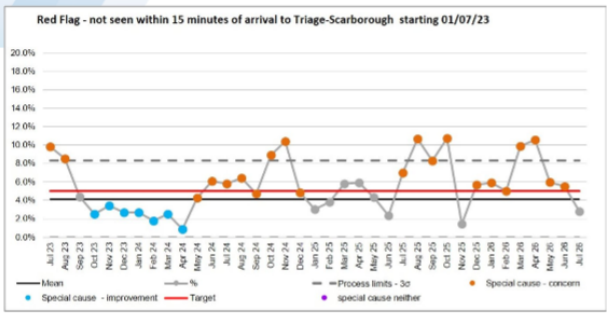


Summary:	Action:	Assurance:
The local SPC charts show common cause variation for births and 1:1 care in labour The data is extracted from Signal	There is a review of the Maternity Escalation Policy and acuity tools in place. Specialist Midwives, Managers and Matrons are deployed to work clinically when 1:1 care cannot be provided.	The data demonstrates 1:1 care has been maintained at the Scarborough site since June 2025. In the event 1:1 care cannot be maintained an incident is completed and review of the staffing and acuity is undertaken.

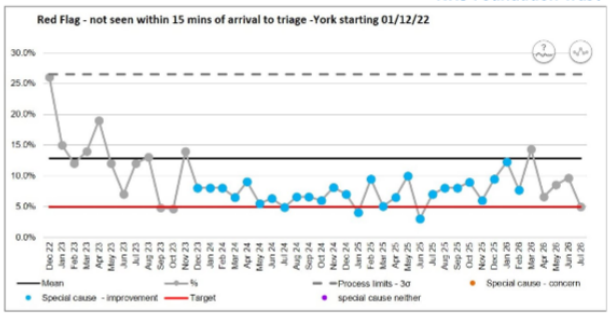
Maternity Triage

York and Scarborough Teaching Hospitals NHS Foundation Trust

Scarborough



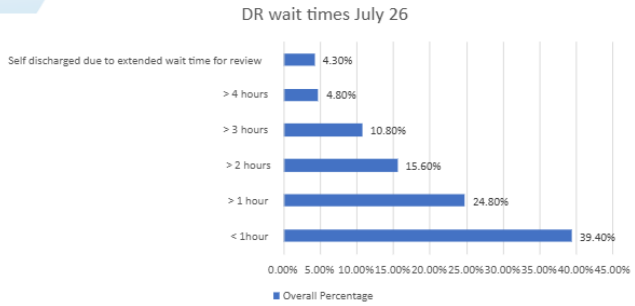
York



Summary:	Actions:	Assurance:
• Red Flags at SGH have significantly decreased to **2.80%** • Red Flags at York have significantly decreased to **5%** Due to increased staffing with investment (staffed by Bank until recruitment has taken place)	• Considering the introduction of a Triage specific OPEL score to allow timely and appropriate escalation • Telephone line being upgraded – collaborative working commenced with IT • Benchmarking exercise has taken place to review and action new National Recommendations.	• Continue to monitor compliance on a weekly basis • Datix and investigate those waiting longer than 30mins • Twilight shifts now rostered and good pick up from staff enhancing the workforce. • Introduction of 2nd midwife shift on a long day in SGH along with Night shift to provide 24/7 telephone triage cover

Medical Review Wait times – York

York and Scarborough Teaching Hospitals NHS Foundation Trust



Focus on:

- Securing a dedicated DR working in MTU.

Findings:

- 19.9% of attendances waited over 3hrs for review or self-discharged due to long wait times.

Action:

- Continue with audit and introduce audit for SGH.
- Benchmark alongside CLO (consultant lead for MTU) against National Maternity Triage Specification.

Report to:	Trust Board
Date of Meeting:	30 September 2026
Subject:	Maternity and Neonatal 10 Point Plan baseline assessment
Director Sponsor:	Sascha Wells-munro - Director of Midwifery and Strategic Lead for Family Health
Author:	Georgina Rowe – Project Manager

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

Approve ☒ Discuss ☒ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The Maternity and Neonatal 10 Point Plan is a national NHS England requirement, developed in response to the urgent findings of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at Nottingham University Hospitals NHS Trust. Sir Jim Mackey, Chief Executive of NHS England, set out the expectation that trusts and the wider system should prioritise these immediate actions while the National Maternity and Neonatal Taskforce develops a comprehensive national action plan.

NHS England subsequently issued the national assurance process requiring every provider Trust Board to approve and submit an evidence-based baseline assessment using the standardised 10 Point Plan assurance tool by 25 September 2026, followed by a progress update by 31 December 2026.

The Trust has completed its baseline assessment and reviewed the supporting evidence through the Maternity and Neonatal Directorate, Family Health Care Group Board and Quality Committee during September 2026. Areas assessed as partially compliant or non-compliant have defined improvement actions, which are being monitored through the Maternity and Neonatal Single Improvement Plan. A final position update will be presented to Trust Board ahead of the national progress submission on 31 December 2026.

Recommendation:
Trust Board is asked to review and approve the completed assurance tool and supporting evidence for submission to NHS England by 25 September 2026.

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity Directorate Meeting	14/9/26	Share with Family Health Care Group Board
Family Health Care Group Board	21/9/26	Share with Quality Committee/Trust Board
Quality Committee	22/9/26	

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 15.2

Report to:	Trust Board
Date of Meeting:	30 September 2026
Subject:	Maternity and Neonatal 10 Point Plan: Board-Level Baseline Assessment Against the NHS England National Maternity Triage Specification
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health
Author:	Gill Locking, Outpatient Matron

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☒

Trust Objectives

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

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

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

- ☒ Yes
- ☐ No
- ☐ Not Applicable

Executive Summary:

This paper presents the Trust Board's baseline assessment of maternity triage services against the NHS England National Maternity Triage Specification. The assessment

supports the Trust's response to the Maternity and Neonatal 10 Point Plan requirement to deliver safe and effective maternity triage.

NHS England requires each Trust to complete a Board-level audit, identify gaps, develop an implementation plan and maintain Board oversight of progress. The baseline assessment must be approved by the Trust Board for submission to the NHS England regional team by 25 September 2026. A further progress return is required by 31 December 2026.

Baseline position

The assessment reviewed 77 standards across the ten principles of the National Maternity Triage Specification. Of these, 75 were assessed as applicable:

- 44 standards, 58.7%, are fully in place;
- 26 standards, 34.7%, are partially in place;
- 5 standards, 6.7%, are not in place; and
- 2 standards are assessed as not applicable.

The findings demonstrate an established operational foundation. Whilst the Trust cannot currently report full compliance with the national specification, . The areas of greatest assurance are data and measurement (85.7% fully in place), service-user voice (80%), telephone triage (75%) and clear information for women and staffing (both 66.7%). clinical assessment. The most significant gaps relate to system-wide access and referral pathways, communication of discharge outcomes, facilities and estates, escalation arrangements, senior medical review, administrative support and equitable access. Not applicable standards are non-use of BSOTs and role of MLUs.

Resources

The initial assessment identifies potential investment of £736,068. This remains subject to validation through the Trust's workforce, estates, digital and business-planning processes. Inclusion within this report does not constitute formal approval of expenditure.

Board assurance

The Board can take reasonable assurance that a structured baseline assessment has been completed and that the principal gaps have been identified. The Board cannot yet take substantial assurance that all requirements of the national specification are embedded or that all required resources have been secured.

Recommendation:

- Note completion of the national specification benchmarking tool and the current baseline position and approve submission to NHS England.
- Approve the action plan and trajectories and endorse the improvement priorities as the framework for delivery towards March 2027.
- Identify named executive lead to support operational leads for each action

- Recognise that delivery of all interventions by March 2027 is currently at risk and support timely senior escalation where milestones or critical dependencies are not being achieved.
- Receive a progress update no later than December 2026, including movement in implementation status, delivery against milestones, exceptions and assurance from audit.

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity Directorate Meeting	14/9/26	Share with Family Health Care Group Board
Family Health Care Group Board	21/9/26	Share with Quality Committee/Trust Board
Quality Committee	22/9/26	

Maternity Triage National Benchmarking – Assurance Report

1. Introduction and purpose

This report provides assurance on York and Scarborough's current position against the national Maternity Triage Specification benchmarking audit and identifies the principal gaps requiring Directorate and Trust Board oversight.

The assessment covers access, urgent-care recognition, assessment and care, information, telephone triage, service-user experience, facilities, staffing, equity, and data. Ratings are based on locally recorded evidence and should be validated through a multidisciplinary evidence review.

The dashboard indicates that 58.7% of applicable standards are fully embedded, 34.7% are partially in place and 6.7% are not in place. No standards are recorded as having incomplete data, although several individual metrics are only partially captured. The latest audit estimates total investment of **£736,068**, concentrated in facilities and estates (£560,000) and staffing (£171,000), with a further £4,000 for urgent-care signage and £1,068 for accessible information.

2. Overall benchmark position

Principle	Fully	Partial	Not in place	Assurance position
1. Access and integration	18.2%	54.5%	27.3%	Priority improvement area
2. Recognition as urgent care	60.0%	40.0%	0%	Generally established
3. Assessment and care	60.0%	20.0%	0%	Strong, with RCOG gaps
4. Clear information	66.7%	33.3%	0%	Good foundation
5. Telephone triage	75.0%	25.0%	0%	Strong, staffing dependency
6. Service user voice	80.0%	20.0%	0%	Well embedded
7. Facilities and estates	50.0%	30.0%	20.0%	Priority improvement area
8. Staffing	66.7%	16.7%	8.3%	Good core model; escalation gap
9. Equity and equality	40.0%	60.0%	0%	Developing
10. Data and measurement	85.7%	14.3%	0%	Strongest area

3. Key strengths and assurance

Area of assurance	Evidence from the audit
Urgent-care model	Maternity triage is recognised as the emergency front door, operates with open access, is distinct from scheduled activity and uses BSOTS.
Clinical assessment	Staff training, competency arrangements and urgency-category monitoring are established; assessment and review-time metrics are captured.
Telephone triage	A dedicated access route, face-to-face safety net, documented limitations and real-time clinical-record documentation are in place.
Service-user voice	Feedback is gathered through multiple routes, reviewed through governance and linked to improvement work with the MNVP.
Governance and data	Routine measurement, scheduled review, PSIRF alignment and continuous-improvement arrangements are largely embedded.

4. Principal gaps and risks

Gap	Risk or consequence	Required response
System-wide access and referral pathways are incomplete.	Variation in where women present, handover quality and care continuity from early pregnancy to six weeks postnatal.	Agree pathways with ED, EPAU, community, neonatology, primary care, ambulance services and NHS 111.
No consistent process for sharing triage discharge outcomes with GPs and community services.	Important actions or follow-up may not be visible to the wider care team.	Develop an interoperable or interim standardised discharge communication process.
Waiting area is not visible; no reception or dedicated confidential office.	Delayed recognition of deterioration, reduced oversight, privacy concerns and inefficient flow.	Progress the estates business case and determine administrative support requirements.
No formal maternity-triage OPEL escalation framework.	Inconsistent response to peaks in demand, acuity, staffing pressure and bed constraints.	Implement thresholds, actions, accountability and governance reporting.
Medical staffing and twice-daily triage oversight are not fully aligned to RCOG expectations.	Potential delay in senior clinical review and escalation.	Agree dedicated medical input and incorporate triage review into consultant-led rounds.
Accessible information, interpretation and equity analysis are inconsistent.	Unequal access and experience for women with language, disability, digital or socioeconomic barriers.	Provide accessible formats, 24/7 interpretation, a digital-exclusion route and stratified equity reporting.

5. Recommended Directorate and Board actions

Priority	Action	Proposed timescale
1	Nominate executive and operational leads and establish a multidisciplinary programme to validate evidence and close all five “not in place” standards.	Within 1 month
2	Approve development of the system-wide access, referral, handover and postnatal pathways, including commissioning clarity to six weeks.	Within 3 months
3	Implement a maternity-triage OPEL escalation framework covering activity, acuity, staffing, bed capacity and service continuity.	Within 3 months
4	Progress the estates and administrative support business case, including approximately £528,000 for 24/7 Band 2 ward-clerk provision across both sites, £25,000 for the York reception desk and £7,000 for signage and buzzer entry.	Business case within 3 months
5	Agree the medical staffing and senior review model required to meet RCOG expectations and confirm the £171,000 requirement for 1.44 WTE medical staffing at the York site.	Within 3 months
6	Develop a metric recovery plan for call handling, attendance routes and stratified equity data.	Within 3–6 months

7	Approve and monitor the quantified investment plan of £736,068, including £4,000 for urgent-care signage, £1,068 for accessible information, £560,000 for estates and administrative support, and £171,000 for staffing.	Next reporting cycle

6. Conclusion and decision required

Conclusion

York and Scarborough have a credible and largely established maternity triage model, with clear strengths in clinical triage, telephone safety-netting, service-user feedback, governance and data. However, the current position is not yet fully compliant with the national specification. The most material risks relate to fragmented system pathways, estate limitations, incomplete escalation arrangements, medical and administrative capacity, digital interoperability and equitable access.

The Directorate is asked to:

- note the benchmark position and areas of assurance;
- endorse the prioritised improvement programme;
- support cross-organisational pathway development and the estates/resource business cases;
- require named leads, delivery dates, funding decisions and evidence of impact in the next update.

Date: 12/2/2026

York and Scarborough Benchmarking against National Maternity Triage Specification – September 2026							
Principle	**Specification summary**	**Fully in place**	**Partially in place**	**Not in place**	**Not relevant**	**Data not complete**	**Estimated cost**
1. Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	18%	55%	27%	0%	0%	£0
2. Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care.	60%	40%	0%	0%	0%	**£4,000**
3. Assessment and care	Every woman receives timely assessment, prioritisation and a clear plan of care.	60%	20%	0%	20%	0%	£0
4. Clear information	Information and messaging must be clear, welcoming and unambiguous.	67%	33%	0%	0%	0%	**£1,068**
5. Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly.	75%	25%	0%	0%	0%	£0
6. Service user voice and experience	Women's feedback must shape service design, improvement and experience.	80%	20%	0%	0%	0%	£0
7. Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	50%	30%	20%	0%	0%	**£560,000**
8. Staffing	Staffing must support timely assessment and prompt review when escalation is needed.	67%	17%	8%	8%	0%	**£171,000**
9. Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	40%	60%	0%	0%	0%	£0
10. Data and measurement	Data must drive oversight, learning and continuous improvement.	86%	14%	0%	0%	0%	£0
						Total estimated cost	**£736,068**

Report to:	Trust Board
Date of Meeting:	30th September 2026
Subject:	Saving Babies' Lives Care Bundle
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health
Author:	Lucy Flatley, Transformation Lead Midwife

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

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☐ Financial Balance
☒ Effective Governance

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This report provides an update on implementation of the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2) across the Trust as of September 2026. A comprehensive self-assessment using the NHS England implementation tool demonstrates that 84% of interventions are fully implemented, with overall delivery assessed as partially compliant.

Strong performance is evident in fetal growth restriction (100%) and reduced fetal movement (100%), supported by established governance and quarterly oversight processes.

However, variation remains in delivery, with key areas for improvement including:

- Smoking in pregnancy (50%) – workforce training, opt-out referrals, and data capture which is underpinned by the need to implement an in-house service
- Preterm birth (85%) – pathway reliability, optimisation bundle delivery, and preterm birth rate
- Diabetes in pregnancy (83%) – service capacity and clinic model

Across element challenges include training compliance below the ≥90% requirement (reducing smoking in pregnancy and fetal monitoring), inconsistencies in data quality, and service configuration across sites.

Targeted improvement actions are in place, including implementation of a maternity tobacco dependency service, optimisation of preterm pathways, and development of the pre-existing diabetes in pregnancy service provision. Progress is monitored through the Single Improvement Plan, with quarterly reporting aligned to MIS Year 8 requirements.

Based on the current level of partial implementation and the dependencies associated with service redesign, workforce training, data quality and pathway reliability, there is a risk that the Trust will not achieve full compliance with SBLCBv3.2 by March 2027. Close monitoring, timely escalation and delivery of the agreed improvement actions will be required to mitigate this risk.

Recommendation:

The Trust Board is asked to:

- Note the current level of compliance and variation across SBLCBv3.2 elements
- Receive assurance that governance, monitoring and improvement plans are in place and aligned to national requirements
- Endorse the prioritisation of key improvement areas, specifically:
    - Smoking cessation pathways and tobacco dependency service implementation
    - Preterm birth pathway optimisation and reduction of unwarranted variation
    - Development of the diabetes in pregnancy service model
- Support a continued focus on equity, addressing identified inequalities in outcomes
- Note the risk that full compliance may not be achieved by March 2027 and support timely escalation where delivery is off trajectory
- Agree ongoing quarterly oversight and reporting to ensure delivery of full compliance

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Assurance Group	8/9/26	
Maternity Directorate Meeting	14/9/26	Share with Family Health Care Group Board
Family Health Care Group Board	21/9/26	Share with Quality Committee/Trust Board
Quality Committee	22/9/26	

Saving Babies' Lives Care Bundle

1. Introduction and Background

This report provides an overview of progress at York and Scarborough Teaching Hospitals NHS Foundation Trust in implementing the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2). It summarises current levels of compliance across all six elements of the care bundle, highlights key areas of achievement and improvement, and outlines the actions required to achieve full implementation.

The Trust has undertaken a comprehensive self-assessment against SBLCBv3.2 using the NHS England implementation tool, supported by local audit data during the report period of quarter one 2026 - 2027, guideline review, and quality improvement activity. This report reflects the position as of August 2026 and will inform ongoing quality improvement.

The Saving Babies' Lives Care Bundle is a national programme developed by NHS England to reduce perinatal mortality and improve outcomes for babies and families. It sets out a series of evidence-based interventions and best practice standards across the maternity pathway.

Version 3.2, published in April 2025, builds on previous iterations by incorporating:

- Updated implementation guidance to reflect MIS requirements
- Updated NICE and RCOG guidance where available
- A stronger focus on reducing unwarranted variation and improving equity of outcomes

The six elements of SBLCBv3.2 are:

1. Reducing smoking in pregnancy
2. Risk assessment and management of fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring in labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

These elements collectively address key contributors to avoidable perinatal mortality.

2. Approach and methodology

The Trust has completed a self-assessment across all six elements, supported by evidence including:

- Clinical audits
- Guidelines and policies
- Training compliance data
- Quality improvement programmes
- MSDS and BadgerNet audit data

The overall position indicates:

- 84% of interventions fully implemented (self-assessed)
- Overall status: Partially implemented across the care bundle

The remaining areas requiring focused improvement, particularly:

- Smoking cessation pathways and workforce training (Element 1)

- Preterm optimisation reliability (Element 5)
- Pre-existing diabetes pathway development and clinic model (Element 6)
- Ensuring projected training compliance for August is met (Elements 1 and 4)

3. Governance

Since the launch of SBLV3 the national implementation tool has been completed on a quarterly basis, reviewed by the LMNS and we have had a quarterly assurance meeting to discuss progress with implementation.

The Humber and North Yorkshire LMNS are no longer operational and as per MIS year 8 requirements we will provide quarterly updates on implementation progress to the trust board.

We will continue to complete the national implementation tool and map identified improvement work into the single improvement plan to ensure progress with identified improvements.

4. Current position for each element

Element 1:

50% compliant. There are 10 interventions to reduce smoking in pregnancy. 5 interventions have been fully implemented, and 5 interventions have been partially implemented.

Two of the partially implemented interventions are on training compliance, this is expected to be met by August 2026 (note this reporting period is April-June).

Two of the partially implemented interventions are around quit data. These are not currently accurate audits in BadgerNet as we refer the women who are pregnant to the local authorities at present. Plans are in progress to implement a maternity specific in-house tobacco dependency service by December 2026 and from this point all quit data will be inputted onto BadgerNet which will support oversight and compliance with these interventions.

One of the partially implemented interventions is the requirement for 90% of women to receive an opt out referral to stop smoking services. Since July 2026 we are no longer able to refer women on an opt-out basis to City of York and North Yorkshire local authorities which will affect compliance with this audit until an in-house service is implemented and embedded.

Element 2:

100% compliant. There are 20 interventions, all of which are fully implemented as of Q1 26/27.

For the element, which was partially implemented, during Q4 25/26 data for fetal growth restricted babies (<3rd centile) born after 38+6 weeks gestation was above the national GAP average. For Q1 26/27 this is now below the national average, and a quarterly meeting has been established to review all cases to ensure oversight and identification of any themes / learning to identify if there were any issues with detection and management

of growth restriction. Such cases can occur and be in acceptable discordance. There is also process in place to exception report these cases and the outcomes of the review are captured on datix.

As per the requirements of the Maternity Incentive Scheme year 8 to provide assurance that and in response to the NHSE and RCOG fetal growth chart safety communication, it is confirmed that fetal grow charts and surveillance pathways are in line with SBLCB 3.2 guidance. Perinatal institute GROW charts are in use for all women accessing maternity care across York and Scarborough which is supported by the RCOG. SGA and FGR detection is monitored on a quarterly basis as per the SBLCB audit requirements.

Element 3:

100% compliant. Compliance remains maintained with all 3 interventions in this element. The RCOG have published a new reduced fetal movement guideline. Following a rapid review of this against the trust guideline, minor amendments may be needed which is being led by the fetal monitoring lead midwives.

Element 4:

80% compliant. There are 5 interventions in this element. 4 are fully implemented and 1 is partially implemented. The partially implemented element is for training compliance across the MDT which is just below the 90% requirements across staff groups.

A trajectory has been completed, and the trust is expected to meet the requirements in August 2026 (note this reporting period is April-June).

Element 5:

85% compliant. There are 26 interventions for this element. 22 interventions are fully implemented and 4 are partially implemented.

The partially implemented elements currently have oversight; improvement work and monitoring are in progress.

A preterm birth leadership team is in place and preterm clinics exist on both sites however will be reviewed to ensure equitable provision across both sites which meets national best practice standards and service user needs.

The preterm birth rate across site is just above the national average of <6%. For Q1 26/27 this is 6% at Scarborough site and 6.7% at York site. Fluctuation in this data is minimal each quarter and we have assurance from other interventions in this element that women are appropriately risk assessed for preterm birth during their antenatal care. From the initial review of the NHS England equalities dashboard, there is a higher number of women living in deprived areas having preterm births compared to those who live in less deprived areas. This data will be reviewed when considering the locations of our preterm birth clinics which is part of preterm birth prevention.

In Q1 26/27 there were 6 babies born at Scarborough site and 2 babies' born at the York site that were 'off pathway' meaning they did not give birth on the appropriate neonatal unit for their gestation. We review each case as an MDT to look at the entire pregnancy

pathway up to birth to identify if there are any learning opportunities and if the 'off pathway' birth was avoidable or unavoidable. These reviews are sent to the regional team for oversight.

The two other interventions which are partially implemented are around compliance with the optimisation indicators. Which includes normothermia and delayed cord clamping. Compliance with these metrics is reviewed monthly and any themes are fed back to the clinical teams. The practice of delayed cord clamping is well embedded however for some preterm infants who require timely resuscitation this is not always clinically appropriate. Normothermia requirements were met on the York site but not on the Scarborough site, this is 2 cases two babies too cold and 1 baby did not have their temperature recorded on the digital system in the first hour This will continue to be monitored, and any learning fed back to the teams.

Element 6:

83% compliant. There are 6 interventions for this element. 5 are fully implemented and 1 is partially implemented.

Compliance has now been met with the HbA1c blood test (which measures blood sugar levels over the last few months and helps with the management of diabetes) being offered between 24-30 weeks gestation for pregnant women with pre-existing diabetes as per the guidance at both sites, this will continue to be monitored.

There is ongoing improvement work to review the diabetes team capacity and the clinics across sites to support the delivery of a pre-existing diabetes clinic as per the care bundle recommendations.

5. Summary

This report provides an update on implementation of the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2) across the Trust as of May 2026. Overall compliance is 84%, with delivery assessed as partially compliant.

High levels of compliance are demonstrated in fetal growth restriction (100%) and reduced fetal movement (100%), reflecting strong governance, established pathways, and effective oversight arrangements.

However, variation persists across several elements, most notably smoking in pregnancy (50%), preterm birth (85%), and diabetes in pregnancy (83%). Key challenges include workforce training compliance below national targets, pathway reliability, data quality, and service configuration across sites. Outcome inequalities are evident, particularly higher preterm birth rates among more deprived populations and at the Scarborough site.

Targeted improvement actions are underway, including implementation of a maternity tobacco dependency service, optimisation of preterm birth pathways and clinic provision, and development of the diabetes in pregnancy service model. These actions are aligned to the Single Improvement Plan and monitored through established governance structures, with quarterly reporting in line with MIS Year 8 requirements.

There is a risk that the Trust will not achieve full compliance by March 2027 if the identified service, workforce, data and pathway improvements are not delivered within the required

timescales. This risk will require close oversight and escalation through the established governance arrangements.

Continued focus is required to reduce unwarranted variation, strengthen equity of outcomes, and deliver full compliance across all elements of the care bundle.

Date: 2/9/26

Report to:	Trust Board
Date of Meeting:	30 September 2026
Subject:	Maternal Care Bundle Implementation Update and Action Plan
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health
Author:	Lucy Flatley, Transformation Lead Midwife

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

The national Maternal Care Bundle implementation tool has now been completed, progressing the programme from an interim readiness review to a structured implementation phase. The completed baseline assesses 14 interventions across five elements. One intervention is fully implemented, six are partially implemented and seven are not implemented, giving an overall self-assessment of partially implemented. Each area of non-compliance now has defined SMART actions, named owners, review arrangements and identified escalations.

There is assurance that the maternity service has completed a comprehensive baseline and established a coordinated action plan. There is not yet assurance of full implementation, and delivery of all interventions by March 2027 is currently at risk due to the scale of work outstanding and reliance on digital development, cross-Trust and system engagement, guideline and pathway updates, training, audit and sustained oversight.

Recommendation:

- Note completion of the national implementation tool and the current baseline position.
- Approve the action plan and trajectories as the framework for delivery towards March 2027.
- Support escalation of cross-organisational and digital dependencies that cannot be resolved within maternity services.
- Recognise that delivery of all interventions by March 2027 is currently at risk and support timely senior escalation where milestones or critical dependencies are not being achieved.
- Receive quarterly progress reports, including movement in implementation status, delivery against milestones, exceptions and assurance from audit.

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Assurance Group	8/9/26	
Maternity Directorate Meeting	14/9/26	Share with Family Health Care Group Board
Family Health Care Group Board	21/9/26	Share with Quality Committee/Trust Board
Quality Committee	22/9/26	

Maternal Care Bundle Implementation Update and Action Plan

1. Introduction and Background

The NHS England Maternal Care Bundle (MCB) was published in January 2026 and establishes a national baseline of best practice across five clinical areas consistently associated with higher rates of maternal mortality and severe maternal morbidity. The care bundle has been developed in response to repeated findings from MBRRACE-UK that a significant proportion of maternal deaths involve missed opportunities for earlier identification, escalation, senior input, and coordinated multidisciplinary care.

The overarching aims of the Maternal Care Bundle are to:

- Reduce preventable maternal deaths and severe morbidity
- Improve early recognition and response to clinical deterioration
- Reduce unwarranted variation in care across services and settings
- Address persistent inequalities in maternal outcomes related to ethnicity, deprivation and access to care
- Support consistent, system-wide approaches to safety across maternity, emergency, primary and specialist services

The five elements of the Maternal Care Bundle are:

1. Venous thromboembolism (VTE)
2. Pre-hospital and acute care
3. Epilepsy in pregnancy
4. Maternal mental health
5. Obstetric haemorrhage

The care bundle is intended to be implemented by all NHS maternity providers in England by March 2027. This will be achieved by working in partnership with wider Trust services (including emergency care, ambulance services, neurology, maternal medicine, mental health and primary care). While the Maternal Care Bundle establishes minimum standards, it is expected these interventions will be embedded into routine practice, supported by governance, audit and continuous improvement.

The June 2026 interim report described local readiness and identified gaps before the national implementation tool was available. This update supersedes that position by presenting the completed national baseline and associated action plan, identifying the principal delivery risks and dependencies, and setting out the governance arrangements for oversight through to full implementation

2. Current implementation position

Completion of the Maternal Care Bundle implementation tool (developed by NHS England) across all elements show that no element is currently fully implemented.

Element	Clinical area	Interventions	Self-assessment	Fully implemented
1	Venous thromboembolism	3	Not implemented	0 of 3
2	Pre-hospital and acute care	3	Not implemented	0 of 3
3	Epilepsy in pregnancy	2	Partially implemented	1 of 2
4	Maternal mental health	3	Not implemented	0 of 3
5	Obstetric haemorrhage	3	Not implemented	0 of 3
Overall	All Elements	14	Partially implemented	1 of 14

3. Action plan by element

Element 1: VTE
Current position: Not implemented
Actions include establishing a trust-wide process for the national early-pregnancy VTE self-assessment at first NHS pregnancy contact, clinical review within 72 hours and an agreed prescribing pathway for LMWH. This requires standard operating procedures, digital integration and quarterly audit. Interim paper arrangements are identified if digital functionality is not available. Key dependencies are System C/Nerve Centre development, pharmacy input, ICB agreement and engagement across primary and acute care.

Element 2: Pre-hospital and acute care
Current position: Not implemented
Actions include implementation of national MEWS across maternity, emergency and relevant acute settings, including digital integration, interim paper mitigation, training, escalation and audit. Further actions include pathway walk-throughs with Yorkshire Ambulance Service and MNVP representatives, signage improvements, incorporation of the Maternal Medicine Network acute referral pathway and establishing a formal annual review process.

Element 3: Epilepsy in pregnancy
Current position: Partially implemented
The complex-care referral pathway is fully implemented. Remaining actions focus on implementing the Scarborough epilepsy service, agreeing a local SOP and service specification, ensuring case review and risk stratification within 14 days of first NHS contact, providing timely medication review for high-risk women and strengthening identification and referral from self-referral to maternity services.

Element 4: Maternal mental health
Current position: Not implemented

Actions include updating the maternal mental health guideline, implementing self-administration of the Whooley questions at all required antenatal and postnatal timepoints, introducing EPDS where indicated, ensuring accessible and translated options, delivering communication and training, and establishing quarterly audit. A local paper process is proposed while BadgerNet changes are awaited. The digital change request and associated system escalation remain material dependencies.

Element 5: Obstetric haemorrhage
Current position: Not implemented
Actions focus on ensuring community birth equipment supports cumulative blood-loss measurement, auditing measurement and escalation for haemorrhage cases, confirming multidisciplinary review within 30 days for significant bleeds and fibrinogen product use, and confirming pathology arrangements for timely Clauss fibrinogen results. Existing case review provides a foundation, but formal evidence and audit are required.

4. Key risks and dependencies

Risk/dependency	Required control
March 2027 delivery trajectory	Delivery of all interventions by March 2027 is at risk because only one of 14 interventions is currently fully implemented and several critical milestones depend on digital development and organisations outside maternity. Monthly milestone review, early escalation and senior support to unblock dependencies are required.
Digital capability	Several interventions require changes to BadgerNet. Interim paper processes reduce immediate risk but do not provide a sustainable solution.
Cross-organisational delivery	VTE prescribing, ambulance pre-alerts, acute referral pathways and specialist services require active participation from the ICB, primary care, emergency care, YAS, pharmacy, neurology, pathology and the Maternal Medicine Network.
Workforce and training	Implementation requires training rollout and compliance monitoring across maternity and non-maternity settings.
Evidence and audit	Most actions require new or strengthened audit arrangements before the maternity service can evidence reliable implementation and outcomes.
Equity and accessibility	Paper and digital routes, translated information and accessible formats must be embedded so implementation does not widen existing inequalities.

5. Governance and monitoring

- An oversight group will be established in September, to commence in October to monitor delivery of the care bundle each month
- Progress will be reported into Maternity and Neonatal Assurance Group and Maternity Directorate Group each month via a highlight report.
- The implementation tool will be updated to record current evidence, action progress, revised implementation status and escalations and a accompanying report will be provided to the trust on a quarterly basis as per the MIS requirements.

6. Conclusion

Completion of the national Maternal Care Bundle implementation tool provides a clear and comprehensive baseline from which the Trust can progress delivery. The current position confirms that full implementation has not yet been achieved, with one of 14 interventions fully implemented. Each identified gap is now supported by a defined SMART action.

Delivery of all interventions by March 2027 is currently at risk. This reflects the limited baseline position, with only one of 14 interventions fully implemented, the scale of work outstanding and the reliance on digital, workforce, training, pathway, audit and wider system dependencies. Sustained multidisciplinary engagement, active management of milestones and timely senior escalation will be required to recover and maintain the delivery trajectory. Interim controls provide proportionate mitigation where longer-term solutions are not yet available, but they do not replace the need for reliable, embedded and auditable processes across maternity and wider Trust services.

The proposed oversight and reporting arrangements will enable progress, exceptions and emerging risks to be monitored and escalated through established governance routes. The Trust can therefore take assurance that a structured implementation plan and monitoring framework are in place, while recognising that assurance of full and sustained compliance will depend on completion of the actions and evidence of effective implementation through audit.

Date: 2nd September 2026

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Homebirth Action Plan in response to National PFD - Progress Update
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health
Author:	Susan Kinsella, Community Matron

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

Approve ☒ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:
This report provides an update on the Trust's response to the Prevention of Future Deaths report issued by the Senior Coroner in November 2025 and the related regional immediate action. The action plan is structured around three assurance themes: safe operational delivery, effective care planning and risk assessment, and strengthened governance and oversight of homebirth services.

Progress and assurance

- Immediate operational controls have been implemented, including review of the community on-call model, monitoring of rest-hour compliance, daily escalation of service suspensions, and continued 24/7 obstetric and midwifery support.
- Standardised homebirth equipment requirements and reporting processes have been introduced across community services, supported by monthly assurance and training compliance monitoring.
- A bespoke homebirth guideline, related patient information, safe lone working and transfer arrangements have been reviewed, ratified and implemented, with audit tools embedded to assess risk, documentation, communication and outcomes.
- Community PROMPT training has been strengthened through multidisciplinary working with ambulance colleagues, including emergency transfer and extraction scenarios.
- Monthly and quarterly reporting routes now provide oversight of homebirth activity, staffing, service suspension, transfers, audit findings and emerging risks through maternity governance and Trust assurance structures.

Outstanding priorities

- Complete stakeholder engagement, consultation and the business case for a sustainable community midwifery and homebirth model, informed by the BirthRate+ staffing-versus-acuity review.
- Complete recruitment to the cross-site Lead Professional Midwifery Advocate role and finalise the review of senior midwifery on-call arrangements.
- Implement the planned programme of quarterly thematic audit and ensure findings lead to documented improvement actions.
- Maintain local guidance under review and update it when national guidance is issued by relevant professional and regulatory bodies.
- Complete the remaining reporting, multidisciplinary communication and assurance actions due between September 2026 and February 2027.

Recommendation:

- Note the progress and assurance provided.
- Endorse completion of the remaining actions and the sustainable community midwifery and homebirth model.
- Maintain executive oversight until completion and sustained compliance are evidenced.

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Maternity Directorate Meeting	14/9/26	Share with Family Health Care Group Board
Family Health Care Group Board	21/9/26	Share with Quality Committee/Trust Board
Quality Committee	22/9/26	

Trust Response to PFD from Senior Coroner November 2025 and Regional Immediate Action 27/11/25
Update 11/09/2026

1. Introduction and Background

This report provides an update on the Trust's response to the Prevention of Future Deaths report issued by the Senior Coroner in November 2025 and the related regional immediate action. The action plan is structured around three assurance themes: safe operational delivery, effective care planning and risk assessment, and strengthened governance and oversight of homebirth services.

2. Considerations

The Trust Board is asked to note the progress made, endorse completion of the remaining actions and support development of the sustainable community midwifery and homebirth model. Continued executive oversight is required until all actions are complete and sustained compliance is evidenced. The preferred approach is to retain the strengthened operational controls, audit, training and governance arrangements as business as usual while completing workforce modelling, stakeholder engagement, consultation and the business case.

3. Current Position and Issues

Immediate controls are in place to support safe operational delivery. These include review of the community on-call model, monitoring of rest-hour compliance, daily escalation of any homebirth-service suspensions and continued 24-hour obstetric and midwifery support. Standardised homebirth equipment requirements and reporting processes have been introduced across community services.

Clinical assurance has been strengthened through a bespoke homebirth guideline, revised patient information, lone-working, audits of risk assessment, documentation, communication and outcomes, and multidisciplinary Community PROMPT training with ambulance colleagues. Monthly and quarterly governance routes provide oversight of activity, staffing, suspensions, transfers, training compliance, audit findings and emerging risks.

The principal outstanding issue is the long-term sustainability of community midwifery and homebirth provision. Remaining priorities are to complete engagement and consultation, submit the business case, complete recruitment to the cross-site Lead Professional Midwifery Advocate role, finalise the senior midwifery on-call review, implement quarterly thematic audit and maintain local guidance until national guidance is issued. Outstanding milestones extend from September 2026 to February 2027.

4. Summary

- A significant proportion of actions are complete, embedded or operating as business as usual.
- Guidance, audit, training, escalation and governance arrangements have been strengthened.

- Residual risk is concentrated on sustainable workforce capacity and the future service model.
- The remaining actions require continued Directorate and executive oversight through to completion.

5. Next Steps

1. Complete stakeholder engagement and consultation on the future community midwifery and homebirth model.
2. Finalise and submit the business case, informed by staffing-versus-acuity modelling.
3. Complete recruitment and the review of senior midwifery on-call arrangements.
4. Implement quarterly thematic audit, document improvement actions and monitor delivery through established governance routes.
5. Update local guidance when national guidance is issued and report completion of all remaining actions to Maternity Directorate.

Date: 30 September 2026

Trust Response to PFD from Senior Coroner November 2025 and Regional Immediate Action 27/11/25
Update 11/09/2026

Action Log

No.	Title	Situation	Measure	Frequency	Action	Responsible Owner	Due Date	Status and completed date
1	**The operational running of your service**	**1.1 Prompt midwifery care is available 24 hours a day; staff have sufficient rest periods.**	Compliance audit: rest hours. Suspension of services audit.	Monthly via PQSM. Daily SitRep.	Review the current on-call model for community midwives. Implement a temporary on-call model for Band 6 community midwives. Complete an Equality and Quality Impact Assessment for full suspension of homebirth services. Complete a community midwifery service provision caseload-versus-staffing review. Develop community service provision, including homebirth provision. Engage staff, service users and the wider care group.	Community Matron.	29/12/2025. TBC. Nov 2025. Aug 2026. Nov 2026. Jan 2027. Feb 2027.	Complete. Completed Jan 2026. Draft completed July 2026; progressing to stakeholder engagement, consultation and investment.

					Consult on the new model. Submit the business case.			
		1.2 Staff are properly equipped, trained, prepared and skilled.	Monthly spot-check audits of homebirth bag equipment. Training compliance: PROMPT childbirth emergencies in home and hospital settings. Agenda item at team meetings.	Monthly Maternity Directorate meeting. Monthly. Maternity Assurance Group and Quality Committee. Reports to the Director of Midwifery, Safety and Quality reporting, dashboard via Digital Midwife, MAG, Maternity Directorate and MNVP.	Develop a universal, standardised equipment list and reporting process for homebirth. Implement the standardised equipment list and reporting process across all community midwifery services. Collaborate with the Practice Development Midwife to ensure community PROMPT includes a home-environment homebirth scenario. Review Clinical Skills Midwives' capacity to attend community team meetings and provide updates. Develop a sustainable homebirth service model in line with national guidance; maintain the local review pending national guidance.	Team Leaders. Practice Development Midwives. Community Maternity Matron.	20/02/2026. 30/11/2026. Sept 2026.	Completed July 2026. Completed Feb 2026; report in Sept 2026. Completed Jan 2026 and shared with NHSR as good practice. Completed July 2026. Completed April 2026; moved to business as usual.

					Maintain robust governance reporting for homebirth activity, staffing and service suspension.			
		1.3 Staff have senior multidisciplinary support available at all times.	Audit themes from maternity case reviews. Professional Midwifery Advocate support. Obstetric consultant support. Audit senior midwifery support accessed out of hours.	Monthly.	Ensure 24/7 on-call availability of an obstetrician and midwife on labour ward. Recruit 1 WTE cross-site Lead Professional Midwifery Advocate. Review and scope 24/7 senior midwife on-call arrangements.	Operational Team. Director of Midwifery / Recruitment and Retention Midwife. Deputy Director of Midwifery / Director of Midwifery.	Embedded. 30/09/2026. 30/11/2026.	Business as usual; reviewed daily on the OPEL sheet and through operational oversight.
		1.4 Potential transfer and extraction processes are clear and planned for each birth.	Audit homebirth transfers. Review each homebirth transfer against the standard operating procedure.	Monthly. Case-by-case at Maternity Directorate.	Collaborate with Practice Development Midwives and YAS Clinical Skills Paramedics to include an extraction and transfer drill in community PROMPT. Review the standard operating procedure for transfer from homebirth to the obstetric unit.	YAS Clinical Skills Paramedic. Community Matron.	30/04/2026. Revised target: 30/09/2026.	Completed.

2	**Care planning and risk assessment**	**2.1 Systematic assessment of complexity and risk.**	Audit completed homebirths. Audit documentation of planned place of birth at 36 weeks. Await national guidance from NHS England, RCM and RCOG.	Monthly. TBC.	Develop a post-homebirth audit tool. Develop a pre-homebirth audit. Map current homebirth risk-assessment points. Review local homebirth guideline, patient information and audit tools to ensure systematic assessment of complexity and risk.	Team Leaders. Community Matron.	30/06/2026. 30/11/2026.	Completed and embedded April 2026.
		2.2 The multidisciplinary team ensures a personalised approach when planning care, particularly where homebirth is not recommended.	Audit homebirths outside standard care. Await national guidance from NHS England, RCM and RCOG.	Monthly. TBC.	Ensure the homebirth guideline contains a multidisciplinary decision-making tool and guidance for use when a homebirth is requested outside standard care. Review and update the local homebirth guideline when national guidance is released.	Community Matron.	Guideline ratified 08/01/2026 and released 31/03/2026. April 2027.	Completed April 2026 and included in the homebirth audit.
		2.3 The multidisciplinary team maintains effective communication with women and between all	Monthly audit of communication during completed homebirths.	Monthly. TBC.	Specify minimum updates from the community team to the labour ward coordinator and audit compliance monthly.	Community Matron. Community Matron and YAS Clinical Skills. YAS.	Audit: 30/06/2026. Guideline live: 31/03/2026. 31/07/2026. Nov 2026.	Completed April 2026 and included in the homebirth audit.

		teams, including ambulance services, and responds dynamically to risk throughout pregnancy, birth and the postnatal period.	Await national guidance from NHS England, RCM and RCOG.		Strengthen emergency communication pathways through additional multidisciplinary training. YAS to implement the pre-hospital maternity decision tool based on maternity MEOWS. Undertake twice-yearly reviews of homebirth activity with YAS to evidence compliance and learning.			Completed April 2026; see curriculum.
3	**Governance and oversight**	**3.1 Governance is structured to ensure robust organisational oversight of homebirth services.**	Monthly review and action of the community risk register.	Monthly Matron report.	Complete monthly homebirth data review, including service provision and homebirth audit. Complete a quarterly thematic review covering service provision, transfers, staff training compliance and completed audits. Review local governance processes so guidance, policies,	Community Matron and Quality and Safety Lead. Quality and Safety Team and Community Matron.	Oct 2026. 30/06/2026 for all guidelines to be live.	Business as usual from April 2026. Ongoing. Completed April 2026.

					patient information and procedures are updated in line with national standards.			
		3.2 The executive board has appropriate oversight.	PQSM data. Maternity and neonatal safety report to Trust Board.	Monthly.	Maintain the agreed process for reporting suspension of homebirth services, outcomes and service provision through appropriate governance channels.	Community Matron and Director of Midwifery.	30/11/2025.	Completed Nov 2025; reported to the Director of Midwifery and through Matron report, MAG and Quality Committee.
		3.3 The audit programme covers outcomes and clinical and operational guidance, and drives continual improvement.	Audits and action planning. Homebirth clinical outcomes, including higher- and lower-risk cases. Communication during homebirth.	Quarterly.	Agree audit reporting requirements with the Governance Lead and add them to the 2026/27 forward audit plan.	Team Leaders and Community Matron.	31/05/2026.	
		3.4 Comprehensive homebirth guidance includes standard operating	Completion of guidelines and procedures relating to homebirth.		Develop a lone-worker community services guideline. Develop a bespoke local homebirth guideline.	Community Matron. Team Leaders.	Jan 2026. 31/03/2026. 30/04/2026.	Completed Jan 2026. Completed and ratified April 2026. Completed, ratified and

		procedures for all stages and aspects of care.			Complete a full review of patient information relating to homebirth. Ensure transfer to the obstetric unit from community and homebirth settings is included in the guideline and community PROMPT training.			released July 2026. Completed April 2026.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 15.6

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Maternity In-House Tobacco Dependency Service
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health
Author:	Lucy Flatley, Transformation Lead Midwife

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes
☐ No
☐ Not Applicable

Executive Summary:

The in-house maternity tobacco dependency treatment service is progressing to plan for implementation in December 2026. Funding has been secured for the full 2.5 WTE Band 5 Maternity Support Worker model, a Public Health Midwife has been appointed to provide clinical leadership and supervision, and a multidisciplinary delivery group is overseeing mobilisation.

The proposed model will provide flexible clinic and home-visiting provision across York and Scarborough and will align with Saving Babies' Lives Care Bundle Version 3 and the National Smoke-Free Pregnancy Incentive Scheme.

Board assurance is supported by established governance and progress with the clinical pathway, service specification, workforce planning and information governance. The principal dependencies requiring continued executive oversight are completion of Tobacco Dependency Advisor recruitment and NCSCT/IPiP training; September sign-off of the data-sharing agreement and DPIA; agreement of NRT supply, storage and the e-cigarette offer; Electronic Health Record configuration for referral, acceptance and first-appointment metrics; and improvement in opt-out referrals before go-live. These controls are being managed through the delivery group, with final clinical documents and the mobilisation plan due to the Maternity Directorate in October. No material change to the December 2026 delivery trajectory is currently reported.

Recommendation:

Trust Board is asked to:

(1) note the progress made and the assurance that implementation remains on track for December 2026;
(2) note the outstanding risks and dependencies relating to recruitment and training, information governance, treatment supply and storage, digital reporting and opt-out referral performance;
(3) endorse continued oversight through the Maternity Tobacco Dependency Delivery Group and established Family Health governance routes; and
(4) request an exception report if any dependency threatens safe mobilisation, with a further readiness update following completion of the October milestones and before go-live.

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Assurance Group	8/9/26	
Maternity Directorate Meeting	14/9/26	Share with Family Health Care Group Board
Family Health Care Group Board	21/9/26	Share with Quality Committee/Trust Board
Quality Committee	22/9/26	

Maternity In-House Tobacco Dependency Service

1. Overview and update on progress

Significant progress has been made over the last eight weeks towards implementation of an in-house maternity tobacco dependency treatment service. Funding has now been agreed support the full 2.5 Band 5 MSW WTE model. Governance, workforce planning and mobilisation are progressing, and the programme remains on track for a December 2026 go-live.

The service specification and clinical pathway are being updated to support evidence-based tobacco dependency treatment in pregnancy, aligned to Saving Babies' Lives Care Bundle Version 3 and the National Smoke-Free Pregnancy Incentive Scheme. The guideline, service specification and NRT protocols will be finalised for presentation to the Maternity Directorate in October.

A multidisciplinary Tobacco Dependency Delivery Group has been established to oversee implementation. Regular meetings are in place with the National Incentive Scheme leads to ensure onboarding aligns to go-live on the in-house service. Information governance is nearing completion: the data-sharing agreement is awaiting final sign-off by the Trust Information Governance Lead and the local DPIA is also close to completion, with both expected to be approved during September.

Recruitment is progressing, a public health midwife has been appointed to. This role will provide leadership and oversight of the service, including supervision of the team. The postholder will be NCSCT trained. Recruitment of Tobacco Dependency Advisors will commence following HR confirmation of indicative matching.

Work is ongoing to finalise a flexible delivery model across York and Scarborough, combining fixed clinic sessions with home visiting across hospital and community locations.

A pharmacy meeting is scheduled to agree NRT supply and storage arrangements and to understand if any amendments are needed to the existing NRT protocol. We are awaiting confirmation on the e-cigarette offer from the ICB and local authorities.

BadgerNet will record appointments and smoking-related activity; work with the Digital Midwife will confirm capture of referrals, referrals accepted into the service and completed first appointments.

NCSCT and IPiP training requirements are being considered, alongside additional training for community and antenatal midwives to strengthen opt-out referrals before go-live.

2. Achievements Since Last Update

- Funding identified to support delivery of service.
- Public Health Midwife role appointed to.
- Tobacco Dependency Delivery Group established and governance documentation nearing completion.
- Proposed Flexible clinic and home-visiting model developed across York and Scarborough.
- DPIA and DSA progressed and to be signed off.

3. Risks / Dependencies

- Timely completion of recruitment and NCSCT/IPiP training.
- Final agreement of NRT, treatment storage and vape offer arrangements.
- Final sign-off of the data-sharing agreement and local DPIA during September.
- BadgerNet configuration to capture required assurance metrics.
- Improvement in opt-out referral performance before December go-live.

4. Next Steps

- Commence recruitment of Tobacco Dependency Advisors.
- Finalise clinic space, home-visiting arrangements and treatment storage.
- Agree the NRT supply model with Pharmacy and confirm the e-cigarette offer with local authorities.
- Meet with digital midwife to confirm BadgerNet capture of referral, acceptance and first-appointment metrics.
- Identify staff requiring NCSCT/IPiP training and deliver additional opt-out referral training.
- Finalise guideline, service specification, NRT protocols and the December mobilisation plan.

Implementation remains on track for December 2026. Funding is secured and key governance, recruitment and service-design milestones are progressing. The next reporting period will focus on completing information governance, recruitment, treatment supply, digital assurance and workforce training to support safe operational readiness.

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	One year post implementation review of the Community Midwife for Equitable Health role
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical lead for Family Health
Author:	Lucy Flatley, Lead Midwife for Transformation

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

☐ Yes

☐ No

☐ Not Applicable

Executive Summary:

- The Community Midwives for Equitable Health role was introduced to improve personalised care, health equity and outcomes for women at increased risk of experiencing health inequalities.
- This review has assessed activity, audit data and service user feedback during the first 12 months of implementation.
- Further work is required to demonstrate sustained impact on maternal and neonatal outcomes over a longer period.

The review demonstrates that the service has been successfully embedded and is contributing to delivery of Trust equity objectives and national maternity inequalities priorities.

Recommendation:

The Board is asked to note the findings of the one-year post-implementation review, support continuation of the Community Midwives for Equitable Health model, and endorse the proposed next steps to strengthen outcome monitoring, develop a maternity health equity dashboard, and undertake a two-year review including East Coast service provision.

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

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation
Quality Committee	18 August 2026	

One year post implementation review of the community midwife for equitable health role

1. Introduction and Background

This report aims to provide assurance on the impact of the Community Midwives for Equitable Health initiative one year following implementation, including its contribution to reducing maternity inequalities, improving access and experience, and supporting delivery of Trust and national objectives.
There are currently two midwives working in the community midwife for equitable health roles, one in the York and Selby area and one working in the East Coast area. This paper includes analysis of the York role only as the Scarborough role is recently established following a gap in service provision and there is not sufficient evidence to complete a full review.
The Community Midwife for Equitable Health role, known locally as the Clover Team was established in April 2025 to reduce maternity health inequalities across York and Scarborough, improve access and experience for women experiencing vulnerability and support delivery of the Trust's Maternity and Neonatal Single Improvement Plan.
Developed in response to national recommendations on persistent inequalities in maternal and neonatal outcomes, the role provides targeted personalised continuity of care for women with complex social factors. It applies proportionate universalism by offering enhanced support to those at greatest risk of poorer outcomes.
The RCM's maternity disadvantage tool is used by wider community midwifery teams to support referrals into the Clover Team and identify women who may benefit from enhanced, targeted care.

2. Methodology

The post-implementation review used quantitative activity data and qualitative service-user feedback to assess the effectiveness of the York Community Midwife for Equitable Health role between June 2025 and June 2026. The review focused on service reach, timeliness of access, intensity of support, support for asylum-seeking women and women's reported experience of care
The findings should be interpreted with caution as this review relates to the York role only and covers the first year of implementation. The review demonstrates evidence of activity, reach and women's experience, but a longer period of outcome monitoring is required to assess sustained impact on maternal and neonatal outcomes and to compare findings across both York and Selby and, East Coast service provision.

Sources of Evidence

Quantitative
- Community Midwife activity and audit data on population served
- Timeliness of access to care
- Support for asylum seeking women

Qualitative
- Women's feedback from an established survey

3. Key findings

Community Midwife activity and audit data on population served

The Community Midwives for Equitable Health service in York (Clover Team) has been successfully established and is providing enhanced maternity support to women experiencing multiple health and social inequalities, including a substantial number of asylum-seeking women and those requiring additional advocacy and support to access maternity services.

During the review period, 61 women were booked under the Community Midwives for Equitable Health service in York. The cohort predominantly comprised women facing complex social circumstances, including asylum seekers, newly arrived migrants, women requiring interpretation services, women living in areas of deprivation, and those experiencing barriers to accessing maternity care.

The midwife delivered a high level of personalised and proactive support throughout the maternity pathway, including:

- 362 antenatal follow-up contacts
- 106 antenatal home visits
- 36 women receiving community postnatal care following birth

The volume of antenatal follow-up and home visiting activity demonstrates the intensive nature of the support provided and reflects the additional needs of the population served. Home visits formed a significant element of the model, enabling care to be delivered in a way that reduced barriers to engagement and facilitated relationship-based continuity of care.

Audit data is also available from the antenatal and postnatal reviews, with 45 antenatal responses and 51 postnatal responses recorded to date. Women were most commonly referred into the Community Midwives for Equitable Health service by the admin team following registration for maternity care and by other community midwives or maternity support workers. No women self-referred during the review period. This suggests that referrals are primarily being generated through professional identification rather than self-referral, highlighting the importance of staff awareness, clear referral criteria and continued promotion of the Clover Team pathway across maternity services.

Referral and involvement data demonstrates the breadth of multi-agency support required by women accessing the Community Midwives for Equitable Health service. In addition to maternity care, women were referred to or supported alongside a range of specialist and voluntary sector services, most commonly the Perinatal Mental Health Team (8), CMHT/Talking Therapies (6), IDAS (5), the Halo Project (4) and the Amethyst Team (3), with smaller numbers involving smoking cessation and drug or alcohol services. While 21 women did not require onward referral and two declined additional support, the data highlights the complexity of need within the caseload and the importance of the Clover Team in identifying wider health and social needs, facilitating timely referrals and coordinating support across services.

Safeguarding data demonstrates that a proportion of women supported by the Community Midwives for Equitable Health service required Children's Social Care involvement. Within the antenatal audit responses, 15 women had a Children's Social Care referral during the current pregnancy, while 30 did not. Previous Children's Social Care involvement was recorded for 6 women, with 37 reporting no previous involvement. Postnatal audit data also indicates that, where recorded, 22 babies were discharged home with parents, and one was not. Together, these findings highlight the importance of the Clover Team's role in

early identification of safeguarding need, multi-agency liaison, advocacy and coordinated support for women and families experiencing additional vulnerability.

Mental health data further demonstrates the complexity of need within the caseload. Recorded mental health needs included anxiety (13), depression (11), PTSD (7), low mood (3), complex PTSD (3), bipolar disorder (2) and EUPD/BPD (1), with a further 4 recorded as “Other”. Twenty women had no recorded mental health need. These findings indicate that a significant proportion of women supported by the Community Midwives for Equitable Health service required trauma-informed, emotionally responsive care, alongside timely identification of need and referral or liaison with specialist mental health services where appropriate.

Interpretation services were required by 43% of women supported by the service, demonstrating the importance of accessible communication and culturally responsive care within the Community Midwives for Equitable Health model. This highlights the need for timely access to interpreting support to enable informed choice, effective engagement and equitable access to maternity care.

Birth preparation support was predominantly delivered through individualised 1:1 discussions, with 44 women receiving 1:1 birth preparation compared with one woman accessing parentcraft. This reflects the personalised nature of the Clover Team model and suggests that women supported by the service may benefit from tailored preparation that can be adapted to individual needs, language, confidence, social circumstances and birth preferences.

Timeliness of Access to Care

Of the 61 women booked under the service:

- **48 women (78.7%) were booked by 10+0 weeks gestation**
- **31 women (50.8%) were booked by 13+0 weeks gestation**

Whilst booking data should be interpreted in the context of women transferring into the service after their initial maternity booking, these findings indicate that 78.7% of women were known to maternity services by 10+0 weeks gestation and 50.8% were booked by 13+0 weeks gestation, supporting opportunities for early assessment, screening and intervention while also highlighting the need to understand barriers to timely booking for women accessing the service later in pregnancy.

Support for Asylum-Seeking Women

A notable proportion of the caseload comprised women seeking asylum.

- **46 women (75.4% of the total caseload) were asylum-seeking women.**
- Within this cohort, **15.2% were booked by 10+0 weeks gestation.**

This finding highlights the significant barriers to accessing maternity care faced by asylum-seeking women, including recent arrival in the UK, language barriers, uncertainty regarding entitlement to services, housing instability and complex social circumstances. The Community Midwives for Equitable Health service has played an important role in engaging and supporting this population, providing continuity, advocacy and coordination across agencies to facilitate access to maternity care and wider support services.

Equity Impact

The demographic profile of women supported by the service demonstrates that the model is successfully reaching populations known to be at increased risk of poorer maternity experiences and outcomes. Through targeted outreach, home visiting, continuity of care and partnership working, the service has improved accessibility and responsiveness for women who may otherwise experience difficulties engaging with maternity services.
The level of activity delivered during the review period provides assurance that the service is operating as intended, with a strong focus on personalised care, relationship-based support and reducing barriers to access for underserved communities.

Women's Experience and Feedback

Feedback received from women supported by the Community Midwife for Equitable Health (Clover Team) demonstrates consistently positive experiences of care, with particularly strong themes relating to continuity, accessibility, emotional support, responsiveness and preparation for labour and birth.

Between 12 January and 10 July 2026, the Clover Team received 24 feedback responses, of which 23 contained substantive responses for analysis. Overall satisfaction with the service was exceptionally high, with 96% of respondents reporting they were either extremely happy (74%) or very happy (22%) with the care they received. Only one respondent reported being neither happy nor unhappy, and no respondents reported dissatisfaction with the service. The responsiveness of the team was rated particularly positively. All respondents (100%) described the Clover Team as either extremely responsive (48%) or very responsive (52%), demonstrating the team's ability to provide timely support and maintain effective communication throughout pregnancy and the postnatal period. Women also reported high levels of satisfaction with the information provided to prepare them for labour and delivery. 100% of respondents stated they were either very happy or extremely happy with the information received regarding labour, birth and what to expect during delivery.

Key Themes

- Continuity of Care: a recurring theme throughout the feedback was the value women placed on seeing the same midwife throughout their maternity journey. Women frequently described the relationship they developed with their named midwife as a key factor in building trust, confidence and reassurance. Individual staff members were repeatedly recognised for their kindness, professionalism and commitment to personalised care.
- Home Visits and Accessibility: home visits were the most frequently cited aspect of care, mentioned by over half of respondents. Women described home visits as convenient, supportive and reassuring, enabling care to be delivered in a way that met their individual needs and circumstances.
- Emotional Support and Advocacy: several women described receiving support during periods of anxiety, social complexity, domestic abuse, loneliness and challenging family circumstances. Feedback highlighted the importance of having a trusted professional who listened, advocated on their behalf and provided ongoing reassurance.
- Preparation for Labour and Birth: women consistently reported that explanations regarding labour, delivery options, caesarean birth, pain relief and signs of labour were clear and helpful. Respondents felt informed and empowered to make decisions about their care and reported increased confidence approaching birth.

- Responsive Communication: the team's accessibility and responsiveness were highlighted throughout the feedback, with women describing prompt responses to queries and feeling supported when they required advice or reassurance.
- Service User Feedback: women described the care provided as compassionate, personalised and responsive:
  "Jill was always looking out for me and making sure all my pregnancy needs were always met and would go above and beyond to make sure I was ok postpartum."
  "From the beginning of my pregnancy through to the postnatal period, she was always there for me, reassured me, listened to me, encouraged me, and supported me."
  "She provided outstanding care and support throughout my pregnancy and birth journey, kind, compassionate and professional."
  "The information was clear and easy to understand, and it helped me prepare for labour and delivery."
- Areas for Learning: one respondent described a negative experience within the maternity triage pathway prior to admission. Whilst the individual subsequently reported receiving good care and treatment, this feedback provides an opportunity for wider learning regarding consistency of experience across interfaces within the maternity pathway. No concerns relating directly to Clover Team care were identified.

The feedback demonstrates that the Clover Team is achieving its intended objectives of providing personalised, continuity-based care for women with additional social and health needs. Women consistently described feeling listened to, supported and well prepared for birth, with continuity of caregiver, home visiting and responsive communication emerging as the principal strengths of the model. The findings provide strong assurance regarding the quality and impact of the service and support its continued contribution to reducing inequalities and improving women's experiences of maternity care.

The feedback provides strong evidence that women value the continuity, accessibility and personalised support provided by the Clover Team. However, the feedback sample is relatively small and represents women who responded to the survey. Ongoing feedback collection should therefore continue alongside activity and outcome monitoring to provide a fuller picture of service impact over time.

Partnership working

Partnership working is central to the Community Midwives for Equitable Health model. The role strengthens links with local authority colleagues, including health visiting and social work teams, community organisations and voluntary sector partners such as Refugee Action York, to improve access to maternity care for women who may face barriers to engagement. This approach supports earlier identification of need, advocacy, signposting and a more coordinated system response for women experiencing complex social circumstances. Collaborative work with Bundles of Joy, Refugee Action York, MEARS and health visiting colleagues has supported development of a streamlined pathway for baby essentials referrals, enabling timely referral and equitable access to practical support. The role also connects with specialist networks, including prison midwives and migrant community midwife networks, to promote shared learning, supervision and consistent care for women with additional vulnerabilities.

4. Summary

The review demonstrates that the Community Midwives for Equitable Health model has been successfully implemented in York and is reaching women who experience significant social complexity and barriers to care. Evidence from activity data and service-user feedback indicates enhanced engagement with underserved populations, positive experiences of continuity-based care, strengthened partnership working and emerging improvements in access. Further work is required to strengthen outcome monitoring and assess sustained impact over a longer period, including East Coast service provision.

5. Next Steps

The Maternity and Neonatal Assurance Group, Maternity Directorate and Maternity and Neonatal Improvement Plan Oversight Group Meetings are asked to support continuation of the Community Midwives for Equitable Health provision, recognising the role's contribution to improving access, experience and targeted support for women experiencing health inequalities. The service should continue to develop maternity health equity outcome monitoring, including a health equity dashboard, to strengthen assurance on activity, outcomes and impact over time. A two-year review should be undertaken to assess sustained impact and include both York and East Coast service provision.

Date: 6th August 2026

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Integrated Safeguarding Annual Assurance Report 2025/26
Director Sponsor:	Joe Hague – Chief Nurse
Author:	Nicola Cowley – Head of Safeguarding & Complex Needs

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:
This annual report provides assurance that during 2025/26 the Trust met its statutory safeguarding responsibilities across children, adults, maternity, domestic abuse, Mental Capacity Act and Prevent. Safeguarding demand remained high and complex, particularly for unborn babies and adult safeguarding activity; however, strong leadership, high supervision compliance, effective partnership working and robust governance arrangements provide assurance of safe and proportionate practice. Key risks relating to training compliance, workforce capacity and digital system transition

remain but are clearly identified, actively managed and supported by mitigation plans, with positive progress evident.
Recommendation: The Board of Directors is asked to receive the 2025/26 Annual Safeguarding Assurance Report for assurance, note the key risks and mitigating actions, and approve onward reporting to Trust governance committees in line with the agreed reporting schedule.

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

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

Meeting/Engagement	Date	Outcome/Recommendation

Integrated Safeguarding Annual Assurance Report 2025/26

1. Introduction and Background

This annual report provides assurance to the Integrated Safeguarding Group on the Trust's delivery of its statutory safeguarding responsibilities for children, adults, maternity, domestic abuse, Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Prevent across the period April 2025 – March 2026.

This report provides an integrated overview of safeguarding across adults, children and maternity services, supported by detailed Quarter 4 reports included as appendices. These demonstrate a safe, responsive and proportionate service with strong governance, statutory compliance and effective partnership working. While demand remains high in children's and maternity safeguarding, there is clear evidence of strengthened oversight, improved system visibility and preventative practice. Key risks relating to workforce capacity, training compliance and digital systems are recognised and actively managed, with positive direction of travel. The appended reports provide detailed assurance and inform priorities for the year ahead.

The report synthesises assurance from quarterly safeguarding reports (Q1–Q4) and is structured in line with the NHS England Safeguarding Accountability and Assurance Framework (SAAF). It provides an integrated overview of safeguarding activity, performance, risks, mitigations and system learning, enabling the Integrated Safeguarding Group to provide onward assurance to Trust governance committees.

2. Considerations

The Board is asked to:

Receive this annual report for assurance
Confirm that statutory safeguarding duties have been met during 2025/26
Approve onward reporting to Trust committees in line with the reporting schedule

3. Current Position/Issues

3.1 Overall Safeguarding Assurance

Across 2025/26, the Trust has continued to meet its core statutory safeguarding responsibilities, supported by:

- **Strong professional leadership and governance**
- **High levels of safeguarding supervision compliance**
- **Robust partnership working**
- **Improved systems assurance and audit processes**

Safeguarding demand increased significantly for parts of the year, particularly for adults and unborn babies, creating sustained pressure on workforce capacity. However, assurance is provided that risks were identified early, escalated appropriately and managed proportionately, with no evidence of systemic failure or under-reporting.

3.2 Safeguarding Children & Maternity- Assurance position

Safeguarding demand for unborn babies and babies born into the care of the Local Authority remained high and sustained throughout the year.

A total of 32 babies were born into care in 2025/26, consistent with the previous year.

All other babies subject to Child Protection Plans were supported to return home through robust pre-birth planning and partnership working.

Safeguarding supervision remains a key strength, with sustained high compliance across maternity and children's services.

Key risks

- **Safeguarding Children Level 3 training remained below the 90% Trust KPI throughout the year, particularly for medical staff.**
- **MCA/DoLS training compliance for maternity and medical staff remained a persistent risk.**
- **Workforce capacity pressures, including vacancy management and reliance on short-term mitigation, continued to present a risk to resilience.**

Mitigation and progress

- **Revised Level 3 training model aligned to updated Intercollegiate guidance (2025) developed and progressed.**
- **Recruitment of safeguarding leadership roles (including Equitable Health Midwives and Lead Midwife) strengthened operational delivery.**
- **Learning from rapid reviews and non-mobile baby cases was embedded through training, SOP updates and partnership learning.**

3.3 Safeguarding Adults, MCA, Domestic Abuse and Prevent - Assurance position

Safeguarding Adults activity fluctuated across the year, with increased demand in earlier quarters followed by an appropriate reduction in Quarter 4, without evidence of under-reporting.

Concerns raised against the Trust reduced by 37% in Q4, and concerns raised by the Trust also reduced, indicating stronger early identification and prevention.

MCA and DoLS governance strengthened following integration into safeguarding adults governance structures.

Domestic Abuse Liaison Practitioners (DALPs) delivered demonstrable impact, with strong staff feedback, increased referrals and improved confidence.

Key risks

- MCA/DoLS educator capacity and face-to-face training compliance remained below target.
- Domestic Abuse Liaison Practitioner posts continued to rely on temporary funding, presenting a sustainability risk.
- Periods of workforce reduction (e.g. maternity leave) required active mitigation.

Mitigation and progress

- Appointment of a Named Nurse for Safeguarding Adults strengthened leadership and oversight.
- Introduction of assessment-based MCA/DoLS training alternatives reduced access barriers.
- Prevent activity was managed appropriately, with assurance of proportionate and timely responses.

3.4 Workforce, Training and Supervision

Strengths

- Safeguarding supervision compliance remains consistently strong and is a core source of assurance.
- Clear leadership oversight through the Integrated Safeguarding Group and Named Professional structure.
- Positive direction of travel for workforce stabilisation across safeguarding functions.

Ongoing challenges

- Training compliance for Safeguarding Children Level 3 and MCA/DoLS did not consistently meet Trust targets.
- Workforce resilience remains vulnerable to vacancies and reliance on short-term funding arrangements.

3.5 Systems, Digital and Information Assurance

- Child Protection – Information Sharing (CP-IS) compliance strengthened during the year, supported by enhanced audit processes.
- The Newborn Body Map SOP and audit processes demonstrated high compliance.
- Electronic Patient Record (EPR) transition risks were actively managed, with safeguarding oversight embedded within programme governance.
- Emergency Department coding and discharge processes remained an identified risk but were closely monitored and escalated.

4. Summary

Safeguarding arrangements during 2025/26 provide clear assurance that the Trust:

- Continues to meet its statutory safeguarding responsibilities
- Has robust governance, professional oversight and partnership engagement
- Demonstrates a Think Family approach embedded across services
- Actively identifies, escalates and manages safeguarding risks
- While training compliance, workforce capacity and digital transitions remain active risks, they are well-defined, controlled and supported by clear mitigation plans, with positive progress evident.

5. Next Steps (2026/27)

- Improve Safeguarding Children Level 3 and MCA/DoLS training compliance, particularly for medical staff.
- Sustain workforce resilience and leadership capacity across safeguarding services.
- Secure longer-term sustainability for Domestic Abuse Liaison Practitioner roles.

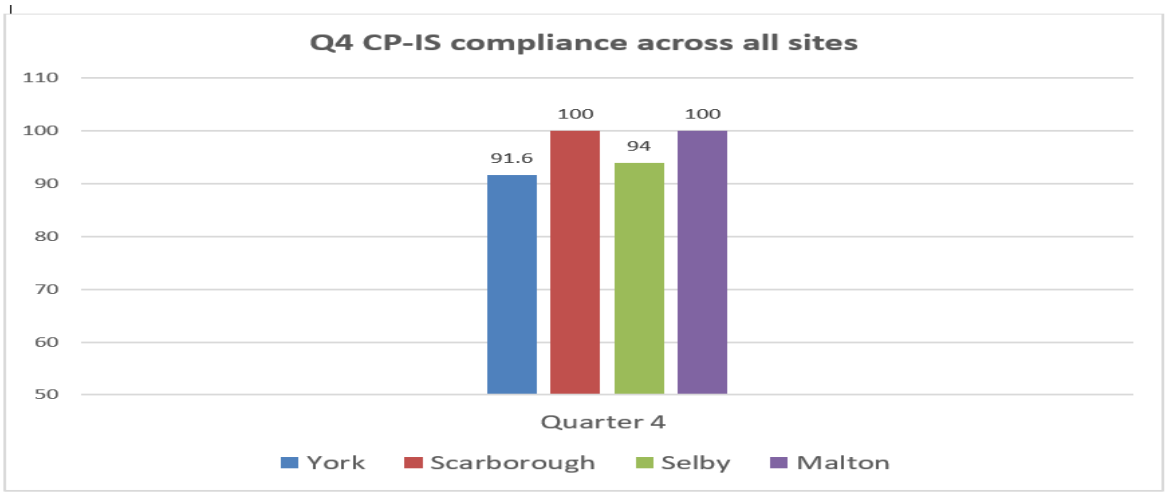
- Maintain enhanced safeguarding visibility in Emergency Department and discharge pathways.
- Embed learning from Safeguarding Adult Reviews, Rapid Reviews and audits into practice and training.
- Provide continued integrated safeguarding assurance to Trust governance committees.

Date: April 2026

Activity & Performance reports
Appendix 1a– Safeguarding Children Activity, Performance and Next Steps Summary - Quarter 4 2025/26
Appendix 1b - Named Midwife for Safeguarding – Activity, Performance and next steps Summary - Quarter 4 2025/26
Appendix 2 – Safeguarding Adults (including Domestic Abuse, MCA and Prevent) - Activity and Performance Summary
Quarter 4 (January–March 2026)

Appendix 1a) Safeguarding Children Activity, Performance and Next Steps Summary - Quarter 4 2025/26

Safeguarding Activity & System Pressure
Child Protection Information Sharing (CP-IS) compliance improved across Q4, with high performance at Scarborough and Malton sites and continued improvement at York and Selby.



Increased volume and complexity of safeguarding concerns linked to:

- Emergency Department attendances
- Discharge coding delays affecting downstream safeguarding assessment.
- Continued **high demand for statutory activity**, including legal statement requests and contributions to multi-agency safeguarding processes.

Conclusion
➡️ Activity levels remain **high and pressurised**, with performance risks concentrated around information flow and system interfaces rather than frontline engagement.

2. Workforce Capacity & Supervision
Safeguarding Children Team capacity remained under pressure but was partially mitigated through recruitment and role alignment.

Performance snapshot:

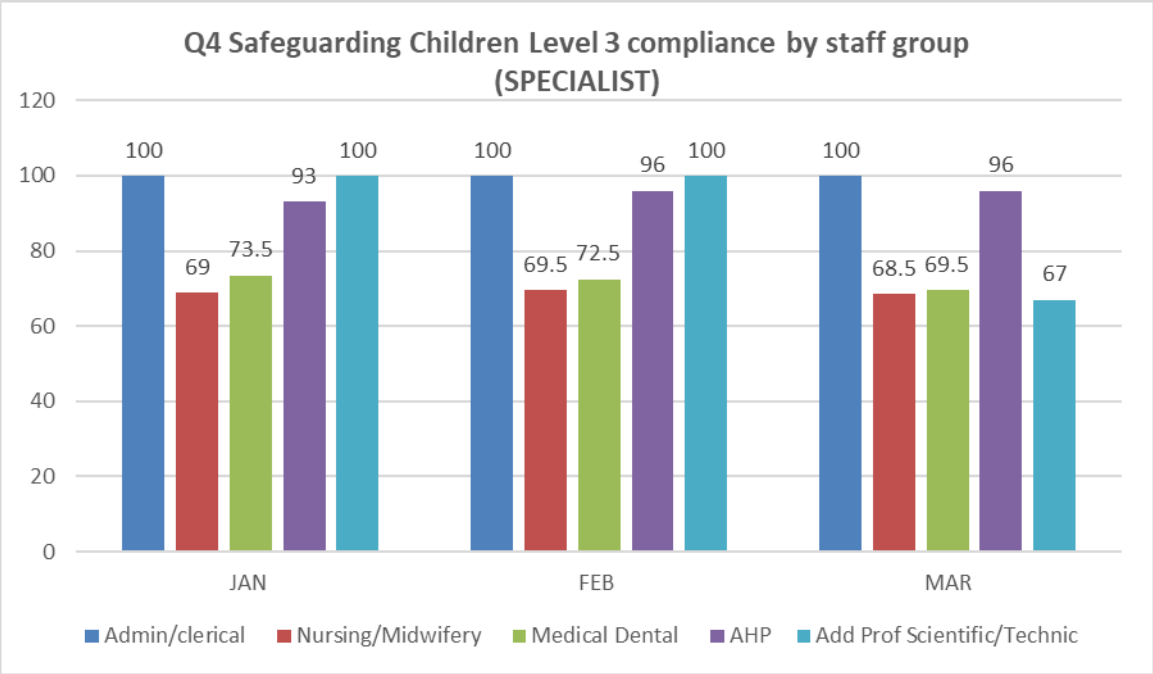
- ✅ Recruitment completed across Safeguarding Liaison Nurse job shares, restoring City of York exploitation meeting coverage.
- ⚠️ **0.8 WTE Band 7 vacancy** remained in place during Q4, with interviews scheduled for April 2026
- 🔴 Removal of supervision self-declaration from CLAD system limits accurate monitoring of compliance against Trust supervision policy.

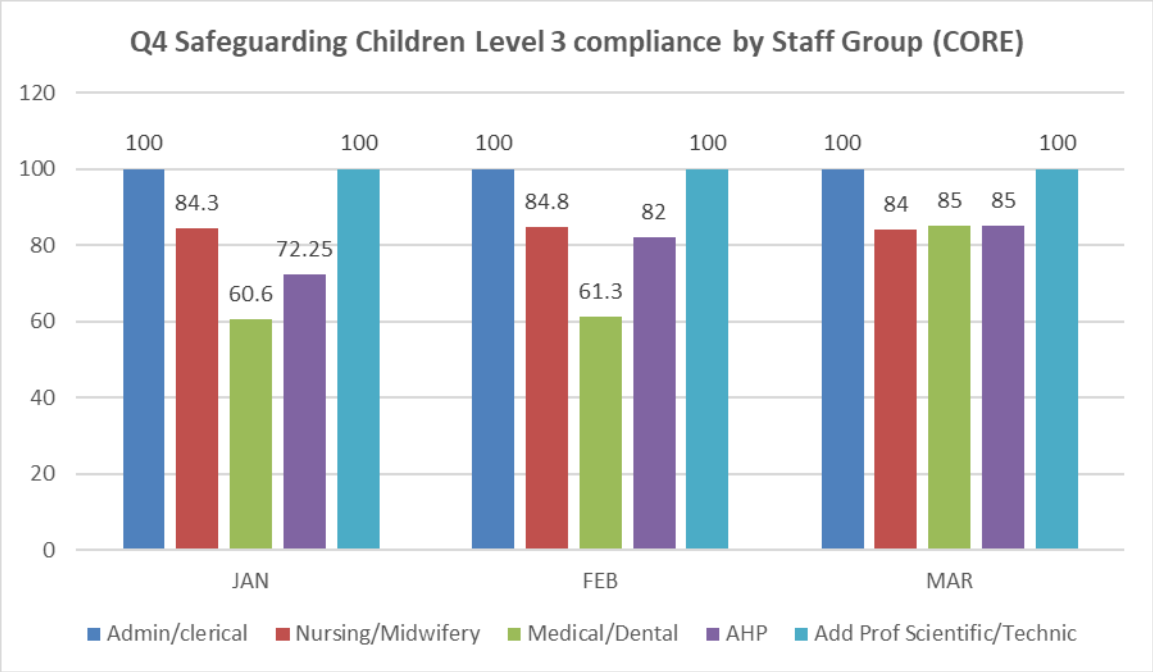
Conclusion:
➡️ Workforce resilience has improved, but **supervision assurance and capacity remain a key risk** pending vacancy resolution and system fixes.

3. Safeguarding Training Compliance

Care Group	Directorate	Department	Staff Group	Certification Name	Percentage Compliant
419 CG Medicine	419 Acute & Emergency Scarborough Directorate	419 Emergency Medicine Scarborough Department	Additional Clinical Services	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	100%
419 CG Medicine	419 Acute & Emergency Scarborough Directorate	419 Emergency Medicine Scarborough Department	Medical and Dental	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	62%
419 CG Medicine	419 Acute & Emergency Scarborough Directorate	419 Emergency Medicine Scarborough Department	Nursing and Midwifery Registered	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	74%
419 CG Medicine	419 Acute & Emergency York Dir	419 Emergency Medicine York	Additional Clinical Services	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	0%
419 CG Medicine	419 Acute & Emergency York Dir	419 Emergency Medicine York	Allied Health Professionals	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	100%
419 CG Medicine	419 Acute & Emergency York Dir	419 Emergency Medicine York	Medical and Dental	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	60%
419 CG Medicine	419 Acute & Emergency York Dir	419 Emergency	Nursing and Midwifery Registered	Core Stat/Mand - Safeguardin	78%

		Medicine York		g Children Level 3 Core (CSTF) 3years	
Specialist					
419 CG Medicine	419 Acute & Emergency York Dir	419 Emergency Medicine York	Nursing and Midwifery Registered	Core Stat/Mand - Safeguarding Children Level 3 Specialist (CSTF) 3years	67%
419 CG Medicine	419 Acute & Emergency York Dir	419 Emergency Medicine York	Students	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	0%
419 CG Medicine	419 Acute & Emergency York Directorate	419 Emergency Medicine Dept	Allied Health Professionals	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	100%
419 CG Medicine	419 Acute & Emergency York Directorate	419 Emergency Medicine Dept	Medical and Dental	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	0%
	419 Acute & Emergency York Directorate	419 Emergency Medicine Dept	Nursing and Midwifery Registered	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	83%





- Training performance improved modestly during Q4 but **remains below the Trust KPI of 90%**, with particular variability across staff groups.
- **Q4 performance highlights:**
- **Level 3 Core compliance (Trust-wide): 79%**
  (+4.7% improvement across the year)
- **Level 3 Specialist compliance: 83.3%**
  (+3% improvement)
- Significant **variation by staff group**, with medical and dental staff showing lower and more volatile compliance in monthly trend charts.

Interpretation:

➡️ Direction of travel is positive, but **risk remains active** until structural changes to training delivery are implemented.

4. Safeguarding Systems & Digital Transformation

- Safeguarding systems performance continues to strengthen, with known and managed risks.
- **Key system indicators:**
- ✅ **CP-IS compliance** improved across all sites, supported by enhanced audit frequency and communication.
- ⚙️ **CP-IS Phase 2** (scheduled care expansion) remains pending national and ICB direction; no current operational risk but active monitoring required.
- ⚠️ **Nervecentre EPR implementation** introduces a transitional risk to safeguarding documentation and information sharing if not tightly controlled.
- 🔴 Delays in ED discharge coding continue to impact timeliness of safeguarding assessment and primary care information sharing.

Conclusion:
➡️ Systems are improving, but **digital transition and ED processes remain a key operational safeguarding risk**.

5. Partnership Working, Reviews & Learning
During Q4, the Safeguarding Children's Team demonstrated strong partnership engagement and system leadership through active participation in multi-agency exploitation audits across City of York and North Yorkshire, contributing to learning on both child exploitation and long-term pathways into offending. The team's impact was formally recognised through a multi-agency award in March 2026. In addition, the team contributed to Child Death Overview Panel (CDOP) activity, including a conference focused on preventing teenage road traffic fatalities and the development of a public health video campaign. Close working with the City of York Safeguarding Children's Partnership supported the identification of learning from recent rapid reviews and the establishment of a clear, focused improvement approach. Q4 included significant multi-agency learning and scrutiny activity.

- **Key partnership activity:**
- Active Trust involvement in **Rapid Reviews**, including the CYSCP 'Yasmin' case, identifying missed opportunities and system learning.
- Contribution to **multi-agency audits**, including a mock JTAI on sexual abuse and exploitation.
- Ongoing participation in **CDOP**, including preventative campaigns and learning dissemination.

Conclusion
➡️ Strong visibility and influence within safeguarding partnerships, with a clear focus on translating learning into practice.

Next Steps – Quarter 1 (2026/27)
1. Training Improvement & Performance Recovery

- Launch the **updated Level 3 Safeguarding Children training package**, aligned to the Intercollegiate Document (2025), with enhanced focus on:
- Injuries to non-mobile babies
- Professional curiosity and respectful challenge
- Target **medical and dental staff compliance**, using directorate-level escalation and monitoring.

- Maintain safeguarding training as a **live risk on the Trust risk register** until KPI recovery is achieved.

2. Workforce & Supervision Assurance

- Complete recruitment to the **0.8 WTE Band 7 Named Professional vacancy** and stabilise team capacity.
- Resolve **supervision compliance monitoring gaps**, including system-based recording aligned to Trust policy.
- Maintain the updated SCT workplan focusing on practitioners holding children on CPPs for extended periods.

3. Systems & Digital Safeguarding

- Continue **enhanced CP-IS auditing** and cross-site performance reporting.
- Prepare for **CP-IS Phase 2 implementation**, subject to ICB and national direction.
- Provide safeguarding oversight and assurance throughout **Nervecentre rollout**, ensuring safe interim arrangements.
- Address ED discharge coding delays in collaboration with operational leads to reduce safeguarding risk.

4. Embedding Learning & Partnership Assurance

- Implement and track actions arising from **recent Rapid Reviews**, with assurance back to ISG.
- Continue multi-agency audit participation and preparation for potential **external inspection activity**.
- Support staff with legal processes, including confidence-building around **statement writing**.

Quarter 1 Focus – At a Glance

• **Domain**	• **Q1 2026/27 Priority**
• Training	• Level 3 compliance recovery
• Workforce	• Vacancy resolution & supervision assurance
• Systems	• CP-IS stability & EPR transition
• Practice	• Learning from non-mobile injury reviews
• Partnership	• Sustained multi-agency assurance

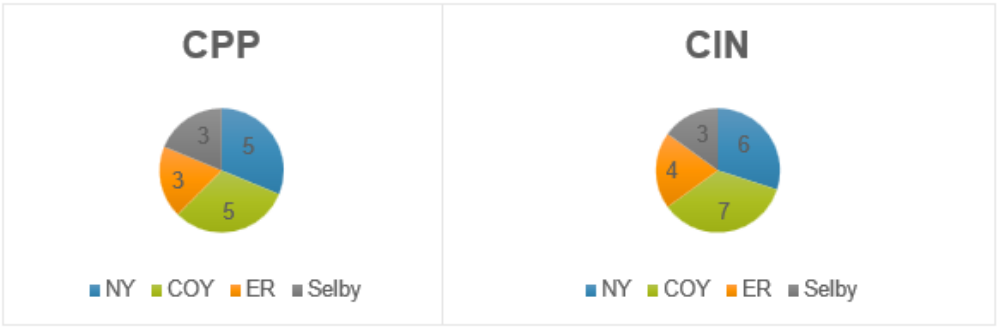
Lynda Fairclough/Polly Newell
April 2026

1b) Named Midwife for Safeguarding - Activity and Performance Summary

1. Safeguarding Demand & System Pressure

High safeguarding activity continues across Q4, with sustained demand relating to unborn babies and babies born into care of the Local Authority.

- Unborn Babies (UBB) in Q4 Subject to Child Protection Plan (CPP) and Child in Need (CIN) (This does not include those receiving Early Help).

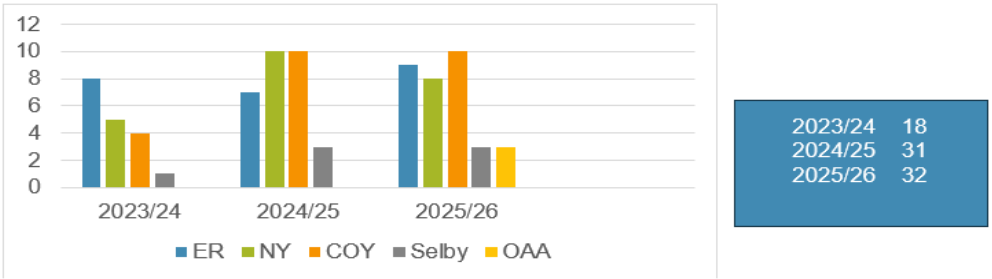


- **Babies placed into the care of the local authority at birth**

Local Authority	Care of LA Q1	Care of LA Q2	Care of LA Q3	Care of LA Q4	Total 2025/26
East Riding	2 & Twins	2	2	1	9
North Yorkshire (Scarborough, Whitby, Ryedale)	2	1	2	3	8
City of York	3	2 & Twins	4	2	13
Selby	3	0	0	0	3
2024/25 Total 31	12	7	8	5	2025/26 32

Key indicators (Q4):

- **Unborn Babies subject to CPP and CIN remain high across all Local Authority areas.**
- **Babies born into the care of the Local Authority remained consistent with Q3 and in line with 2025/26 trend**



- **2025/26 total: 32 babies born into care**, a slight increase on 2024/25 (31).

- All remaining babies subject to CPP were **supported to return home with their mothers**.

Conclusion

➡️ Demand remains **systemic and sustained**, reinforcing the importance of pre-birth planning, Early Help, and Family First reforms.

2. Workforce, Supervision & Training Compliance

Safeguarding Mandatory Training

Safeguarding Level 3 Mandatory Training Compliance: The current training is not aligned with the intercollegiate document 2025. New training proposal submitted Level 3 core to undertake e-learn only, specialist to continue with e-learn and face to face every 3 years.

Care Group	Certification Name	Staff Group	Jan 2026	Mar 2026	Directorate	Dec 2025
419 CG Family Health Care Group	Core Stat/Man - Safeguarding Children Level 3 Core (CSTF) 3years	Medical and Dental	68%	67% ↓	Obs & Gynae	64%
419 CG Family Health	Core Stat/Mand - Safeguarding Children Level 3 Core (CSTF) 3years	Nursing and Midwifery Registered	86%	85% ↓	Maternity	81%
419 CG Family Health Care Group	Core Stat/Mand - Safeguarding Children Level 3 Specialist (CSTF) 3years	Medical and Dental	67%	64% ↓	N/A	N/A
419 CG Family Health Care Group	Core Stat/Man - Safeguarding Children Level 3 Specialist (CSTF) 3years	Nursing and Midwifery Registered	81%	82% ↑	Maternity	80%

MCA/DOLS Mandatory Compliance

Care Group	Certification Name	Staff Group	Quarter 4 2026
419 CG Family Health Care Group	Mental Capacity Act Higher Level	Medical and Dental	51%
419 CG Family Health Care Group	Mental Capacity Act Higher Level	Nursing and Midwifery Registered	69%

Safeguarding supervision performance is strong, with workforce capacity risks being mitigated.

Performance snapshot:

- ✅ **Safeguarding Supervision**
  - 100% compliance with 3 required sessions
  - 98.2% compliance with 4 sessions (annual requirement)
- ⚠️ **Safeguarding Children Level 3 Training**
  - Nursing & Midwifery: **~85% core / ~82% specialist**
  - Medical staff: **~64–67%** (ongoing risk)
- 🔴 **MCA / DoLS compliance remains low**
  - Medical: **51%**
  - Nursing & Midwifery: **69%**

Workforce mitigation:

- Band 7 Safeguarding Lead Midwife in post
- Band 6 Equitable Health Midwives recruited (April 2026 start)

Conclusion

➡️ **Supervision is a strength**, while **training compliance (MCA/DoLS and medical staff)** remains the key performance gap.

3. Safeguarding Practice & Systems Assurance
Clinical systems and documentation continue to be strengthened through audit and escalation.
Key system indicators:

- ✅ **Newborn Body Mapping**
  - 100% compliance at York site
  - Visibility issues at Scarborough identified and escalated.
- ✅ **CP-IS**
  - SOP ratified
  - Monthly audit programme in place
- ⚙️ **Nervecentre EPR**
  - Safeguarding functionality held outside initial go-live.
  - Interim arrangements maintained via CPD to ensure continuity

Conclusion:
➡️ Risks are **identified early, monitored, and escalated**, with clear assurance actions in place.

4. Quality, Domestic Abuse & Statutory Activity
High volumes of statutory safeguarding activity were managed within timescales.
Q4 activity highlights:

- **Routine Enquiry (Domestic Abuse)**
  - Booking: **99.3%**
  - 34 weeks: **97.8%**
  - Post-birth: **100%.**
- **172 disclosures** received in Q4
- **44 Mother & Baby Forms** completed.
- **11 FGM cases** reported (submitted via quarterly return)
- **Court activity:**
  - 2 court orders received.
  - No court summons issued.

Conclusion:
➡️ **Very strong performance** against national expectations for routine enquiry and statutory responsiveness.

5. Partnership Working & Learning
Partnership engagement remains a core strength, with visible alignment to NHSE SAAF priorities.
Key achievements:

- Active participation in:
  - Pre-Birth Panels (City of York)
  - Family First Reform programmes
  - Rapid Review and learning processes.
- Delivery of:
  - Safeguarding Masterclasses
  - Early Help training and awareness sessions.
- Learning events planned to embed rapid review findings

Conclusion:
➡️ Clear evidence of **system leadership, shared learning, and assurance across partnerships**.

Next Steps – Quarter 1 (2026/27)

1. Reducing Safeguarding Demand & Improving Early Intervention

- Continue monthly monitoring and reporting of Unborn Babies (CPP/CIN) and babies born into care, using existing dashboards and year-on-year trend charts.
- Strengthen health contribution to **Family First reforms**, with a focus on pre-birth planning and early engagement to reduce escalation to statutory intervention.
- Maintain Named Midwife representation on **Pre-Birth Panels** and partnership forums to influence prevention and shared decision-making.

2. Training Compliance & Workforce Capability

- Implement the **approved Safeguarding Level 3 training model** (core e-learning only, specialist blended) to support improved compliance, particularly for medical staff.
- Deliver targeted **medical staff engagement and escalation** to address persistently low safeguarding and MCA/DoLS compliance.
- Finalise and implement the **MCA/DoLS improvement action plan** in collaboration with MCA leads, with quarterly assurance reporting to ISG.
- Embed review of safeguarding and MCA training compliance within **annual appraisal processes** across maternity and family health services.

3. Safeguarding Supervision & Professional Assurance

- Maintain **100% safeguarding supervision coverage** for caseload holders, supported by quarterly Named Midwife audit and reporting.
- Use supervision intelligence to identify emerging risks, learning needs and support requirements linked to increased safeguarding demand.

4. Systems, Documentation & Digital Transition

- Resolve **newborn body map visibility issues** on the Scarborough site and confirm consistent access across CPD and Badger systems.
- Continue monthly **CP-IS audits** following SOP ratification, with exception reporting through safeguarding governance routes.
- Support the phased introduction of **Nervecentre EPR**, ensuring safeguarding documentation pathways remain safe, accessible, and auditable during transition.

5. Partnership Working & Learning from Reviews

- Embed learning from **Rapid Reviews**, including delivery of the planned under-1 learning event hosted by the City of York Safeguarding Partnership.
- Continue Named Midwife participation across **Family First, Early Help and safeguarding partnership structures**, ensuring health assurance is visible and consistent.
- Agree and formalise the **Trust's health contribution** to multi-agency Family First activity during 2026/27.

Quarter 1 Focus (At a Glance)

Priority Area	Q1 2026/27 Focus
Safeguarding Demand	Early intervention and pre-birth planning
Training Compliance	Medical staff & MCA/DoLS improvement
Supervision	Sustained 100% coverage
Systems	Body mapping & EPR safeguarding pathways
Partnership	Embedding Family First & review learning

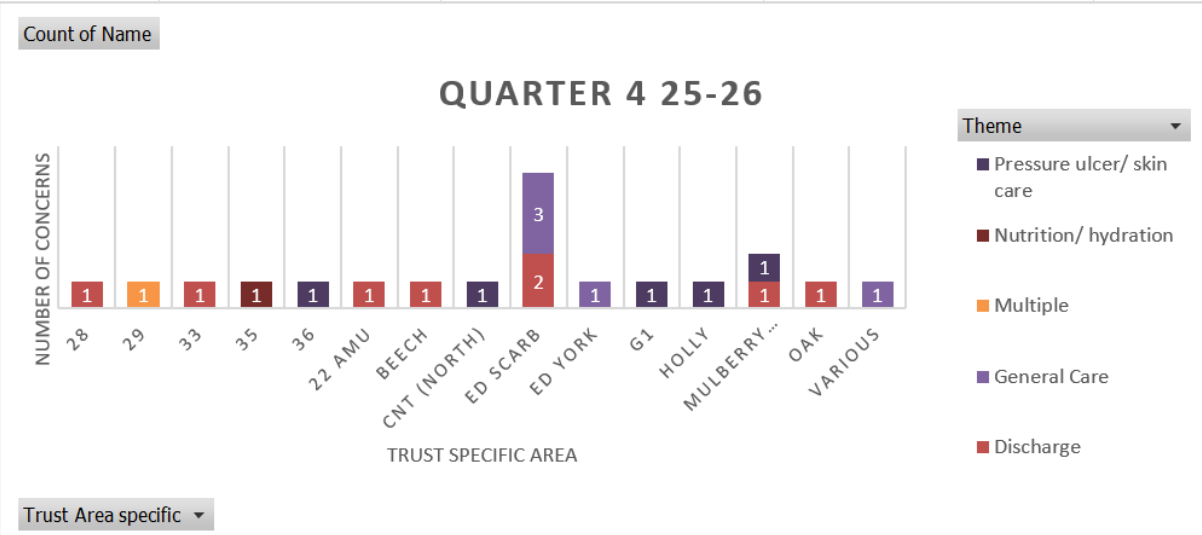
Lynda Fairclough - Named Midwife for Safeguarding

Appendix 2 – Safeguarding Adults (including Domestic Abuse, MCA and Prevent) - Activity and Performance Summary
Quarter 4 (January–March 2026)

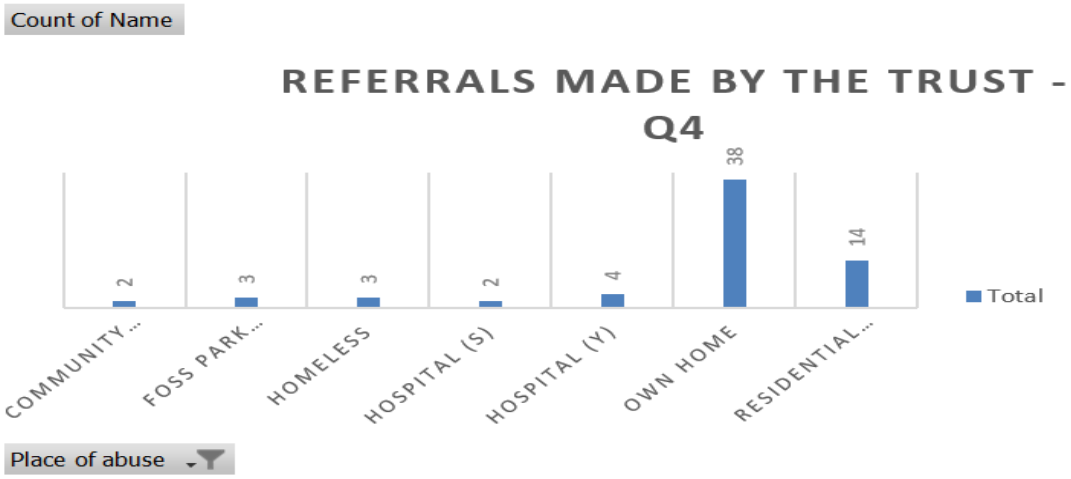
1. Overview of Activity

Safeguarding Adults activity in Quarter 4 reflected a seasonal reduction in overall safeguarding workload, consistent with previous years, while maintaining strong visibility, assurance, and statutory compliance across the Trust. The quarter demonstrated effective safeguarding oversight, targeted workforce interventions, and sustained training delivery, alongside identified risks requiring ongoing mitigation.

2. Safeguarding Adults Referrals and Concerns



- A total of **20 safeguarding concerns** were raised **against the Trust** in Quarter 4 2025/26, representing a **37% reduction** compared to the same quarter in 2024/25 (29 concerns).
- **Discharge-related concerns** remained the most common theme (8 concerns, 40%), though this represents a **40% decrease** compared to Quarter 4 2024/25.



- The **Safeguarding Adults Team raised 68 safeguarding concerns to Local Authorities**, a reduction of **18.7%** compared with Quarter 4 2024/25 (82 concerns).
- Joint reviews between the **Tissue Viability Specialist Nurse and Safeguarding Adults Specialist Nurse** reviewed **211 patients**, resulting in **13 safeguarding concerns** (6.2%), evidencing effective multidisciplinary scrutiny.
- Comparison across quarters indicates an **8.7% increase in patients reviewed**, alongside a **3.6% reduction in formal safeguarding concerns**, suggesting earlier identification and preventive intervention.

Performance assurance:
Safeguarding activity has reduced appropriately without indicators of under-reporting, demonstrating a proportionate and preventive safeguarding approach.

3. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- During Quarter 4, **565 DoLS applications** were submitted:
  - 481 from Care Group Medicine
  - 84 from Care Group Surgery
- **189 applications** were identified as **non-compliant or invalid** (34% Medicine; 30% Surgery) and have been **appropriately datixed**.
- Quality assurance processes within the MCA/DoLS service are well-embedded and highly visible.
- The transition of MCA and DoLS into the Safeguarding Adults workstream has strengthened governance; however, educator capacity constraints remain a recognised risk.

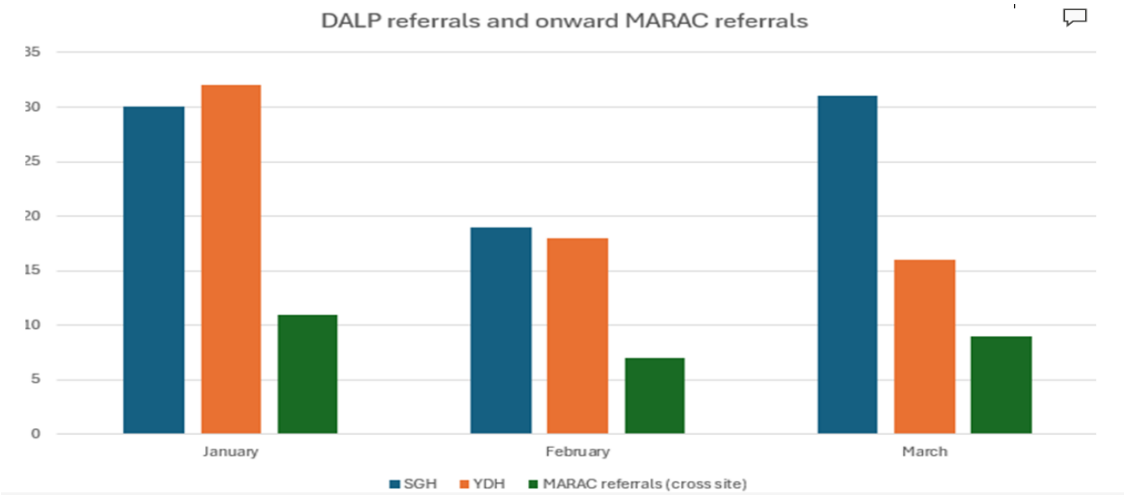
Performance insight:
High application volumes and robust quality assurance processes demonstrate strong safeguarding oversight, with clear actions in place to address compliance risks.

4. Emergency Department and Prevent Activity

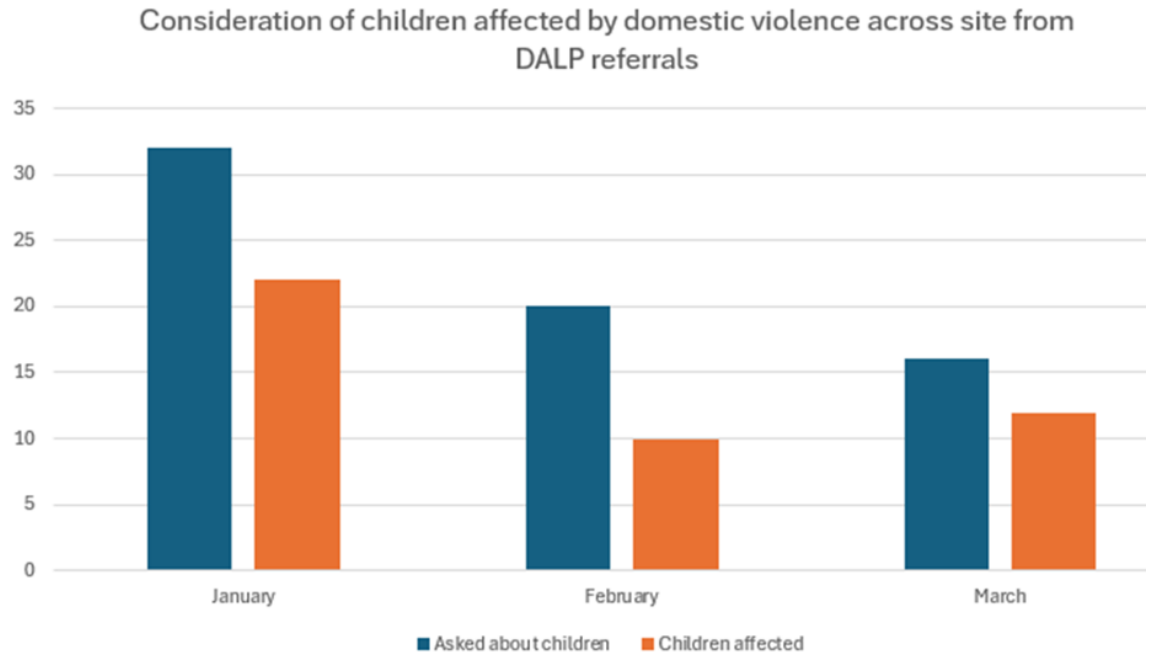
- **Emergency Department safeguarding coding increased by 22%** (1,570 patients compared to 1,255 in Quarter 4 2024/25), attributed to the **increased visibility and embedded presence** of the Safeguarding Adults team.
- The Trust received **21 Prevent information requests**, a **17% reduction** compared to the same period last year.
- **Eight Safeguarding Adult Review (SAR) requests** were received:
  - 3 cases currently in scoping phase
  - 5 confirmed as nil returns
- Learning from SARs will be disseminated through established Trust governance routes where applicable.

5. Domestic Abuse Liaison Practitioners (DALP) – Activity and Impact

- DALP referral activity **continued to rise across Quarter 4**, with sustained onward MARAC referrals.



- Practitioners maintained a strong **"Think Family" approach**, ensuring safeguarding support for both adults and children.



- DALPs delivered both **8-hour training sessions and bespoke departmental teaching**, reaching staff across York and Scarborough sites.
- Training feedback demonstrated:
  - **100% of staff learned something new.**
  - **98% would recommend the training.**
  - Strong confidence improvements in responding to disclosures and signposting.

MEASURE	COMPLETELY AGREED	FAIRLY AGREED
Learned something new	100%	–
Training valuable to role	91%	–
Would recommend training	98%	–
Understanding of abusive relationships	91%	–
Confidence dealing with disclosure	77%	23%
Confidence in signposting	89%	12%

Performance assurance:
DALP activity continues to demonstrate high value, measurable impact, and strong staff engagement, supporting the case for longer-term funding sustainability.

6. Training Performance

- **Safeguarding Adults Levels 1 and 2 and Prevent training** compliance remains **above 90%**, providing strong statutory assurance.
- **MCA/DoLS Level 1 training** compliance remains above the **80% target** across all care groups.
- **Face-to-face MCA/DoLS training** compliance improved from **69% to 72%**, though remains below target.
- Introduction of an **assessment-based alternative** for medical staff (approved January 2026) has reduced access barriers while maintaining educational standards.

Performance insight:
Training compliance remains strong overall, with targeted mitigations in place for face-to-face MCA/DoLS learning.

7. Workforce and Capacity

- Appointment of a **full-time Named Nurse for Safeguarding Adults** in February 2026 has strengthened leadership and assurance.
- **Maternity leave within the Specialist Nurse team** has been mitigated through agreed **0.8 WTE backfill funding**.
- Temporary CPD funding for DALP roles has been extended to **June 2027**, though recruitment gaps present a short-term delivery risk.

8. Summary Performance Position

- ✅ Reduced safeguarding demand with maintained quality and oversight
- ✅ Strong training compliance and statutory assurance
- ✅ Increased visibility in ED and multidisciplinary working
- ⚠️ Ongoing risks related to MCA/DoLS capacity and training compliance
- ⚠️ Sustainability risks linked to temporary funding models

Overall assurance:
Quarter 4 activity demonstrates a **safe, responsive, and proportionate safeguarding**

service, with clear governance, measurable impact, and defined actions to address emerging and residual risks.

- Safeguarding Adults activity reduced appropriately, with no evidence of under-reporting, reflecting effective early identification, prevention, and proportionate responses.
- Strong assurance is provided through reduced safeguarding concerns raised against the Trust, improving MCA/DoLS governance, increased safeguarding visibility in Emergency Department pathways, and the demonstrable impact of Domestic Abuse Liaison Practitioner activity using a Think Family approach.
- Key organisational risks relating to workforce capacity, training compliance and digital systems remain active but are well controlled, with clear mitigations in place and positive direction of travel.

Next Steps

- Sustain proportionate, preventative safeguarding practice through early identification, discharge planning, and multidisciplinary working.
- Strengthen workforce resilience and leadership, maintaining Named Professional capacity and progressing recruitment and succession planning.
- Improve Safeguarding Level 3 and MCA/DoLS training compliance, particularly for medical staff, while maintaining strong Adults and Prevent compliance.
- Deliver the MCA/DoLS improvement programme, addressing educator capacity and strengthening governance oversight.
- Maintain safeguarding visibility and assurance across Emergency Department pathways, digital systems (CP-IS/EPR) and partnership learning.

Safeguarding Adults – Quarter 1 2026/27 Next Steps (At a Glance)

Priority Area	Q1 2026/27 Focus
Safeguarding Demand & Prevention	Sustain reduced safeguarding demand through early identification, preventative practice and strengthened discharge-related safeguarding processes.
MCA / DoLS Assurance	Deliver the MCA/DoLS improvement programme, strengthening application quality, training compliance, and educator capacity within existing governance arrangements.
Training & Workforce Capability	Improve MCA/DoLS training compliance, particularly for medical staff, while maintaining strong Safeguarding Adults and Prevent training performance.
Emergency & Acute Pathways	Maintain enhanced safeguarding visibility and coding within Emergency Department and acute pathways to support timely identification and escalation.
Governance, Learning & Sustainability	Embed learning from Safeguarding Adult Reviews and audits, maintain leadership capacity, and manage short-term sustainability risks linked to temporary funding.

Sophie Miners
Named Nurse for Safeguarding Adults
April 2026

Item 17

Report to:	Trust Board of Directors
Date of Meeting:	30th September 2026
Subject:	Winter Plan Pack 2026/27
Director Sponsor:	Claire Hansen, Chief Operating Officer
Author:	Ab Abdi, Deputy Chief Operating Officer

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

The Winter Plan 2026/27 sets out the Trust's approach to maintaining safe and resilient services across York and Scarborough during winter. It is a whole-pathway plan, with the first priority being to avoid unnecessary admission, increase same-day care, improve discharge and reduce length of stay. Additional escalation beds are retained as a safety

back-up and will be activated only where demand and patient-safety risk cannot be managed through core capacity and delivery of the planned improvement actions.

Winter planning assumptions are informed by the North East and Yorkshire Regional Winter Planning Test Event, NHS England winter preparation packs and local operational intelligence. These indicate that the principal pressure is expected to arise from the combination of increased acuity, ambulance conveyance, admission demand, delayed discharge and workforce fragility, rather than attendance growth alone. Delivery will therefore be monitored through conversion, Same Day Emergency Care utilisation, length of stay, discharge, occupancy, ambulance handover and corridor-care measures.

Current modelling identifies a gross bed gap of 52 beds at York Hospital and 32 beds at Scarborough Hospital. Improvements in Same Day Emergency Care, zero-length-of-stay pathways and length of stay have the potential to provide the equivalent of approximately 30 beds at York and 13 beds at Scarborough. A 50% probability has been applied to these benefits, recognising that they are improvement assumptions rather than secured capacity. This leaves a risk-adjusted residual gap of 22 beds at York and 19 beds at Scarborough.

The plan therefore retains implementation-ready escalation capacity of up to 31 beds at York and 21 beds at Scarborough. At York, Ward 25 is proposed as the primary escalation and respiratory-virus cohort ward between November 2026 and February 2027, with Ward 29 supporting respiratory cohorting as required. At Scarborough, Lilac and Mulberry wards will provide respiratory-virus cohorting within the existing bed base, with up to 15 escalation beds available through the former CCU footprint and a further six beds within Haldane, subject to the agreed operational model.

Escalation capacity will not open automatically. Activation will be considered where the defined operational and patient-safety triggers are met and will require confirmation of safe nursing and medical staffing, pharmacy, therapy, diagnostics and facilities support, estates and equipment readiness, digital arrangements, infection prevention compliance and completion of the ward-readiness checklist. The ability to secure a sustainable multidisciplinary workforce remains the principal delivery risk and may limit or prevent safe activation.
The plan proposes mobilisation of a portfolio of winter resilience measures with a current total value of £1.015 million. These include senior review of medical outliers, weekend and bank-holiday discharge support, additional Allied Health Professional capacity, enhanced decontamination, additional acute and trauma operating lists, Emergency Department portering and the facilities support required to respond to increased operational pressure. The Trust has an initial winter provision of circa £1 million. The small difference between the provision and the portfolio will be managed through scheme-level validation and prioritisation, and the total approved funding limit will not be exceeded without a separately identified funding source.

The portfolio does not constitute automatic authority to spend. Funding will be retained centrally and released only following Finance revalidation, confirmation of a named budget holder and cost centre, completion of the relevant readiness requirements, and evidence that the scheme is additional, deliverable and supported by a measurable benefit. Committed and actual expenditure will be monitored monthly, with schemes

scaled down or stopped where operational conditions improve or the anticipated benefit is not demonstrated.

The potential £2.164 million cost of opening the escalation wards is excluded from the initial funded portfolio. Escalation capacity remains a separate contingency and can only be activated following confirmation of operational need, safe staffing and clinical readiness, completion of the required quality and operational checks, and agreement of an affordable funding source.

The financial requirement will be incorporated into the Trust's financial recovery position. There is an initial £1 million winter provision to support the highest-priority resilience measures and provide flexibility to respond to operational pressures as they arise included in the Trust's financial plan. To the extent any expenditure exceeds the £1m provision then a clear funding plan will be agreed. This is most likely to draw on the remaining activity investment provision in our plan.

The Trust will continue to work with system partners to reduce avoidable attendance and admission, accelerate discharge and strengthen the response to escalating system pressure. The bed model will be reassessed following the October internal desktop exercises, finalisation of the acute medical model and further development of system plans. Delivery and emerging risks will be overseen through the Trust Resilience Group, daily site-management arrangements and established clinical and financial governance.

The plan provides a credible framework for managing winter demand, but delivery remains dependent on achieving the planned improvements in same-day care, length of stay and discharge; securing a safe multidisciplinary workforce; maintaining system support; and completing operational readiness requirements. Retaining funded initiatives and escalation capacity within a controlled, trigger-based model balances the need to protect patient safety and operational resilience with the requirement to maintain financial discipline and avoid unnecessary expenditure.

Recommendations:

The Trust Board is asked to:

1. **Approve** the Winter Plan 2026/27 operating model, including the principle that admission avoidance, same-day care, discharge improvement, length-of-stay reduction and effective use of core capacity will precede activation of additional escalation beds.
2. **Approve** the proposed winter resilience portfolio, currently valued at £3.179 million (£1.015 million of winter initiatives and £2.164 million of winter escalation capacity as described in this paper)
3. **Approve** mobilisation of individual schemes within that portfolio only where:
    - the cost has been revalidated by Finance;
    - a named budget holder and cost centre are confirmed;
    - the scheme is additional and deliverable within the winter period;

- the relevant workforce, clinical, quality, estates, digital and operational requirements have been completed; and
- a baseline, expected benefit and monitoring arrangement are in place.

4. **Approve in principle** Ward 25 as the preferred York escalation and respiratory-virus cohort ward, providing capacity for up to 31 beds, subject to confirmed availability, safe multidisciplinary staffing, clinical and operational readiness and completion of the required assurance checks.
5. **Approve in principle** the former CCU footprint as the preferred Scarborough escalation option, providing up to 15 beds, together with the potential use of six escalation beds within Haldane, subject to confirmation of the final clinical model, operational impact, safe staffing, estates and equipment readiness and completion of the required assurance checks.
6. **Note** that the £2.164 million escalation-ward provision is not included within the initial funded winter portfolio and represents a separate contingency. No escalation ward may be activated until the defined operational or patient-safety triggers are met, a safe staffing and clinical model is confirmed, the necessary readiness and quality checks are complete, and an affordable funding source has been agreed.
7. **Delegate** authority to activate and deactivate approved winter schemes and escalation capacity to the Chief Operating Officer, Chief Nurse or Medical Director, following recommendation from the Deputy Chief Operating Officer, within the approved financial authority and subject to completion of the documented activation and readiness requirements.
8. **Require** regular assurance through the agreed governance arrangements on:
   - demand, flow and bed occupancy;
   - corridor care and patient-safety indicators;
   - delivery of the anticipated improvement benefits;
   - workforce availability and temporary staffing reliance;
   - respiratory-virus and infection prevention pressures;
   - expenditure against the approved provision;
   - use of escalation capacity; and
   - impact on elective, cancer and diagnostic activity.
9. **Note** that the demand-and-capacity model and operational triggers will continue to be refined following the October internal desktop exercises, finalisation of the acute medical model and development of system plans, with any material change to the risk, capacity or financial position reported through the established governance arrangements.

Report History

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

Meeting/Engagement	**Date**	**Outcome/Recommendation**
Executive Committee	16/09/26	Approach approved and financial envelope supported
Resources Committee	22/09/26	Approach supported

YORK AND SCARBOROUGH
TEACHING HOSPITALS NHS FOUNDATION TRUST

Winter Plan 2026/27

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1 Purpose and strategic context

The purpose of this paper is to set out the Trust's final proposed approach to winter 2026/27, secure approval for the prioritised initiatives and financial ceiling, and confirm the controls required to move from planning to implementation. The plan covers York and Scarborough and should be read with the supporting respiratory-virus management and surge and business-continuity arrangements.

This winter plan builds on the Trust's established urgent and emergency care (UEC), acute model of care and discharge improvement programmes. It is not a stand-alone capacity plan. The first call on management attention and available winter resource is delivery of transformational schemes that avoid admission, increase same-day care and reduce length of stay. Escalation beds are a time-limited safety back-up, activated only where evidenced demand exceeds the benefit delivered by those schemes and agreed operational triggers are met.

The Trust's winter planning assumptions are informed by the North East and Yorkshire Regional Winter Planning Test Event, NHS England Winter Preparation Packs and local operational intelligence. Collectively, they indicate that winter pressure is driven not simply by increased attendance volumes, but by a combination of higher patient acuity, increased ambulance conveyance, greater admission pressure, delayed discharge and workforce fragility.

Oversight will therefore be used in weekly oversight of conversion, SDEC, length of stay, occupancy, ambulance handover and corridor-care risk, rather than using attendance alone as the escalation signal.

1.1 National expectations

Expectation	Plan
Robust, clinically led and deliverable local winter plans developed with system partners.	This winter plan has been developed in conjunction with partners and was tested in an exercise on 17th September 2026.
A named executive winter lead in each provider and integrated care board.	Chief Operating Officer, Y&S Director of Commissioning and Insights, ICB
Draft plans completed by the end of August 2026 and tested through regional stress-test exercises in September.	Trust Resilience Group drafted the plan, and approved this final version, this will be tested through a desktop exercise internally in early October 2026. Regional stress testing was on 17th September 2026 and learning fed back into the Trust plan.
Board sign-off through the national Board Assurance Statement by 30 September 2026.	The plan is tabled for the 30th September Trust Board
Whole-system demand and capacity analysis across baseline, surge and extreme-surge scenarios.	This was tested via the 17th September workshop.

Clear arrangements for prevention, vaccination, IPC, operational flow, escalation, discharge, elective protection, on-call leadership and maintaining safe care	Management plan for inpatients with suspected or confirmed RVI alongside this document IPC plan summarised in this plan Patient Flow, Escalation and Surge Policy including Full Capacity Protocol has been developed for review alongside this document On Call Policy has already been approved Elective plan is included
Implementation of model emergency, acute and discharge pathways, with elimination of corridor care treated as a safety priority.	The Trust continues to implement the national Model Emergency Department, acute and discharge pathways, with elimination of corridor care treated as a patient safety priority. Progress has been made through the introduction of EAU, EDAC and EEMAC models and a dedicated corridor care eradication programme. Improvement priorities remain focused on discharge, flow, frailty, mental health pathways and reducing delays to admission and discharge, with delivery overseen through established governance arrangements.

1.2 Local strategic intent

This plan is a whole-system operating plan, not solely an escalation-bed plan. Additional beds are the final mitigation after prevention, admission avoidance, Model ED/Acute Pathway implementation, discharge optimisation, community capacity and mutual aid have been applied. Each mitigation is linked to a quantified contribution, owner, trigger, readiness test and outcome measure.

The Trust's winter response will apply common safety, quality and financial-control principles across both sites while using site-specific solutions. It will seek to

- maintain timely access
- protect privacy and dignity
- reduce avoidable delay,
- support safe discharge
- preserve planned care
- deploy additional resources only where evidence shows that existing mitigations are insufficient

2 Lessons from winter 2025/26

- York and Scarborough sites require different operational solutions, but both must meet the same readiness, quality and governance standards.

- Respiratory virus cohorting supports flow and IPC by reducing avoidable transmission and ward closures.
- Winter actions must protect elective activity and avoid transferring unmanaged risk elsewhere.
- Operational teams require early, repeated and practical communication about triggers, roles, ward moves and supporting procedures.
- Escalation capacity must be implementation ready. Ad hoc, short-notice opening increases clinical, operational and financial risk.
- Approved capacity should open only when pressure requires it and should close promptly when the pressure reduces.
- Costings must capture the whole service impact, including medical, nursing, AHP, pharmacy, facilities, equipment, linen, waste, catering, transport and digital support.

3 Planning methodology and assurance

3.1 Approach

Stage	2026/27 approach	Required output
1	Review demand, flow, capacity, IPC, workforce, finance and after-action learning.	Defined assumptions and site-level capacity risks. **COMPLETE**
2	Compile and challenge the initiative long list from care groups and corporate services.	Cost-neutral and funded initiatives with named leads. **COMPLETE**
3	Finance and Workforce confirm-and-challenge of pay, non-pay, duration and infrastructure assumptions.	Validated cost and workforce schedules; duplication removed. **COMPLETE**
4	Panel appraisal against bed days, admissions, ED impact, safety, cost-effectiveness and feasibility.	HIGH, MEDIUM, LOW and non-winter classifications. **COMPLETE**
5	Approve, prepare, test, implement, monitor, de-escalate and evaluate.	Final plan pack, BAS, SOPs, activation matrix and benefits review as below.

3.2 Assurance

- 02 Sep 26 – Winter Plan pack 2026/27 to Executive Committee.
- 22 Sep 26 – Winter Plan pack 2026/27 to Resource Committee.
- 30 Sep 26 – Winter Plan pack 2026/27 to Trust Board..

3.3 System Interdependencies

The Trust is working with system partners to develop and implement a coordinated winter response that will support delivery of safe and timely care throughout periods of increased demand. This includes the development of joint plans to prevent avoidable hospital attendance and admission, accelerate discharge and ensure that patients receive care in the most appropriate setting.

Partners are currently reviewing escalation processes and operational responses to ensure that, where system pressure increases, the System Coordination Centre can coordinate a timely and effective whole-system response. Escalation triggers are being reviewed collectively to enable support to be mobilised earlier and more consistently across organisations. The Trust's Discharge Command Centre is being further developed as a focal point for coordinating complex discharge barriers, escalating delayed decisions and supporting timely patient flow from inpatient wards and the Emergency Department.

The Trust and its partners are developing opportunities to strengthen out-of-hospital and front-door support, including consideration of virtual ward input at the front door and expansion of successful pathway innovations such as respiratory and COPD models. These developments are intended to support earlier specialist intervention, admission avoidance and care closer to home, with pathway design being undertaken jointly with clinical teams, community providers and primary care partners.

Work is also underway with mental health partners to improve pathways for patients whose immediate physical healthcare needs can be safely managed outside an acute hospital setting. This includes development of clearer arrangements for patients presenting with minor illness and improved responsiveness for patients already admitted to hospital who require mental health assessment or intervention.

The Trust is working with voluntary, community and social enterprise sector partners to identify opportunities to support admission avoidance, patient transport and discharge, including practical assistance for patients returning home. Alongside this, discussions are ongoing with local authority commissioners and care home providers to understand and address out-of-hours receiving arrangements where these contribute to avoidable delays in discharge.

A joint communications approach is also being developed with system partners to provide clear and coordinated public messaging throughout winter. This will promote appropriate use of services, awareness of urgent care alternatives, self-care advice and the actions members of the public can take to help services support those with the greatest clinical need.

These arrangements will build on existing operational and strategic system partnerships, including established escalation routes with Yorkshire Ambulance Service (YAS) for individual patient cases and established partnership forums such as the Discharge Improvement Group (DIG), Community Improvement Group (CIG) and wider system coordination meetings. Through these forums, partners are jointly developing, monitoring and refining plans ahead of the winter period.

3.4 Governance

A summary of the oversight rhythm and timeline is below.

Implementation, monitoring of actions and communication through fortnightly winter TRG
Daily Management through site meetings three times a day.

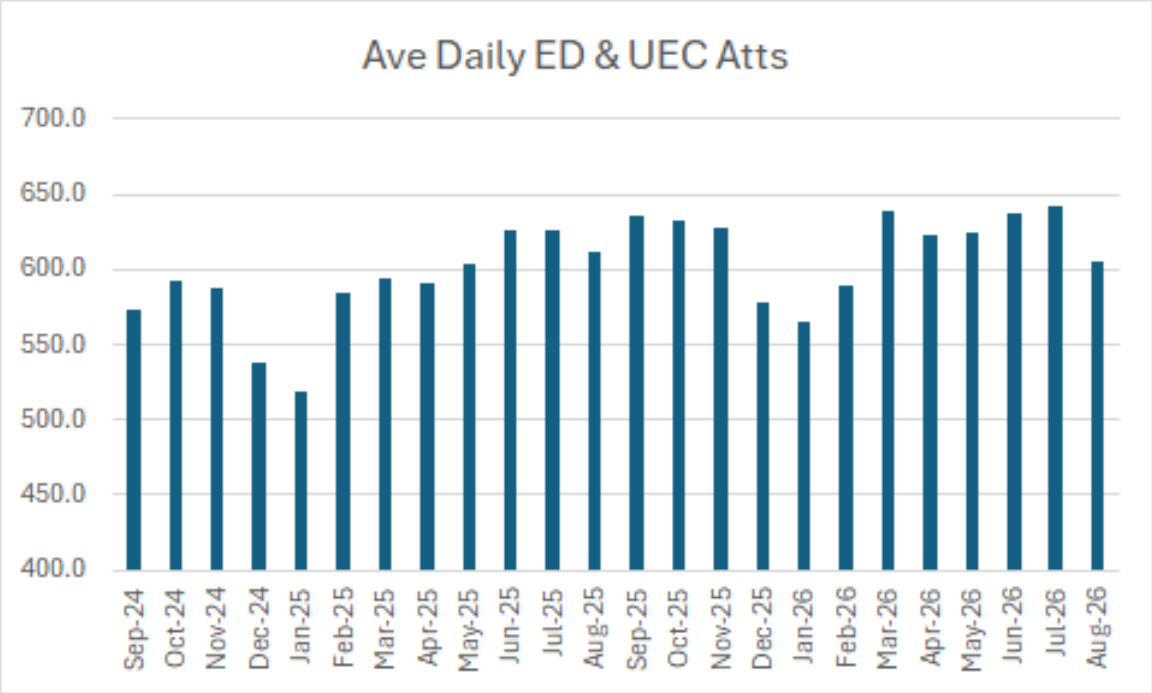


4 Winter Plan 2026/27

4.1 Expected Demand

4.1.1 Attendance

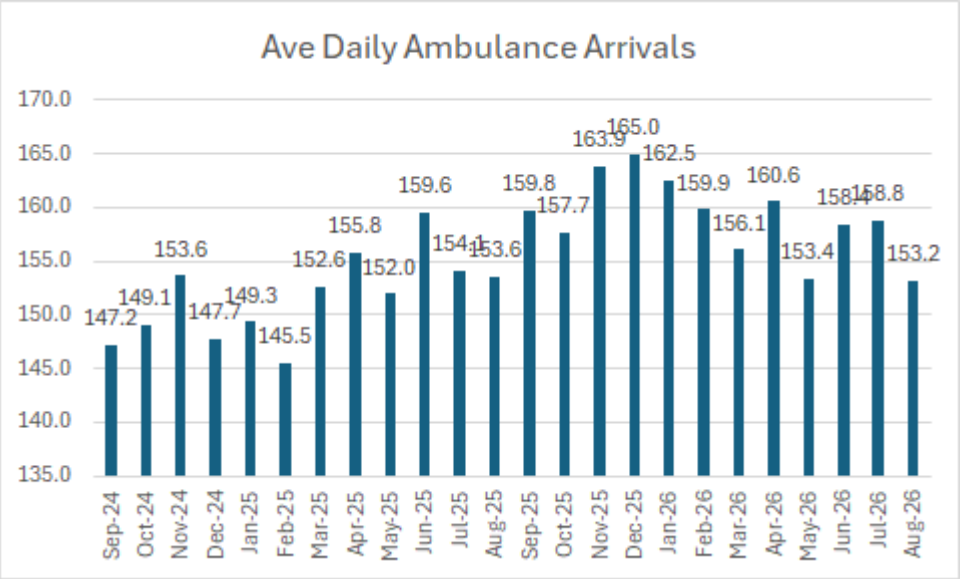
Overall emergency attendances are expected to increase during winter, with approximately 12 additional attendances per day compared with summer levels. Over the last two years however although we experienced increasing demand month on month, when split just into attendances we saw a reduction attributed to the system winter diversionary schemes.



Historically, winter has been associated with a reduction in four-hour performance by 2.4 percentage points, increased 12-hour waits by 3.5 percentage points and longer time spent in the Emergency Department (a rise to 43 minutes 33 seconds). Common presentation groups include respiratory illness, gastrointestinal and genitourinary conditions, neurological presentations and care-process attendances.

4.1.2 Ambulance Conveyance

The impact of ambulance-conveyed patients is disproportionately greater than the increase in total attendances with 7 more per day. Historical analysis suggests ambulance-conveyed attendances are associated with larger deterioration in four-hour performance (3.4 percentage points), greater growth in 12-hour waits (7.1 percentage points) and significantly longer department stays (1 hour 25 minutes 55 seconds). Along with the aforementioned specialties of respiratory, neurological, and gastrointestinal/genitourinary presentations in attendances, cardiology is also a key contributor specific to ambulance conveyance.

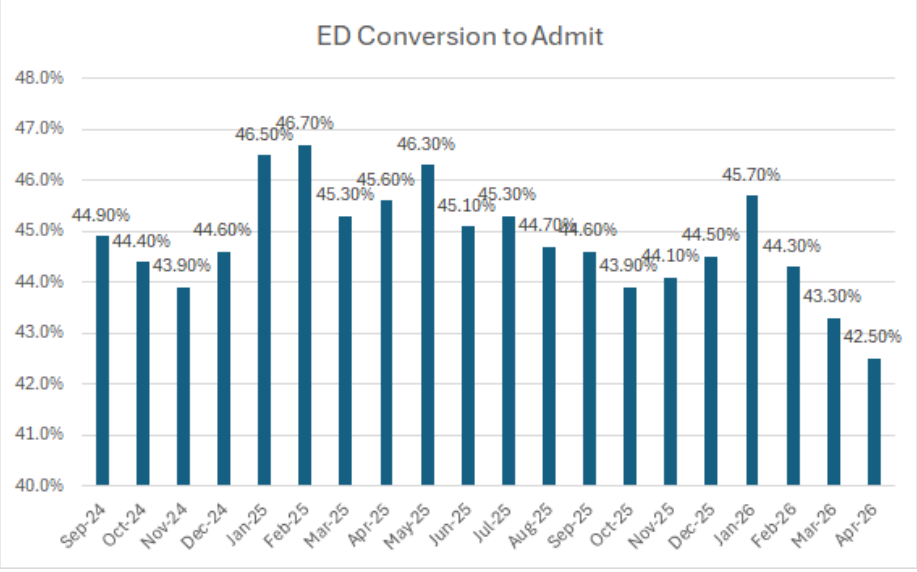


4.1.3 Acuity

Higher-acuity attendances are expected to increase during winter (16 patients per day) and are associated with a significant deterioration in four-hour performance (2.8 percentage points), 12 hour waiting times (increasing by 5.1 percentage points) and mean time in department (1 hour 6 minutes and 29 seconds) and overall flow. Patients requiring urgent, very urgent or resuscitation-level care and are concentrated within the same specialties of respiratory, gastrointestinal/genitourinary, cardiac and neurological pathways.

4.1.4 Admissions

The combined effect of increased acuity and ambulance activity creates the greatest pressure through higher conversion rates to admission, greater demand for inpatient beds and increased crowding across urgent and emergency care pathways. This places length of stay, discharge performance and occupancy at the centre of winter resilience rather than attendance volumes alone. Historically over the last two years the measures we put in place however did enable lower conversion rates than the summer months.



4.2 Bed Capacity

Bed modelling based on the current acute model demonstrates at York Hospital a gap of 52 beds; and at Scarborough Hospital, a gap of 32 beds. This incorporates demand as described above, and includes the current ED queue, elective and IPC closed empty beds. Capacity is calculated via core and escalation beds.

GAP:	York = 52	Scarborough = 32

4.3 Improvement Opportunities

In previous years, winter wards have been at the core of the winter plan. This year the focus is on transformation, with escalation beds as the exception.
The Trust has completed a self-assessment against NHS England's Model Emergency Department, Model Acute and Model Discharge Pathway standards. The assessment identified a number of areas of good practice alongside opportunities for further development. Whilst not all elements of the national models are yet fully embedded, the improvement actions within this winter plan have been explicitly aligned to the gaps identified through the self-assessment process. Delivery of these actions, supported by system partners where required, will continue to move the Trust towards closer alignment with the national models and the longer-term ambition of safe, timely and effective patient flow across urgent, emergency and inpatient pathways.

4.3.1 Acute Model of Care – Front Door Senior Decision Maker

The acute model of care developments for increased senior decision making at the front door, and increased use of SDEC's along with specialty specific capacity in respiratory and cardiology in particular are key to success this winter. This is being developed through a separate business case to be completed by the end of September.

4.3.2 Same Day Emergency Care (SDEC) and Zero Length of Stay Activity

The Trust will continue to maximise the use of SDEC pathways to avoid unnecessary admissions and provide timely assessment, treatment and discharge on the day of attendance wherever clinically appropriate. SDEC services support a wide range of medical and surgical pathways and enable patients to receive specialist assessment without occupying an inpatient bed.

Expansion and optimisation of SDEC capacity will support earlier senior clinical decision-making, reduce conversion rates from the Emergency Department, and improve patient experience by enabling patients to return home on the same day. By increasing the proportion of emergency patients managed through SDEC, the Trust will release inpatient capacity to support the sickest patients requiring admission during periods of sustained winter demand.

4.3.3 Reducing Length of Stay

An element of the Trust's strategy is the continued reduction of avoidable inpatient length of stay through enhanced patient flow, early senior clinical decision-making. The Trust recognises that every unnecessary inpatient day reduces available capacity for urgent and emergency admissions, contributes to emergency department crowding, and increases the risk of delayed care and poorer patient outcomes. Improving flow therefore remains one of the most effective and sustainable methods of creating capacity ahead of and during winter pressures.

Daily Management includes site meeting reviews of Pathway 0,1,2,3 and an escalation process of bronze, silver as happens throughout the year with an added gold (Director level) system meetings, stood up during winter (November through to February).

In addition, as part of the improvement programme for the Trust – there are ongoing initiatives to strengthen mechanisms that support discharge planning from the point of admission. These include daily multidisciplinary review of patients against clinical criteria, proactive management of patients with no criteria to reside, and earlier identification and escalation of discharge barriers. This is overseen through the Corridor Care Programme.

Together, improvements in length of stay, SDEC utilisation and zero length of stay performance form a critical component of the Trust's whole-pathway approach to winter planning, reducing reliance on escalation beds while supporting safer, more timely care for patients throughout the winter period.

The table below summarises these improvement opportunities at York Hospital:

Bed Base	SDEC 10% improvement (30 to 40%)	NE LoS Improvement (1 day improvement to average)	Probability	Total Benefit (Bed)
Elderly Medicine	3	17	50%	**10**
Specialty Medicine	10	15	50%	**12**
Surgery	6	6	50%	**6**
T&O	0	4	50%	**2**
Total	**19**	**42**	**50%**	**30**

The table below summarises these improvement opportunities at Scarborough Hospital:

Bed Base	SDEC 10% improvement (30 to 40%)	NE LoS Improvement (1 day improvement to average)	Probability	Total Benefit (Bed)
Elderly Medicine	3	1	50%	**2**
Specialty Medicine	15	3	50%	**9**
Surgery	1	1	50%	**1**
T&O	1	0	50%	**1**
Total	**20**	**5**	**50%**	**13**

GAP REMAINING:	York = 22	Scarborough = 19

Table below includes the UEC recovery action plan for the acute hospitals currently in train with completion date of end of October:

UEC Recovery Plan 2026/27

Workstream	Action	Lead
Front-door streaming, assessment and early decision-making	Reconfirm front-door streaming criteria for ED, UTC, GP, pharmacy, dental, EEMAC, SDEC and direct specialty pathways	Senior ED team / UTC / Acute Leads
Front-door streaming, assessment and early decision-making	Implement and evaluate the Scarborough First Assessment model, including daily review of operational, safety and patient experience measures	Senior ED team / EPIC / NIC / Operational team
Front-door streaming, assessment and early decision-making	Establish a standardised front-door assessment model across York and Scarborough, including responsibilities, escalation and documentation expectations and ensure documentation updated	Senior ED team / Jemma Cropley/Zoe Jennings
Front-door streaming, assessment and early decision-making	Implement a waiting-room clinical safety and escalation process, including clear review triggers, observations, deterioration criteria and escalation routes	Senior Nursing, clinical and operational team
Front-door streaming, assessment and early decision-making	Introduce 8-hour and 10-hour risk identification for patients awaiting clinician review for both ED and EAU	Senior ED team Jemma Cropley/Zoe Jennings / Ally Crossley/Hester Baverstock/Ops team
EEMAC and EAU model reset	Increase EEMAC utilisation and ensure patients	Clinical Lead / Senior ED team / Matron
SDEC, alternatives to admission and right-team-first-time pathways	Review missed SDEC opportunities from ED, Acute Medicine and EAU and share learning	ED / Acute Clinical Leads / SDEC Leads
SDEC, alternatives to admission and right-team-first-time pathways	Increase utilisation of SDEC through strengthened streaming and direct referral routes	ED Team / SDEC Leads / UTC Leads
SDEC, alternatives to admission and right-team-first-time pathways	Establish weekly review of bring back patients who may have been suitable for MES, virtual ward or other ambulatory pathways	Acute Medicine / SDEC / Performance
SDEC, alternatives to admission and right-team-first-time pathways	Review protection of SDEC capacity during escalation and OPEL pressure	Operations / Site Team / SDEC Leads
Ambulance handover and receiving capacity	Daily review of ambulance handovers over 30 and 45 minutes	ED Operations / YAS / Performance
Ambulance handover and receiving capacity	Strengthen real-time escalation when handovers exceed agreed thresholds	ED Senior Team / Site Team / YAS
Ambulance handover and receiving capacity	Document ambulances conveyances that can be challenged from both York and Scarborough sites	Site Team / Operations / ED Leadership
Ambulance handover and receiving capacity	Audit fit-to-sit and ambulance cohorting safety processes	Matrons / Governance / ED Senior Team
Ambulance handover and receiving capacity	Include ambulance delays within weekly 12-hour reduction review	Performance / Operations / ED Senior Team
Long waits, corridor care and internal flow	Daily review of all patients waiting over 8, 10, 12 and 24 hours in ED, EEMAC and EAU	Matrons / NIC / EPIC / Site Team
Long waits, corridor care and internal flow	Implement and monitor the 12-hour reduction framework and trajectory	Performance / ED Senior Team / Operations
Long waits, corridor care and internal flow	Review top three causes of 12-hour waits and implement corrective actions	ED / Acute / Operations / Performance
Long waits, corridor care and internal flow	Assure completion and quality of 12-hour checklists and prolonged-wait safety reviews	Nursing / Governance / Matrons
Long waits, corridor care and internal flow	Review corridor care episodes, staffing mitigations and Datix themes	Matrons / Governance / Senior Nursing
Long waits, corridor care and internal flow	Strengthen ward pull and transfer processes for admitted patients ready to leave ED	Site Team / Ward Teams / Operations
Long waits, corridor care and internal flow	Review delays relating to diagnostics, specialties, discharge and mental health pathways	Operations / Clinical Leads / Mental Health Liaison
Long waits, corridor care and internal flow	Review all paediatric long waits and environmental concerns, safeguarding, nutrition, hydration, pain and escalation	Paediatric ED Team / ED Matrons / Site Team

5 Corridor Care and Discharge

Corridor care is unacceptable and will not be normalised. Eradicating corridor care initiative started in September 2026, led by the Trust Chief Nurse. Any patient in an inappropriate ED or ward setting triggers immediate clinical review, incident recording and site escalation; duration exceeding 45 minutes triggers executive notification and a documented recovery plan. Placement must cease immediately where oxygen/call-bell access, monitoring, privacy, dignity, toileting, nutrition or IPC safety cannot be maintained.

A key area of improvement for corridor care is discharge processes.

5.1 Daily discharge requirements by pathway

A good average number of daily discharges during the winter is aimed at minimum of 110 discharges per day in York hospital and 70 discharges per day at Scarborough hospital. Out of this total, it is estimated that approximately 25 discharges at York hospital and 15 discharges at Scarborough hospital on a daily basis to be complex discharges on pathway 1-3; the rest being zero pathway discharges.

For information the tables below show the number of daily discharges in York and Scarborough hospitals during last winter 2025/26 (November to February)

York Hospital Discharges 03/11/25 – 23/02/26

Week Commencing	Week Ending	Week	Discharges
03/11/2025	07/11/2025	03 Nov – 07 Nov 2025	568
10/11/2025	14/11/2025	10 Nov – 14 Nov 2025	587
17/11/2025	21/11/2025	17 Nov – 21 Nov 2025	548
24/11/2025	28/11/2025	24 Nov – 28 Nov 2025	569
01/12/2025	05/12/2025	01 Dec – 05 Dec 2025	570
08/12/2025	12/12/2025	08 Dec – 12 Dec 2025	584
15/12/2025	19/12/2025	15 Dec – 19 Dec 2025	563
22/12/2025	26/12/2025	22 Dec – 26 Dec 2025	460
29/12/2025	02/01/2026	29 Dec – 02 Jan 2026	460
05/01/2026	09/01/2026	05 Jan – 09 Jan 2026	550
12/01/2026	16/01/2026	12 Jan – 16 Jan 2026	509
19/01/2026	23/01/2026	19 Jan – 23 Jan 2026	497
26/01/2026	30/01/2026	26 Jan – 30 Jan 2026	620
02/02/2026	06/02/2026	02 Feb – 06 Feb 2026	547
09/02/2026	13/02/2026	09 Feb – 13 Feb 2026	527
16/02/2026	20/02/2026	16 Feb – 20 Feb 2026	578
23/02/2026	27/02/2026	23 Feb – 27 Feb 2026	569

Scarborough Hospital Discharges 03/11/25 – 23/02/26

Week Commencing	Week Ending	Week	Discharges
03/11/2025	07/11/2025	03 Nov – 07 Nov 2025	192
10/11/2025	14/11/2025	10 Nov – 14 Nov 2025	185
17/11/2025	21/11/2025	17 Nov – 21 Nov 2025	186
24/11/2025	28/11/2025	24 Nov – 28 Nov 2025	170
01/12/2025	05/12/2025	01 Dec – 05 Dec 2025	159
08/12/2025	12/12/2025	08 Dec – 12 Dec 2025	172
15/12/2025	19/12/2025	15 Dec – 19 Dec 2025	213
22/12/2025	26/12/2025	22 Dec – 26 Dec 2025	147
29/12/2025	02/01/2026	29 Dec – 02 Jan 2026	175
05/01/2026	09/01/2026	05 Jan – 09 Jan 2026	190
12/01/2026	16/01/2026	12 Jan – 16 Jan 2026	203
19/01/2026	23/01/2026	19 Jan – 23 Jan 2026	184
26/01/2026	30/01/2026	26 Jan – 30 Jan 2026	204
02/02/2026	06/02/2026	02 Feb – 06 Feb 2026	196
09/02/2026	13/02/2026	09 Feb – 13 Feb 2026	182
16/02/2026	20/02/2026	16 Feb – 20 Feb 2026	180
23/02/2026	27/02/2026	23 Feb – 27 Feb 2026	176

5.2 Discharge Improvement - Model Discharge Pathway

To address this, the trust is focusing on some key improvement for discharge decision making.

5.2.1 Discharge planning from admission

The trust is working towards planning from admission. This is an improvement journey. While examples of good practice exist, there is variation in approach across clinical areas. Admission to discharge standards are defined.

5.2.2 Seven-day consultant-led review

On a day-to-day basis the care groups plan for all patients in G&A beds is to be reviewed by a senior decision maker preferably a consultant.

Currently board rounds are delivered Monday to Friday across the Trust, with consultant involvement generally maintained across specialties during the working week. However, there is variation in the leadership and decision-making structure of board rounds. In a number of areas, rounds are not consistently led by senior clinical decision-makers, with operational leadership often provided by Ward Managers. While this approach supports day-to-day coordination, the quality, consistency and effectiveness of board rounds can vary between clinical areas.

Evidence from observational reviews and operational feedback demonstrates examples of excellent practice in several wards, where strong multidisciplinary leadership, proactive discharge planning and timely decision-making contribute positively to patient flow and length of stay. To reduce variation and spread best practice, a programme of peer support and shared learning will be implemented during the coming off corridors programme, enabling high-performing teams to support other areas in adopting effective board round processes and behaviours. This will support greater consistency in operational delivery and strengthen discharge planning and patient progression across the organization.

The Trust is progressing with an Integrated Assessment Unit (IAU) that will help positively with the senior review of the patient in real time, but this will not be complete for winter 26/27. The Acute Medical Model therefore is looking at workforce and interim arrangements and will be developed for engagement by the end of September 26.

5.2.3 Criteria-led discharge

The Trust is currently working to embed the Criteria-Led Discharge (CLD) consistently across the Trust. Whilst a Standard Operating Procedure (SOP) is in place and supporting tools, including discharge stickers, have previously been implemented, adoption remains variable across clinical areas.

There is evidence of good practice within some specialties, where clinically-led approaches have been established to support timely discharge. In particular, the use of "Friday discharge stickers" has enabled nurse-led discharges over weekends for cohorts of clinically appropriate patients, reducing delays and supporting patient flow.

The implementation of Criteria-Led Discharge has been identified as a key improvement priority within the Coming Off Corridors Programme. Work is underway to support specialty-specific adoption, focusing on defined patient cohorts where criteria-led discharge can safely and effectively be embedded within clinical pathways. This approach will be supported through clinical leadership, pathway redesign and the sharing of existing good practice from areas where CLD is already established.

5.2.4 Early-day discharge

Early discharge performance is improving but is inconsistent, with discharge-related tasks such as Electronic Discharge Notifications (EDNs) and To Take Out (TTO) medications not always prioritised sufficiently in advance of the planned discharge date.

The Trust is working to improve proactive multidisciplinary planning, earlier completion of EDNs, timely prescribing and dispensing of TTO medications, and clear ownership of discharge actions through board rounds and daily operational reviews.

Embedding a culture of anticipatory discharge planning will support an increase in early-in-day discharges, improve patient experience, reduce length of stay, and create earlier capacity to accommodate emergency admissions and reduce corridor care.

5.2.5 92% occupancy standard

The Trust remains above the recommended 92% bed occupancy standard, limiting operational resilience and contributing to patient flow pressures. Reducing occupancy through improved discharge performance, reduced length of stay and more effective use of capacity is a key priority within the Coming Off Corridors programme.

Current occupancy is approximately 95% for G&A beds.

6 Multi-agency Discharge Event (MaDE)

To support operational resilience throughout winter, the Trust will undertake two focused Multi-agency Discharge Events (MaDEs) in partnership with health and social care colleagues. MaDEs are recognised system-wide improvement interventions designed to accelerate the discharge of patients who no longer meet the criteria to reside, remove barriers to timely discharge, and improve patient flow across acute and community services.

6.1 December 2026 MaDE (Early December)

A week-long Multi-agency Discharge Event will be delivered in early December to create additional capacity ahead of the anticipated escalation in winter demand. The event will bring together hospital teams, community services, local authorities, and discharge partners to undertake daily reviews of patients with delayed discharges, support rapid resolution of barriers, strengthen discharge planning, and maximise the use of discharge pathways. The emphasis will be on reducing the number of patients with no criteria to reside, improving bed availability, and ensuring patients are receiving care in the most appropriate setting.

6.2 January 2027 MaDE (Early January)

A second Multi-agency Discharge Event will be undertaken in early January to support recovery following the Christmas and New Year period, when discharge activity traditionally reduces and system pressures increase. The January event will focus on restoring patient flow, reducing long lengths of stay, increasing discharge volumes, and addressing any backlog of delayed patients that has accumulated over the holiday period. Working with system partners, the Trust will utilise senior clinical oversight, enhanced discharge coordination, and real-time escalation processes to maximise capacity and support safe, timely discharge for patients.

6.3 Expected Benefits

- Increased discharge activity across both hospital sites.
- Reduction in patients with no criteria to reside.
- Improved bed occupancy and flow through urgent and emergency care pathways.
- Earlier identification and resolution of discharge barriers.
- Enhanced collaboration between acute, community, social care, and local authority partners.
- Increased resilience to manage sustained winter demand and maintain patient safety.

7 Elective Activity

Cancer, urgent/time-critical surgery and agreed diagnostic capacity will be protected in baseline and surge. Planned-care cancellation is a last resort after documented OPEL/FCP mitigations are exhausted. The Chief Operating Officer (COO) may authorise a stepped reduction beginning with clinically reviewed non-urgent/non-cancer activity. The decision must quantify patients, theatre/clinic hours, RTT/cancer/diagnostic consequences and equality/clinical risk.

7.1 Management of Elective Activity

York and Scarborough Teaching Hospitals have established a clear approach to preserving elective activity throughout winter, balancing operational pressures against the need to maintain planned care delivery. Any potential impact on Elective, cancer and diagnostic capacity is reviewed routinely through site operational meetings, with escalation to the DCOO and subsequently the COO where service pressures may affect scheduled activity. A formal elective cancellation Standard Operating Procedure (SOP) is in place, requiring DCOO and subsequently COO approval before elective activity can be cancelled. The SOP also requires agreement of re-provision arrangements and replacement dates to minimise the impact on patients and ensure cancelled activity is recovered at the earliest opportunity.

Whilst Operational Pressures Escalation Level (OPEL) 4 may necessitate changes to service delivery, the Trust seeks to minimise the impact on elective pathways wherever possible. Outpatient appointment cancellations are considered only in line with the agreed escalation framework. Consultant Supporting Professional Activity (SPA) time may be released to support

clinical redeployment during periods of significant operational pressure, while any proposed cancellation of Direct Clinical Care (DCC) activity is reviewed through site operational meetings and requires approval by the DCOO and COO.

Agreed thresholds for escalating into elective bed capacity in out of hours periods are agreed and discussed on the site handover meeting, which reduces the risk of elective cancellation of patients and maintains a minimum bed requirement to deliver the next day's elective programme.

8 Additional Actions Requiring Funding

To support safe and effective operational delivery during winter 2026/27, the trust has undertaken a structured assessment of proposed winter initiatives. The assessment considered the anticipated impact of each proposal on bed utilisation, admissions, Emergency Department performance, patient safety, cost-effectiveness and deliverability. Initiatives were subsequently prioritised as high, medium or low, with a number of wider service developments recognised as valid priorities but not considered to be specifically within the scope of winter planning.

The following portfolio is placed before escalation capacity deliberately. TRG will fund only activity that is additional, deliverable in winter and accompanied by a named owner, baseline, monthly trajectory and measurable benefit. The circa £1 million provision is a ceiling, not a commitment to fund the full long list.

8.1 To approve for mobilisation

1) Daily clinical review of medical outliers at York is a high priority. Additional consultant and resident doctor capacity will be considered to ensure that growing numbers of outlying medical patients receive timely senior review, appropriate clinical decision-making and active discharge planning. The proposed investment is £194,133, with implementation from mid-October 2026.
2) Weekend and bank holiday discharge capacity will be strengthened through the introduction of a dedicated discharge registrar at York, working from 08:00 to 20:00. The role will focus specifically on progressing discharges and addressing clinical decisions or actions that might otherwise delay patients remaining in hospital over a weekend or bank holiday period. The proposed cost is £40,936.
3) Additional weekend Allied Health Professional capacity is included to support assessment, rehabilitation, equipment provision and discharge activity across both main hospital sites. Additional 7.5-hour bank shifts are proposed, with an estimated cost of £9,209. This initiative will help ensure that therapy-related discharge actions continue to progress consistently at weekends.
4) Infection prevention resilience will be enhanced through additional hydrogen peroxide vapour and ultraviolet cleaning capacity. The proposal includes two Band 3 decontamination operatives, together with the necessary consumables and transport arrangements to move equipment between relevant clinical areas. The estimated cost is £63,000. This will improve the Trust’s ability to undertake enhanced environmental decontamination and return affected clinical capacity to use.
5) Additional weekend operating capacity is proposed to support the timely treatment and discharge of acute and trauma patients. This comprises 12 additional half-day acute or trauma lists at York and 10 additional half-day lists at Scarborough, targeted at key weekends and bank holidays. The 22 additional half-day lists are costed at bank rates, with a total estimated requirement of £108,944.
6) Dedicated Emergency Department portering capacity is proposed through two Band 2 porter posts, at a cost of £189,000. This will provide more consistent support for patient movement and associated operational activity within the Emergency Departments.

7) The facilities response will also include a plan for providing food and beverages for additional inpatients and for patients who may remain in cohort areas for prolonged periods. This proposal includes four Band 2 catering operatives, with two supporting each main hospital site, two additional regeneration trolleys or hot boxes, and additional provisions. The estimated cost is £273,566.50.
8) Waste and linen capacity will be increased to reflect the expected uplift in activity. This will include ensuring that adequate waste receptacles are available and that linen supply and uplift arrangements can meet higher daily requirements. The provisional cost identified is £84,000.
9) Additional transport capacity has been identified to support the movement of decontamination equipment and the laundering of curtains across sites. The proposal includes one Band 2 driver and the hire of a tail-lift vehicle for three days each week, at an estimated cost of £33,300.
10) A rapid domestic response is also proposed to support additional activity and patient flow, with a cost of £18,729.90. Although assessed as a lower priority, this capacity may be required to allow clinical areas to be cleaned and returned to operational use promptly during periods of heightened pressure.

8.2 Financial Control

A central reserve and scheme-level drawdown model will be used.

- Finance re-validation of each initiative and confirmation that costs are complete and not duplicated.
- Named budget holder and cost Centre before activation.
- Recorded authorisation against an agreed trigger and completed readiness checklist.
- Regular reporting of committed and actual expenditure.
- Scale-down or cessation where conditions improve or benefit is not demonstrated.

The process to release the winter funding is as follows:

- The winter plan 2026/27 approved budget is kept in a central reserve.
- The Care Groups / teams seek approval through preparation of a case using the Project Brief to the Deputy Chief Operating Officer following finance approval for authorisation.
- The Care Group / team Head of Finance, providing evidence of the approval, will ask the Deputy Head of Financial Management to draw the approved budget from the central reserve which is then subsequently drawn into their operational budgets.
- Deputy Head of Financial Management will then update the central tracker (to be saved on teams).
- The Care Group / team (with Finance support) will report their actual expenditure against the drawn budget on a monthly basis.
  The above information is collated by Deputy Head of Financial Management and reported to Deputy Chief Operating Officer.

The financial requirement will be incorporated into the Trust's financial recovery position. There is an initial £1 million winter provision to support the highest-priority resilience measures and provide flexibility to respond to operational pressures as they arise included in the Trust's financial plan. To the extent any expenditure exceeds the £1m provision (for example the need to open any additional capacity) then a clear funding plan will be agreed. This is most likely to draw on the remaining activity investment provision in our financial and operational plan, but this would have to be balanced alongside the elective recovery needs, and alongside a potential recycling of the original £1million commitment.

Priority / initiative	TRG request	Primary impact	What the investment adds	Decision within £1m envelope
HIGH Priority				
1. Daily senior review of York medical outliers	£194,133	LOS reduction	Additional consultant/resident-doctor review to accelerate decisions and discharge for outlying medical patients. Quantified bed benefit to be agreed before release.	Fund subject to owner, rota, baseline and monthly LOS/discharge trajectory.
2. Weekend/bank-holiday discharge registrar, York	£40,936	LOS reduction	08:00–20:00 dedicated clinical decision-making to prevent avoidable weekend/bank-holiday delay.	Fund subject to explicit festive-period rota and discharge delta.
3. Weekend AHP capacity, both sites	£9,209	LOS reduction	Additional 7.5-hour bank shifts for assessment, rehabilitation, equipment and discharge actions.	Fund subject to seven-day gap analysis and activity measure.
4. Enhanced HPV/UV decontamination	£63,000	LOS/capacity protection	Two Band 3 operatives, consumables and transport to return closed capacity to use sooner.	Fund subject to turnaround-time and bed-days-restored measure.
SUB TOTAL:	£307,278			
MEDIUM PRIORITY				
5. Additional weekend acute/trauma lists	£108,944	LOS reduction	22 additional half-day lists across York and Scarborough at identified pressure weekends.	Reserve; release only against dated schedule and expected discharges.
6. ED portering	£189,000	SDEC/flow enablement	Two Band 2 posts to support timely movement through ED/SDEC.	Reserve; benefit and hours must be evidenced before release.
7. Catering resilience	£273,566	Operational resilience	Four Band 2 operatives, hot boxes/trolleys and provisions for additional/cohorted patients.	Not an initial transformation priority; contingency only if capacity opens.
8. Waste and linen	£84,000	Operational resilience	Additional receptacles, linen supply and uplift for higher activity.	Contingency only; release linked to actual capacity activation.

9. Transport for decontamination/curtains	£33,000	Capacity protection	Driver/vehicle support to move equipment and curtains between sites.	Do not fund until cost and incremental bed benefit are confirmed.
10. Rapid domestic response	£18,729	LOS/capacity protection	Additional cleaning response to return clinical areas to use.	Reserve; release against response-time and bed-days-restored measure.
SUB-TOTAL:	£707,239			
TOTAL:	£1,014,517			
ESCALATION				
Escalation/flu wards	£2.164m	Additional beds (back-up) 31 York 21 Scarborough	Readiness and, only when triggered, staffed inpatient capacity.	Outside £1m initial portfolio; separate executive authorisation and funding source required.

FINAL BED CAPACITY	York = +9	Scarborough = +2

The bed capacity calculations will be reassessed following the internal desktop stress test in October, the finalisation of the acute medical model, and development of system plans with partners which are anticipated to reduce the gap further.

9 Respiratory-virus arrangements

The implementation plan must confirm safe staffing, senior medical cover, pharmacy, therapy, diagnostics, equipment, ward clerking, catering, linen, waste, cleaning, bed hire and digital requirements.

- Phase 1: use side rooms for suspected or confirmed influenza and COVID-19 patients where clinically appropriate.
- Phase 2: cohort patients in same-sex bays on Ward 25.
- Phase 3: open the whole ward for separately managed influenza and COVID-19 cohorts when required.
- De-escalate dynamically when respiratory-virus occupancy reduces and safe separation can be maintained.

No respiratory cohort or escalation area will open until all rostered staff requiring RPE are confirmed fit tested for an available mask, records are auditable, PPE stock is sufficient and contingency fit-testing sessions are available. Compliance will be monitored and reported by ward and staff group as per the Trust Flu Plan.

10 Winter Escalation and Flu Wards

Escalation and flu wards are the final, safety-back-up mitigation. They will be opened only when transformation delivery and available core capacity are insufficient to manage the residual bed gap safely, respiratory cohorting is required, and the Executive-led trigger decision confirms staffing, quality, finance and decommissioning arrangements.

The table below summarises the capacity, improvement opportunities as well as the escalation capacity.

Site	Core and Escalation Beds	Gap	Improvement Opportunities	Escalation Capacity
York	699	52	30	31
Scarborough	335	32	13	21
Bridlington	103	0	0	0
Community IPU	96	0	0	0

10.1 York Hospital.

The Trust Resilience Group considered the following courses of action for flu and escalation wards for winter 2026 in York Ward 25. W25 has capacity of 31 beds. W25 is currently used as a decant for Ward 31 but it will be completed and cleaned in time for November. This could be used as the flu and escalation ward from 2nd November 2026 to end of February 2027 (26/02/27). One risk to be considered is the ability to recruit the nurse and medical staff for this ward.

- October 2026
  - Ward 29 is used as the 1st flu ward as appropriate. There is no additional cost associated as it is already established.
- November 2026 – February 2027
  - Ward 25 (31 beds) is used as a winter escalation ward with funding identified in this plan.
  - Ward 25 is used as the 1st Flu ward.
  - Ward 29 is used as the 2nd flu ward. There is no additional cost associated as it is already established.
- March 2027
  - Ward 29 is used as the 1st flu ward as appropriate. There is no additional cost associated as it is already established.

10.2 Scarborough Hospital

Lilac is the planned first respiratory-virus cohort ward. Mulberry is the planned second-stage cohort area, subject to confirmation that ward moves do not remove its availability during the required period.

- October 2026 – March 2027
    - LILAC (AMU) **–** LILAC has a capacity of 32 beds. It was used as the Scarborough Flu Ward in previous 2 winters and the proposal is that it will do the same this year to use Lilac ward as the first flu ward from 1st October 2026 to end of March 2027. There are no additional costs associated with it being run as the Flu Ward**.**

- November 2026 – February 2027

    - Mulberry will be the 2nd flu ward from November 2026 to end of February 2027, as required. There is no additional cost associated as it is already established.

    - Haldane (Day Case Electives). The use of Haldane provides capacity for 6 escalation beds used for escalation. This is not related specifically to winter, but Haldane is usually used as an escalation capacity during times of pressure and bank holidays as appropriate.

    - Escalation Ward - CCU – reopening CCU would provide 15 beds as a winter escalation ward – when this is required.

The supporting arrangements will cover medical, nursing, healthcare assistant, therapy, pharmacy, domestic, catering, portering, administrative and estates requirements. Clear admission criteria, opening and closure arrangements, infection prevention controls, equipment requirements and operational checklists will be established in advance. The proposal also includes the phased implementation of "Rota F" at York as part of the resident doctor expansion arrangements. The identified cost is £2.164 million, with implementation proposed from mid-October 2026.

10.3 Winter Escalation Ward Activation Criteria

Activation should be considered when two or more of the following criteria are met for 48 consecutive hours, or immediately following executive review where patient safety is compromised:

- General and Acute bed occupancy exceeds 95% for 48 hours
- Fewer than 10 escalation beds remain available across the hospital
- At OPEL 4, Hospital predicts inability to accommodate emergency demand within next 24 hours.
- Risk assessment identified regarding long waits across the UEC demonstrate need for more escalation capacity
- Ambulance handover delays exceed:
    - 5 patients over 60 minutes, or
    - YAS and site teams identify significant risk to ambulance offload capacity.
- Daily discharge volumes fall below:
    - 100 discharges at York or 60 discharges at Scarborough for 3 consecutive days.
    - Patients with no criteria to reside exceed agreed trajectory for 3 consecutive days
- Respiratory Virus Pressures
    - Respiratory-virus occupancy exceeds available cohort capacity.
    - Ward 29 respiratory cohort arrangements nearing capacity.
    - IPC advises need for dedicated respiratory-virus cohort ward.

Prerequisites

- Safe nursing establishment is confirmed for a minimum of 7 days.
- Medical cover arrangements are confirmed, including consultant oversight and resident doctor rota.
- Pharmacy, therapy, diagnostics and facilities support are available.

- Required beds, mattresses, monitoring equipment, IT devices and consumables are in situ and tested.
- Ward readiness checklist has been completed and signed off by Chief Nurse or nominated deputy.

Executive Approval Process

- Winter escalation capacity activation may be approved by the Chief Operating Officer or Chief Nurse or Medical Director once request is signed off by Deputy Chief Operating Officer.

De-escalation / Closure Criteria

- Winter escalation capacity should be considered for closure when the above triggers are not met any more for at least 7 consecutive days or 26/02/26 if earlier.

11 Governance and Quality Impact

Clinical Oversight and patient safety through winter

Clinical Control	Minimum Requirement	Timing/evidence
Daily in-season oversight operational throughout winter	Clinical input to site huddles and escalation decisions, including crowding, infection, staffing and service risk.	Tested in September;
Safety triggers and escalation	Clear thresholds for corridor care, unsafe staffing, outbreaks, critical-care pressure and elective de-escalation.	Included in stress tests and escalation cards.
Quality surveillance	Review harm, incidents, complaints, deterioration, readmission/return and staff concerns alongside performance.	Weekly clinical review; monthly Committee summary.
Learning	Rapid debrief after material escalation or outbreak, with actions, owners and retest dates.	Event-triggered and included in winter governance.

11.1 Governance

- Governance responsibility for York escalation capacity will rest with the Medicine Care Group, including oversight of incident reporting, clinical standards, documentation, and audit.
- Governance responsibility for Scarborough escalation capacity will sit with the Medicine Care Group where the CCU footprint or Bridlington is utilised. Use of Haldane will remain within existing Surgical Care Group governance structures.

11.2 Quality Outcomes

Each activated scheme will have process, outcome, and balancing measures. Some quality outcome measures include corridor care, ECS 4 hour and 12-hour wait, ambulance handover delay, and agency reliance.

12 Staff Vaccination

The 2026/27 staff vaccination programme will report weekly, including vaccinations delivered, uptake by site/staff group, against the Trust-approved ambition. Exceptions will have targeted recovery actions.

13 Staff Wellbeing

The Trust recognises that maintaining colleague wellbeing is essential to sustaining high-quality services throughout the winter period. A range of support measures are in place to promote the physical and psychological wellbeing of colleagues. These include access to a confidential Employee Assistance Programme (CiC), available 24 hours a day, seven days a week, which provides emotional and practical support. In addition, managers have access to specialist advice and guidance to support colleagues effectively during periods of increased operational pressure. Colleagues and their families can also access a digital wellbeing platform, providing online support, resources and self-help tools at any time.

Awareness and uptake of wellbeing support will be promoted throughout the winter period via the Trust's Wellbeing Hub, intranet channels, colleague communications, posters and other promotional materials. Support services have also been promoted through staff fairs, ward visits and wider organisational communications activity. The Trust's seasonal flu vaccination campaign will commence on 1 October, with a programme of drop-in clinics running through to the end of November. The campaign aims to maximise vaccination uptake amongst eligible colleagues, supporting workforce resilience and helping to reduce the risk of winter illness-related absence. Wider colleague wellbeing and occupational health services will remain available throughout the winter period to ensure timely access to support where required.

14 Next Steps

The Winter Plan will be submitted to the governance and assurance process outlined in section 3 and will include supporting documents, the level of maximum funding approved for the implementation of initiatives, a governance and assurance process for managing expenditure and the triggers for initiatives to be implemented.

The operational pressure encountered over winter will determine when initiatives are implemented between 2 Nov 26 and 26 Feb 27 however approved funding limits will not be exceeded.

15 Quality Impact Assessment (QIA)

QIA attached.

Appendix 1

Quality Impact Assessment Tool

1.0. Overview

An impact assessment is a continuous process to ensure that possible or actual business plans, changes to use of clinical areas, new information technology (IT) software for patient management or any other proposed business, change or implementation plans that impact on patient services are assessed and the potential consequences on quality of care for patients and any impact on staff are considered and any necessary mitigating actions are outlined in a uniformed way.

This tool involves an initial assessment (Stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered, policies that are reviewed / developed and any new services. Where potential negative impacts are identified they must be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 10 areas, each of which must be assessed at Stage 1. Where a potentially negative risk score is identified and is greater than (>) 9 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 9 must go on to a detailed assessment at Stage 2.

2.0. Scoring

A total score is achieved by assessing the level of severity and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score. The following tables define the impact and likelihood scoring options and the resulting score:

LIKELIHOOD		SEVERITY	
1	EXTREMLY UNLIKELY	**1**	NO HARM
2	UNLIKELY	**2**	MINOR HARM
3	POSSIBLE	**3**	MODERATE HARM
4	SOMEWHAT LIKELY	**4**	SEVERE HARM
5	VERY LIKELY	**5**	CATASTROPHIC HARM

Risk score	Category
1 - 3	Very Low risk
4 - 6	Low risk
8 – 9	Medium risk
10 - 12	High risk
15 - 25	Extreme risk

A full description of likelihood and severity scores can be found at Appendix 2.

3.0. Stage 1

The following assessment screening tool will require judgement against areas of risk in relation to quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score of greater than (>) 9 is identified in **any area** this will result in the need to undertake a more detailed Quality Impact Assessment (Stage 2).

Title and lead for scheme: Winter Plan 2026-2027

Brief description of scheme: *(If there is a referenced scheme as above then a description is not required)*

Answer positive / negative (P/N) in each area. If 'N', score the impact, likelihood and total in the appropriate box. If score > 9 insert 'Y' for full assessment

Area of Quality	Impact question	Positive/Negative	Impact	Likelihood	Score	Full Assessment required
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	P				
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	P				
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	P				
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence-based practice, clinical leadership, clinical engagement, staff experience and / or high-quality standards?	P				

Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	P				
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost-effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	P				
Resourcing	Could the proposal impact positively or negatively on the number of vacancies or on the need for temporary workforce?	N	1	4	4	An increase in the number of patients over winter could impact on required workforce needed to care for these patients adequately
Resource Impact	Could this proposal impact positively or negatively regarding estates, IT resource, community equipment service or other agencies or providers e.g Social Care/Voluntary Sector / District Nursing	N	1	4	4	Additional space may require utilisation, in turn leading to requirement of appropriate staffing as above.
People Experience	Could this proposal impact positively or negatively on the experience of our people? E.g. impact on morale, increase in turnover.	P				
Equality, Diversity and Inclusion	Could any colleagues or patients with a protected characteristic (Equality Act 2010) suffer detriment because of the proposal?	P				

Please describe your rationale for any positive impacts here:

Duty of Quality

The plan promotes timely, safe and effective care, aligning with the NHS' duty to ensure patients come first, with the highest standards of excellence being provided by our staff.

Patient Experience
The framework will maintain personalised and compassionate care for patients even in case of influx of patients in winter.

Patient Safety
Patient safety should be maintained over winter despite the additional risk of infections due to a robust approach to IPC and flu management.

Clinical Effectiveness
Implementing the winter plan will empower clinical leaders and operational teams in decision making, reducing pressure as far as possible on emergency departments and staff, and increase cross-speciality clinical engagement, thus, leading to high standards of practice across the Trust.

Prevention
The plan promotes equitable care access for patients.

Productivity and Innovation
The plan supports effective and high quality clinical pathways, which in turn help reduce inefficiencies.

People Experience
Reducing pressures should allow staff morale to maintain / increase.

Equality, Diversity and Inclusion
The winter plan supports patients and staff who may have protected characteristics.

Stage 2 not necessary as no score >9.

4.0. Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?					
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?					
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?					
	What is the impact on strategic partnerships and shared risk?					
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS					
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?					
	Will this impact on the organisation's duty to protect children, young people and adults?					

PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)					
	How will it impact on choice?					
	Does it support the compassionate and personalised care agenda?					
PATIENT SAFETY	How will it impact on patient safety?					
	How will it impact on preventable harm?					
	Will it maximise reliability of safety systems?					
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?					
	What is the impact on clinical workforce capability care and skills?					
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence-based practice?					
	How will it impact on clinical leadership?					
	Does it support the full adoption of Right Care Value metrics?					
	Does it reduce/impact on variations in care?					
	Are systems for monitoring clinical quality supported by good information?					
	Does it impact on clinical engagement / staff experience?					
PREVENTION	Does it support people to stay well?					
	Does it promote self-care for people with long term conditions?					

	Does it tackle health inequalities, focusing resources where they are needed most?					
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost-effective way?					
	Does it eliminate inefficiency and waste?					
	Does it support low carbon pathways?					
	Will the service innovation achieve large gains in performance?					
	Does it lead to improvements in care pathway(s)?					
RESOURCE IMPACT	Will the proposal result in additional/reduced accommodation requirements					
	Will the proposal require an increase/purchase of IT products or services.					
	What impact will the proposal have on the cost of prescribing community equipment?					
	Will this proposal affect any existing partnership/commissioning arrangements when service is implemented					
WORKFORCE AND PEOPLE IMPACT	Does the proposal involve increasing or reducing staff posts? If so describe the impact this will have					
	Could services be negatively impacted by this workforce change for a short term, medium term or longer term?					
	Could this proposal impact positively or negatively on the experience of our people? E.g. impact on morale, increase in turnover.					
	Is the loss of posts likely to impact on the number of vacancies or the need for temporary workforce?					
	Could any colleagues or patients with a protected characteristic (Equality Act 2010) suffer detriment as a result of the proposal?					

Appendix 2

Table 1 Severity score (s): How do I assess the severity?

Severity is the term given to the resulting loss, injury or disadvantage if a risk materialises. Remember – there are likely to be a range of outcomes for this event.

Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the severity score, which is the number given at the top of the column. (Consider how severe the impact, or consequence, of the risk would be if it did materialise) **Note the Score**

Severity score (severity levels) and examples of descriptors - this is not an exhaustive list					
Domains	**1 No Harm**	**2 Minor Harm**	**3 Moderate Harm**	**4 Severe Harm**	**5 Catastrophic Harm**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days. Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death(s) Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint /inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis
Statutory duty / inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating, critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Cost increase /schedule slippage <1% over project budget /plan	Cost increase /schedule slippage >1<5% over project budget /plan	Cost increase/schedule slippage >5<10 % over project budget /plan	Cost increase/schedule slippage >10<25 % over project budget /plan Key objectives not met	Cost increase /schedule slippage >25% over project budget /plan Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results , Claim(s) >£1 million
Service / business interruption Environmental impact	Loss or interruption of >1 hour Minimal or no impact on the environment	Loss or interruption of >4 hours Minor impact on environment	Loss or interruption of >1 day Moderate impact on environment	Loss or interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L): How do I assess the likelihood?

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever possible to identify a frequency. Consider how likely it is that the risk will occur using the following descriptors:

Note the Score

	1	2	3	4	5
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Somewhat Likely**	**Very Likely**
Frequency (general) How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not	<5 per cent	6-25 per cent	26-50 per cent	51-75 per cent	76-100 per cent

Table 3 Risk Scoring: Severity x Likelihood (S x L)

Then **multiply** the two scores together from the table below.

L↓ S→	No Harm	Minor Harm	Moderate Harm	Severe Harm	Catastrophic Harm
Very Likely	**5**	**10**	**15**	**20**	**25**
Somewhat Likely	**4**	**8**	**12**	**16**	**20**
Possible	**3**	**6**	**9**	**12**	**15**
Unlikely	**2**	**4**	**6**	**8**	**10**
Extremely Unlikely	**1**	**2**	**3**	**4**	**5**

For grading risk on Datix, the scores obtained from the risk matrix are assigned the following grades.

Very Low (1 – 3)	Low (4 – 6)	Medium (8 – 9)	High (10 – 12)	Significant (15 – 25)

Plans scoring 9 and above will require Executive approval from both the Chief Nurse and Medical Director.

Plans scoring 15 and above will be reported through to the Quality Committee in line with the Trust's Quality Governance processes.

Winter Planning 26/27
Board Assurance Statement (BAS)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	York And Scarborough Teaching Hospitals Foundation Trust
If Other, write Provider/Trust Name:	
Contact details (email, phone number):	Ab Abdi, abolfazl.abdi@nhs.net
Date:	22/09/2026

Please complete these sections

Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes		
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes		
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	This winter plan has been developed in conjunction with partners and tested in an exercise on 17th September 2026.	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes		
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Claire Hansen, Chief Operating Officer	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes		

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

		Section B: 26/27 Winter Plan checklist	Please complete these sections Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes		
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes		
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	No	Some pathway and cohort-specific work is in place, but the Trust cannot yet demonstrate systematic use of population-health intelligence and risk stratification with s	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes		
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	No	Partial assurance is available. Executive-led escalation and discharge governance are in place, and the Trust has defined daily discharge requirements and actions to address long delays. However, seven-day discharge optimisation is not consistently embedded across acute, community and social care. Board-round effectiveness, criteria-led discharge and early-day discharge remain variable, while Discharge to Assess capacity and seven-day partner provision remain material constraints.	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Two Multi-agency Discharge Events are planned, one in early December to create capacity before peak winter demand and a second in early January to restore flow	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	No	Partial assurance is available. Medical, surgical and frailty SDEC and the EA	Blocker to full assurance is limited workforce capacity to ensure EEMAC and EAU are
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	No	Partial assurance is available. Frailty services, including the York Frailty Hub	Scarborough frailty pathways are different but operational
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	No	Partial assurance is available. Workforce requirements and safe-staffing prerequisites have been identified, but the Trust cannot yet confirm a sustainable multidisci	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	No	Partial assurance is available, Rotas have been reviewed and the plan includes investment in senior review of York medical outliers and weekend and bank-holiday	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	No	Partial assurance - The Trust has defined arrangements to protect cancer, ur	Insufficient resource to create additional capacity in the lead-up to winter.
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	No	The Winter Plan provides mitigations against additional seasonal risk but doe	Medical staffing levels at both EDs, particularly Scarborough, is a challenge. Other wor
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	No	Clinical triage and escalation arrangements are in place, but the Trust cannot independently assure the availability and prioritisation of sufficient urgent community c	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	No	Partial assurance is available. The Trust has established a dedicated corridor-care improvement programme and defined immediate clinical review, incident reportin	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Ambulance handover is monitored through daily operational arrangements and forms part of the escalation framework. Defined triggers include five patients waiting	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	No	Executive and operational escalation routes with system partners are in place, including daily second-line escalation and System Coordination Centre arrangements	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	No	The Trust has completed self-assessments against the Model Emergency Department, Model Acute and Model Discharge pathways. Elements are in place, includin	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes		
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes		
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes		
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes		
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes		
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes		
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	No	Mutual-aid and system-escalation routes are in place, but available capacity and the speed with which support can be mobilised remain dependent on system pressu	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes		
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		n/a	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		n/a	

	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.		n/a	

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name:	York and Scarborough Teaching Hospitals NHS Foundation Trust
Provider CEO name:	Clare Smith
Date reviewed:	30/09/2026
Provider Chair name:	Martin Barkley
Date reviewed:	30/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Claire Hansen, Chief Operating Officer claire.hansen@nhs.net

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
Confirmed

Please confirm date reviewed
22/09/2026

BAS Self-Assessment Dashboard

Trust		
	Overall Assessment Rating: 3 - Moderate assurance	
		Rating
Section B	Prevention	4 - Substantial assurance
	Flow, occupancy and discharge	2 - Partial assurance
	Capacity and community	1 - No or limited assurance
	UEC Flow	2 - Partial assurance
	Infection Prevention and Control (IPC)	**5 - Full assurance**
	Leadership and operational grip	4 - Substantial assurance
	Specific actions for Mental Health Trusts	Awaiting assessment

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 18

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Quarter 1 Mortality and Learning from Deaths Report
Director Sponsor:	Dr Karen Stone – Medical Director
Author:	Dr Owen Bebb- Associate Medical Director for Patient Safety Alice Hunter- Patient Safety Specialist

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☐ Not Applicable

Summary of Report and Key Points to highlight:

This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:
  - Nationally mandated data
  - Locally mandated data

- Quality account data
- Learning from deaths – themes, actions and escalations
  - Poor care was given to 2/18 SJCR's reviewed, none were escalated to a PSII.
  - SJCR training continues

Metric	Result
Crude mortality	Crude mortality is 2.9% (March 2025 to February 2026) (12 month rolling HES data)
SHMI - NHS England[1]	SHMI for 12months (March 2025 to February 2026) for the whole trust is 0.896

[1] SHMI NHS England - Summary Hospital Mortality Indicator 12month rolling, NHSE SHMI dataset

Recommendation:
The Board of Directors is asked to note the report and receive the escalations.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation
Patient Safety & Clinical Effectiveness Subcommittee	12/08/2026	
Quality Committee	22/09/2026	

1. Y&SH NHS FT mortality rates

The references in section 6 provide details about the methodologies for measuring mortality and their context.

1.1 Crude Mortality - unadjusted

Crude Mortality rate is the percentage of patients that have died. The crude rate includes all deaths up to 30 days post discharge. The crude mortality rate is the sum of the in-hospital deaths and the out-of-hospital deaths against all provider spells. The rolling 12month trend is now decreasing compared previous 12month periods. The crude mortality rate (12-month rolling, March 2025 to February 2026) remains at 2.9%. It was 3.1% for March 2024 to February 2025. We currently sit on the lower control limit for out trust.
Benchmarking of crude mortality against other Trusts is not recommended due to significant operational variations between Trusts. Instead, Trusts should monitor local trends comparing data from the same month or quarter each year. This takes account of seasonal variation seen locally and nationally. For our trust we see an increase in the winter months but overall there is a downward trend in crude mortality rates.

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust, including those receiving palliative care, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the Trust. It covers patients who died either while in hospital or within 30 days of discharge.

A standard approach is taken to 'adjust' the figures so that the England average is always reported as '1'. Values below 1 represent a better outcome, i.e. lower mortality, and vice versa.
Further information regarding the methodology can be found in the references towards the end of the report.

There is now one risk-adjusted mortality rate model.

- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.

The latest NHS-Digital Summary Hospital Mortality Index (SHMI) to November 2025 (covering March 2025 to February 2026) shows the SHMI was 0.896. The SHMI across both sites has increased slightly compared with previous reporting periods. Figure 1 shows the trust position in relation to other trusts. However, we continue to see an overall decrease in SHMI for the same 12-month period ending February 25 the SHMI was 0.9284. The numbers in this period were for expected deaths 3415 and observed deaths 3060. These remain in line with previous values.
Figure 2 shows the position of both sites in a funnel plot format in relation to other sites. You will note from the funnel plots that we are near the lower control limit and both sites sit below the national baseline. Figure 3 shows the SHMI for the last 18 reporting periods.
Important to note is we see a higher percentage of our hospital spells in patients belonging to quintile 5 (least deprived) with a lower percentage from quintile 1 with an associated lower proportions of death from quintile 1 compared with the national average.

Figure 1 SHMI(HES data) Funnel plots (in comparison with other Trusts (Mar 2025 to Feb 2026)

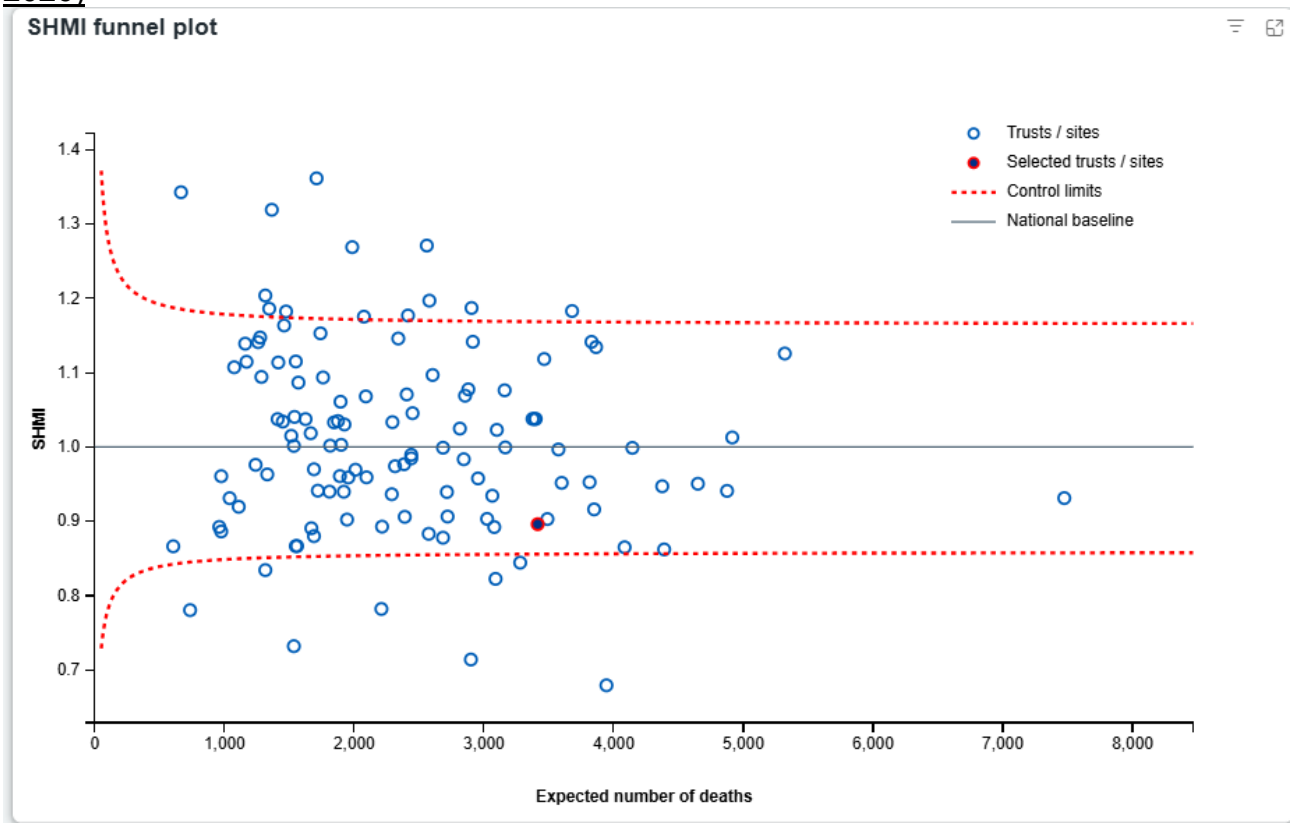


Figure 2 SHMI site comparison Mar 2025 to Feb 2026

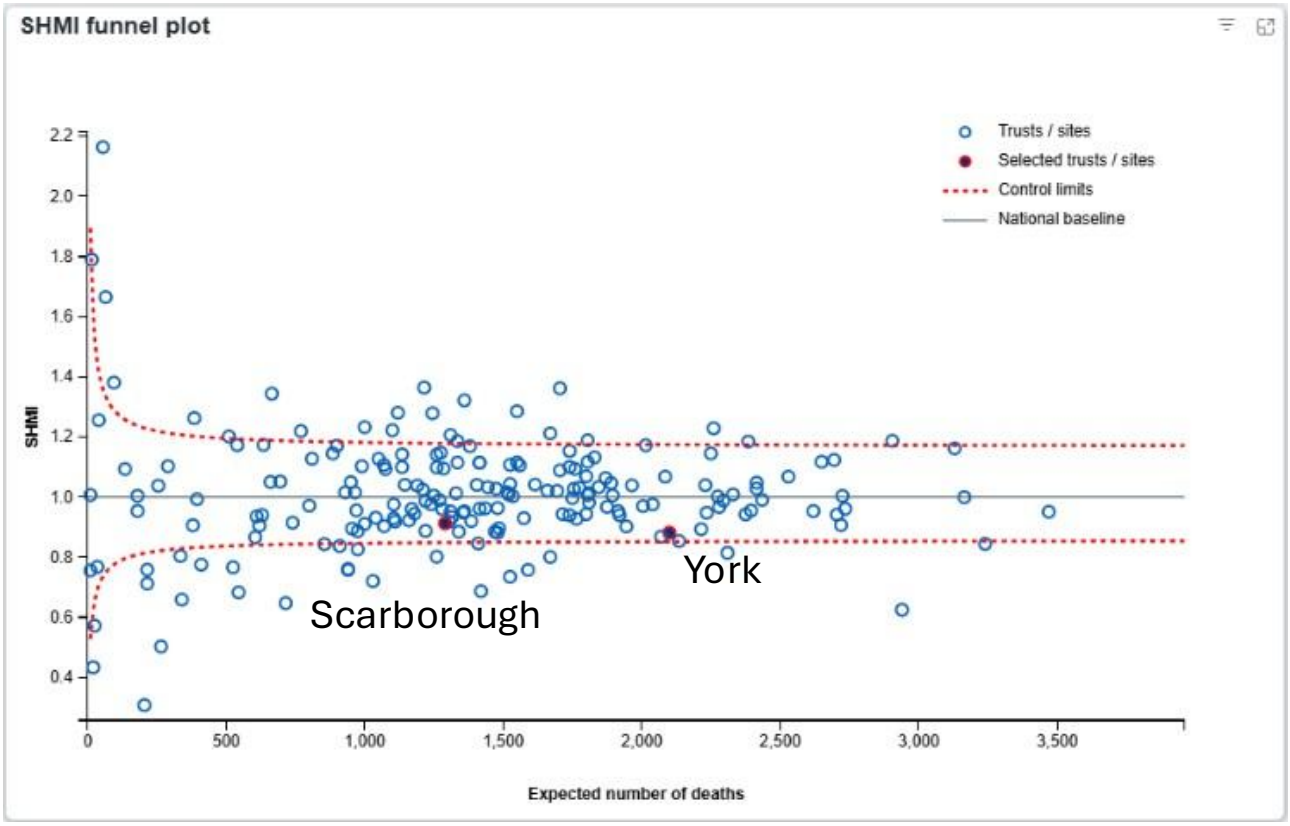
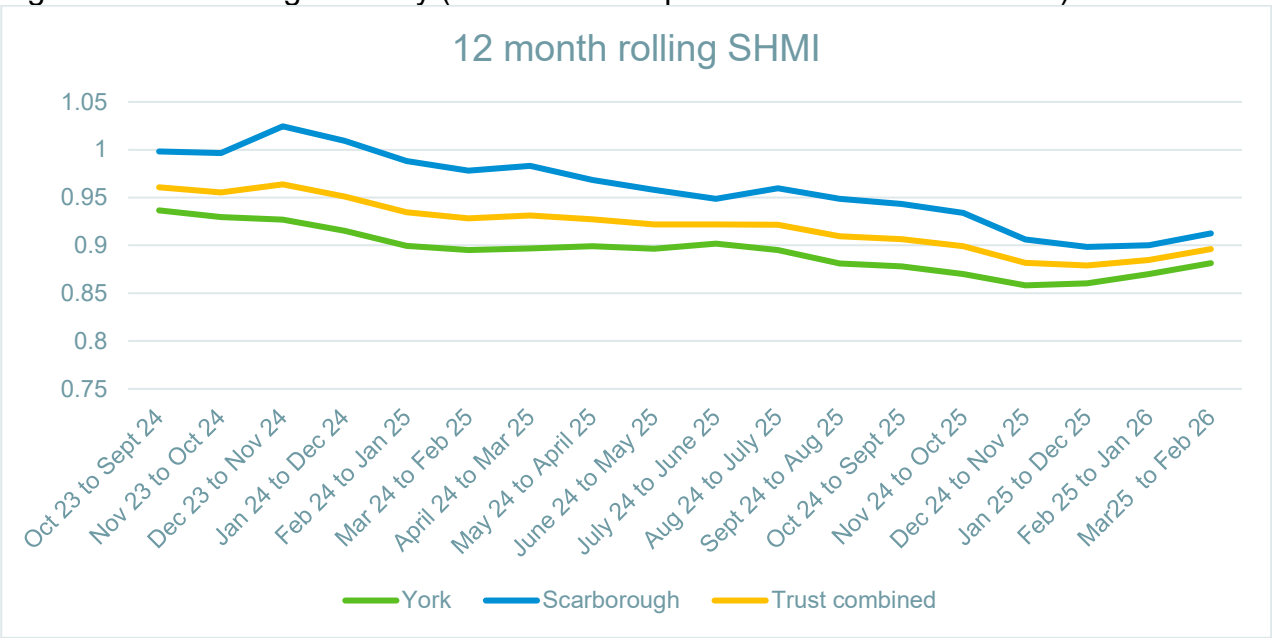


Figure 3 SHMI rolling mortality (Oct 2023 to Sept 2024 to Mar 25 to Feb 26)



2. Diagnostic groups contributing to our mortality rates

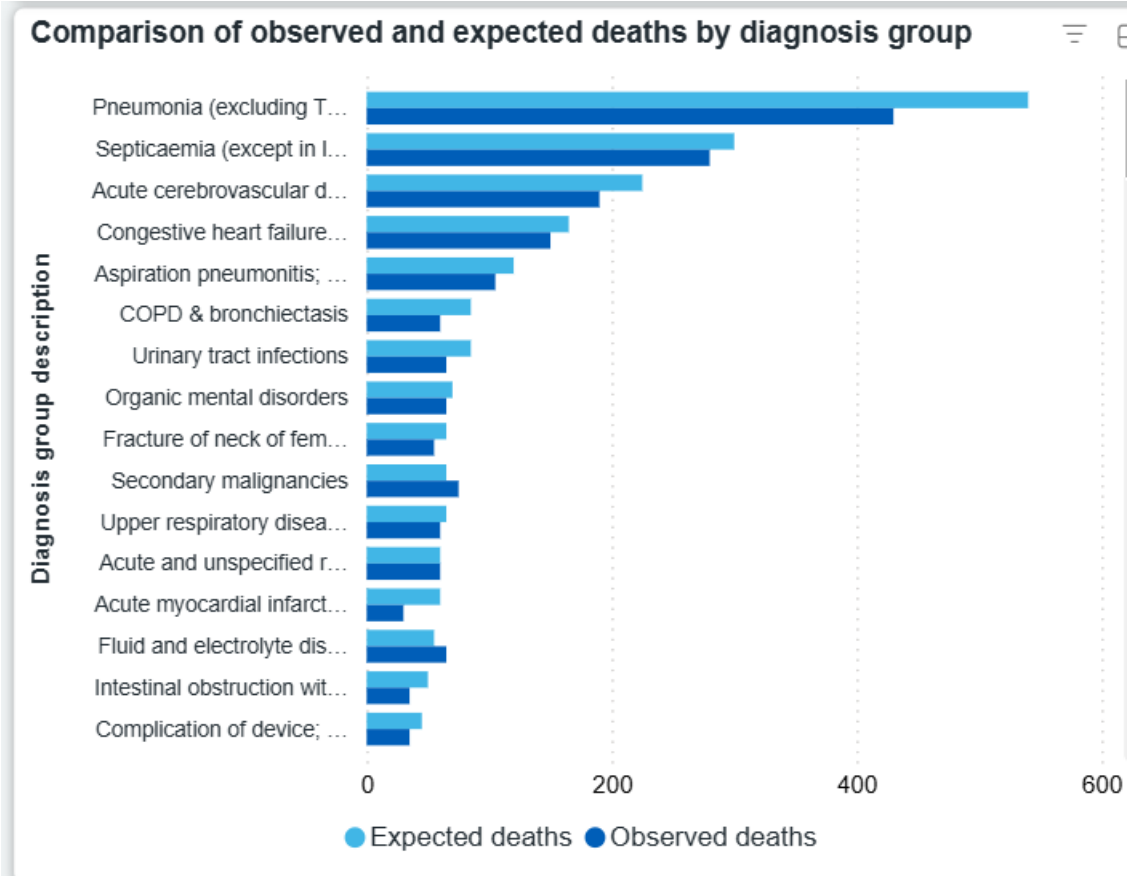
There are 144 diagnostic groups that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

The way in which coding is applied to patients that die in the Trust can significantly affect mortality statistics. The “depth of coding” (coding of co-morbidities as well as primary diagnosis) is important as it allows for more accurate calculation of the expected number of deaths that should be seen during a specific time period. Coding of the primary diagnosis will also affect mortality statistics in particular diagnostic groups. We continue to work with the coding team to understand how better to managing this reporting and we are using the learning provided from Trust mortality reviews via the Learning from Deaths process to triangulate our current mortality outliers and ascertain if any further investigation is required.

The most recent breakdown of differential SHMI for common diagnostic groups is displayed in Figure 4 below. At present there remain no diagnostic groups causing concern (all are at or below the expected level when adjusted for SHMI). There continue to be more observed than expected deaths in secondary malignancies and fluid and electrolytes. Septicaemia which has been a key focus in the Trust continues to see more expected deaths than observed deaths in this group, as does pneumonia. There has not been a change in the groups that may contribute to NELA, accepting the data does not allow direct evaluation.

Our depth of coding is good at 6.3 the national average being 6.4. Coding is essential for accurate evaluation of the data. Since the pandemic we have seen an increase in the number of provider spells with a site of treatment change 2.6% of our inpatient stays have a site change. This has been stable for the last 18 months. The national average is 1. Obviously we would expect to see a higher than national average as we operate across two sites with some services such as stroke/vascular surgery located only on the York site.

Figure 4: SHMI associated with various diagnostic groups (from HES data) for September 24 to August 25 (Top 16 by expected deaths)



3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

This section provides data and outcomes in line with the requirements of the:

- National Guidance on Learning from Deaths (National Quality Board, 2017)
- Trust's Learning from Deaths Policy
- Department of Health and Social Care NHS (Quality Accounts) Amendment Regulations 2017

Whilst the report focuses on quarter 3 data, some information is provided for quarter 1 and 2 for comparison.

3.1 Nationally mandated data and information

The data provided in the table below is mandated by the national LfD framework. A narrative on learning and actions is provided in section 4.

When reading the table, SJCRs are Structured Judgement Case-note Reviews; PSII are Patient Safety Incident Investigation. It should be noted that that PSIIs replaced SIs when the new PSIRF was introduced in December 2023.

Table 1 – National data summary

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	Quarter 2 (25/26)			**Quarter 3 (25/26)**			**Quarter 4 (25/26)**			**Quarter 1 (26/27)**		
Total in-patient deaths (inc ED, exc community)	168	141	171	185	166	197	251	182	170	170	209	180
No. SJCRs commissioned for case record review[1]	2	2	5	5	9	2	3	7	3	5	4	5
No. PSII commissioned of deceased patients	0	1	1	1	1	0	1	2	0	0	0	2
No. deaths likely due to problems in care	See tables below			See tables below			See tables below			See tables below		

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 24/25).

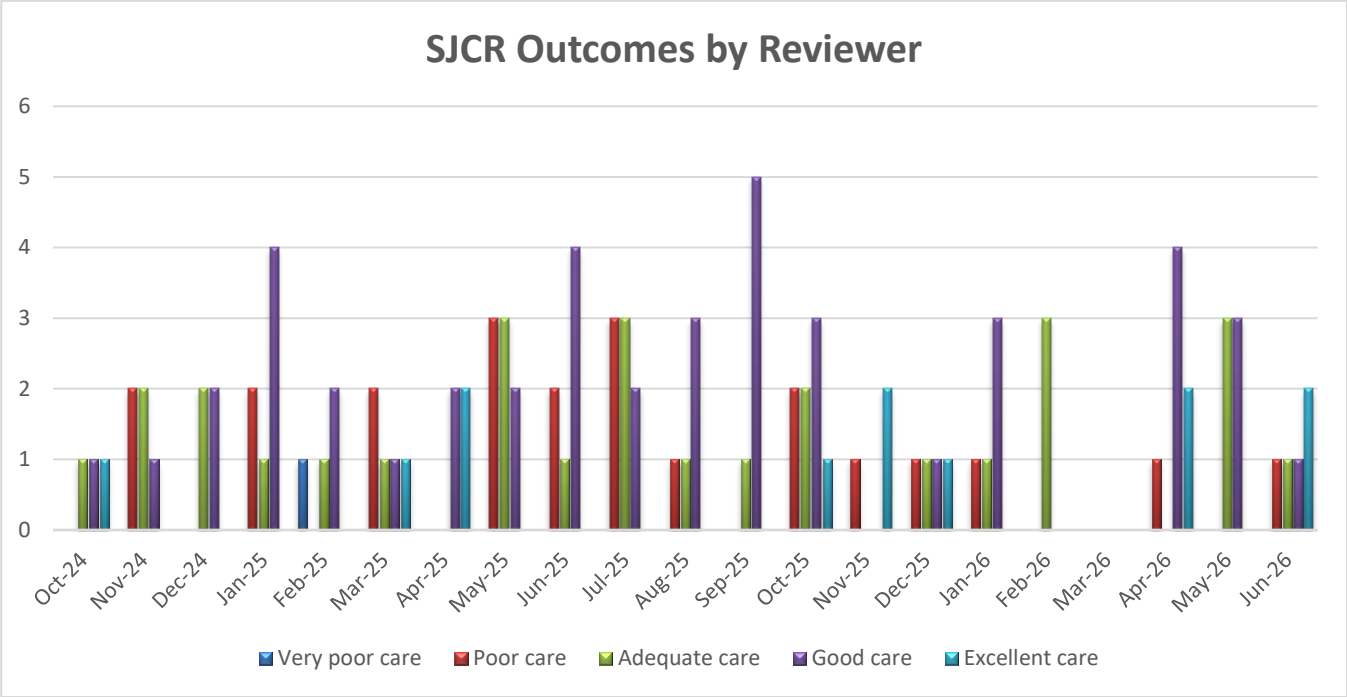
National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Figure 6 shows the outcomes of the SJCRs completed and reviewed during, Q2, Q3 and Q4 25/26 and Q1 26/27:

- Figure 6 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission.
- Figure 7 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q1 18 SJCRs were reviewed (8 in Q4) NB there was no LfD in March:

Figure 6 – SJCR outcomes assigned by the Reviewer (overall score)



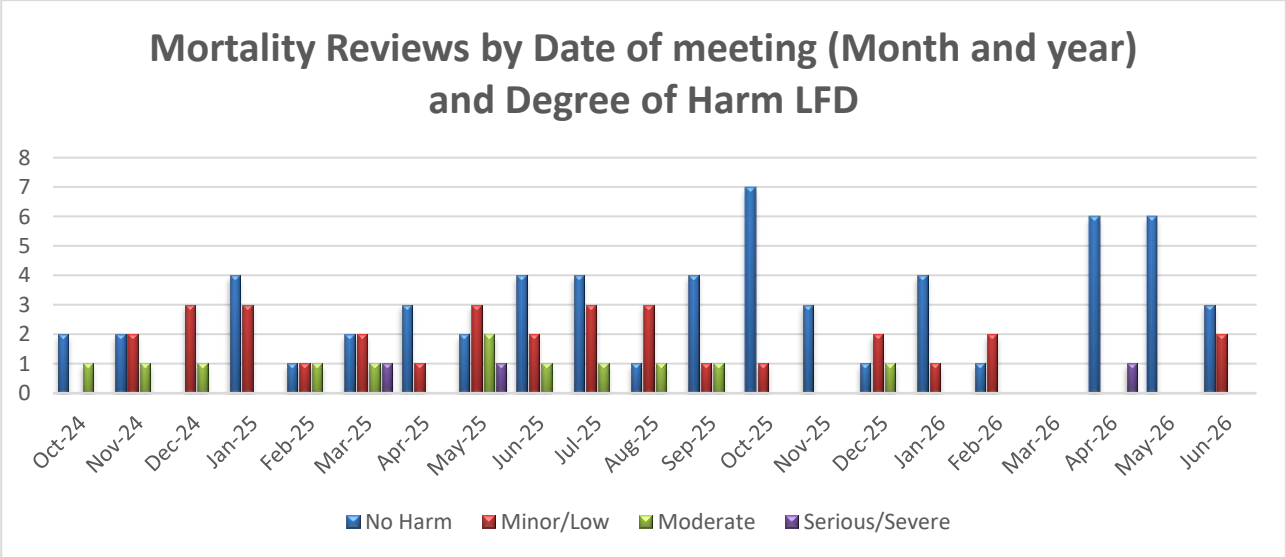
The Reviewer found there to be:

- Good care in 8/18 cases.
- Excellent care in 4/18 cases
- Adequate care in 4/18 cases
- Poor care in 2/18 cases
- Very poor care in 0/18 cases

The Poor care cases were all discussed at Q&S prior to LFD to ensure they were not potential Patient Safety Incident Investigations (PSII's).

The LfD group will decide on the level of harm for the SJCRs presented. The degree of harm levels is No harm, Minor, Moderate, Severe and Death.

Figure 7 – SJCR outcomes following review by LfD Group (degree of harm)



The Learning from Death Group agreed harm leading to death in 0 cases, severe in 1 cases, moderate harm in 0 cases, low in 2 of the cases and no harm in 15 cases.

3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance now Medical Examiners review all deaths; and the timely completion of structured judgement case-note reviews.

Data on progress of investigations at point of reporting (20/07/2026)

Overall no. of SJCRs open 39 (previously 40 as of 14/04/2026)

Figure 8 – Mortality Reviews by SJCR Status (date collected (20/07/2026)

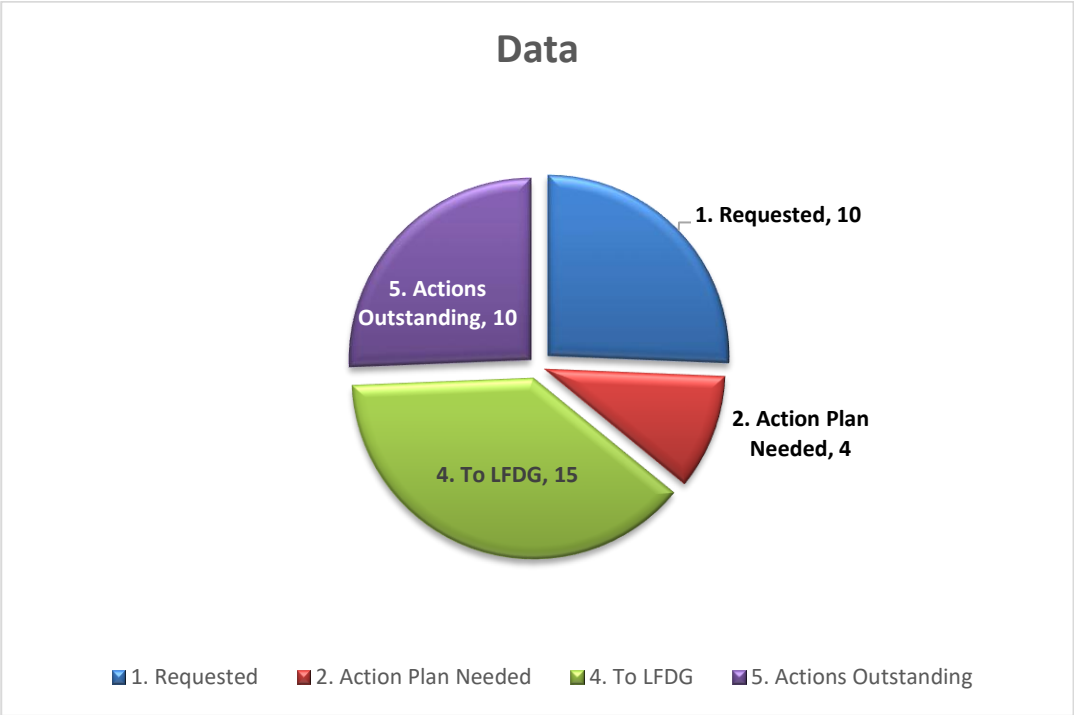


Table 2 - Status of open SJCRs

	Q2 (25/26)	Q3 (25/26)	Q4 (25/26)	Q1 (26/27)
Number under review	17	20	26	25
Awaiting action planning	5	3	4	4
Actions outstanding	12	11	10	10
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	5	4	4	2

The number of SJCR's more than 60 days overdue has decreased over the year, this has been evident since the increase in the number of trained SJCR investigators.

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 3 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2025/26. (please note that the numbering of these relate to the numbering dictated by the Quality Account Report which is why they differ from the rest of the report.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2024/25 but were investigated during 2025/26 and hence not reported in the 2024/25 Quality Account.

	Requirement	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
27.1	Total number of in-hospital deaths	480	548	603	559
27.2	No. of deaths resulting in a case record review or PSII investigation (requested reviews of patients who died in 25/26 or 26/27)	ME:480	ME:548	ME:603	ME:559
		SJCRS:9	SJCRS:16	SJCRS:13	SJCRS: 14
		PSII:2	PSII:2	PSII:1	PSII:2
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 24/25)	0	0	0	0
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 6	SJCR:	SJCR:0	SJCR: 0
		PSII:0	PSII:3	PSII:0	PSII:2
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 2026/27 after the 2025/26 Quality Account was published

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

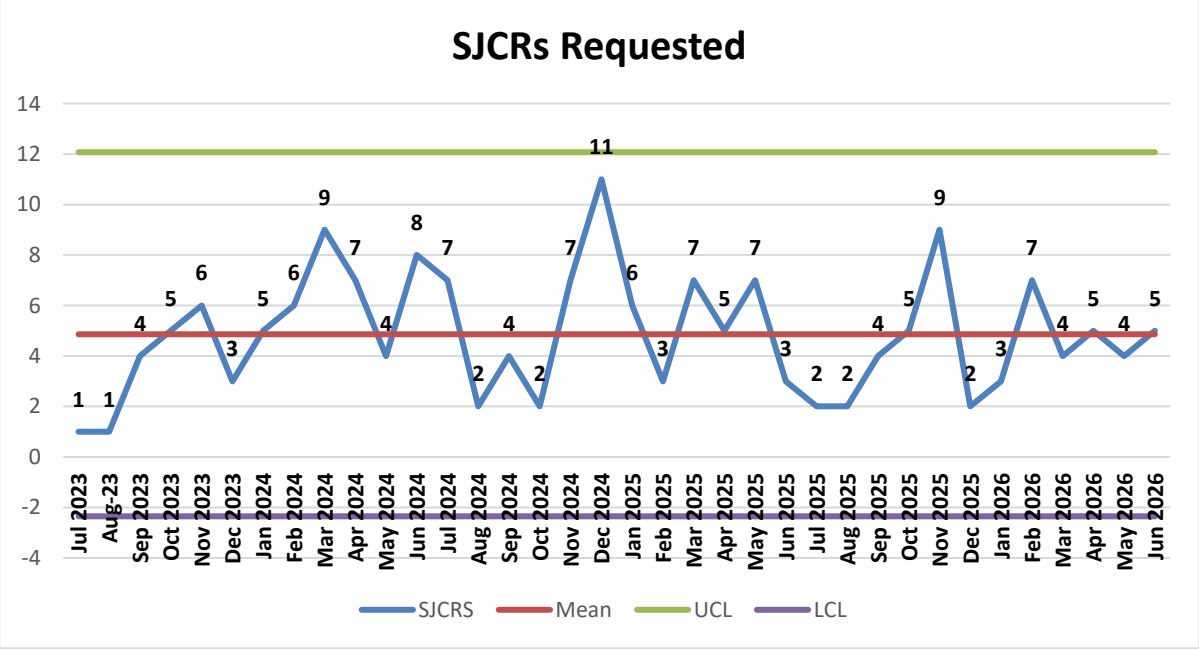
a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

Local PSII investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.
- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

Table 4 – SJCRs Requested



During Q1 of 26/27, there were 14 requested SJCRs. The numbers for the following quarters were: 9 in Q2 25/26, 16 in Q3 25/26 and 14 in Q4 of 25/26.
The aim is to conduct more SJCRs, focus on poor care, excellent care and areas of concerns for the trust such as Sepsis or NELA, to uncover important learning from what went well.

Table 5 – Source of request for SJCR

*It should be noted that there can be more than one source, however, to avoid duplication only the original inputted source is considered.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SJCR Request Source	**Quarter 2 (25/26)**			**Quarter 3 (25/26)**			**Quarter 4 (25/26)**			**Quarter 1 (26/27)**		
Care Group	1	1	1	4	6	1	2	2	4	4	1	2
Learning Disabilities	0	0	2	1	3	1	4	0	1	1	3	1
Medical Examiner Review	1	0	1	0	0	0	1	0	0	0	0	0
NoK Concern/ Complaint	0	0	1	0	0	0	0	0	0	0	0	1
Elective Admission	0	0	0	0	0	0	0	0	0	0	0	1
Q & S	0	1	0	0	0	0	0	0	0	0	0	0
Initial Mortality Review	0	0	0	0	0	0	0	0	0	0	0	0

Table 5 presents the origins of SJCR requests. Most of these requests still come from Care Groups, with learning disabilities being the next most common source.

4.1 Themes from SJCRs considered by the LfD Group in Q1:

Case record reviews highlight issues related to quality of care, revealing patterns that help guide organisations' improvement efforts.
With the introduction of DCIQ and its mortality module, theme identification was updated. The mortality module uses the same themes as other DCIQ modules, enabling cross-comparison and data triangulation.

The themes are identified within the Learning from Deaths meeting. These themes identified are shown in Table 6.

Table 6 – Themes identified

	Quarter 2 25/26			Quarter 3 25/26			Quarter 4 25/26			Quarter 1 26/27		
THEME	**Jul 2025**	**Aug 2025**	**Sep 2025**	**Oct 2025**	**Nov 2025**	**Dec 2025**	**Jan 2026**	**Feb 2026**	**Mar-26**	**Apr 2026**	**May 2026**	**Jun 2026**
Acting on Results	0	0	0	0	0	0	0	0	0	0	0	0
Capacity/Demand	0	0	1	1	1	0	0	0	0	0	2	1
Clinical Assessment	2	3	0	1	0	1	2	0	0	0	3	1
Communication/Documentation	1	0	1	3	1	0	0	1	0	0	1	1
Consent	0	0	2	0	1	0	0	2	0	0	0	0
Delayed Diagnosis/Treatment	1	2	0	1	0	1	2	0	0	1	1	0
Escalation	4	0	0	0	0	0	1	1	0	0	0	1
Guidance/Policies	1	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities	0	0	0	0	0	0	0	0	0	0	0	0
Medication Errors	0	0	0	0	0	0	0	0	0	0	0	0
No Themes Identified	2	1	0	1	1	1	1	0	0	5	1	1
Not listed (please specify)	0	0	0	1	1	1	1	0	0	0	0	0
Nutrition and Hydration	0	0	1	0	0	0	0	0	0	0	0	0
Pathways/Process	0	0	1	1	1	0	1	0	0	0	0	0

Patient Factors	1	0	0	0	0	0	0	0	0	0	0	0
Staffing/Workload	0	0	0	0	0	0	0	0	0	0	1	0
Team Factors	0	0	0	0	0	0	0	0	0	0	0	0
Transfer Issues	0	0	0	0	1	0	0	0	0	0	0	0

The key themes identified in Q1 were varied clinical assessment, capacity/demand and delayed diagnosis/treatment being the most identified. An area of focus currently ongoing is how we share the learning from our learning responses and wider Patient Safety data to improvement groups and learning from SJCRs will be apart of this.

5.0 Escalations & Learning

5.1 Maternity update Q1

Current Position/Issues
Eligible losses in Q1 2026/2027

There has been a total of two (twin pregnancy at 22+6 weeks gestation) eligible losses reported to MBRRACE-UK via the PMRT in Quarter 1 2026/2027.
One reported case met the criteria for an external investigation conducted by the Maternity and Newborn Safety Investigations (MNSI) however this was under the criteria of possible HIE rather than stillbirth.

Summary of all losses closed in Quarter 1
There were no perinatal mortality reviewed completed in the period Q1 2026/27.

5.2 Learning from deaths group overview

5.21 Nutrition and Hydration Group update

Key summary:

- Trust Food and Drink Strategy (2026–2028) approved and published.
- Collaborative review of inpatient menus underway, including service user involvement with new menu expected in autumn.
- Sustained improvement in malnutrition screening within required timeframes.
- Good assurance in paediatrics and neonates for NG tube competency, improvements ongoing in adults.
- Majority of actions from the swallowing PSII now completed and signed off.
- Ongoing risk of harm related to patients with swallowing difficulties.
- Variation in practice around fluid balance recording.

5.24 End of Life update

The End-of-Life Professional Standards Group Terms of Reference has been updated, and the revised Terms of Reference will be presented at the next meeting. The Palliative and End of Life Care Annual Report has also been completed and is being presented to the Quality Committee and Patient Experience Subcommittee. Ongoing involvement in Trust strategy meetings was also noted.

6. Service developments

6.1 SJCR Training

There are currently 70 doctors as active reviewers. Additionally, 15 nurses have completed training. SJCR training is conducted biannually for consultants and specialty programme participants. The forthcoming training sessions are scheduled for 27 May and 24 June.

6.2 Shared learning at LFD

Quarterly updates from specialist groups continue, including the End-of-Life group, Nutrition and Hydration Group, and Deteriorating Patient Group are scheduled as per the table.

Group	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Nutrition Steering Group			✓			✓			✓			✓
Deteriorating Patient Group		✓			✓			✓			✓	
End of life		✓		✓		✓		✓		✓		✓
ME update	✓			✓			✓			✓		
Family health update		✓			✓			✓			✓	
SJCR training	✓		✓		✓		✓		✓		✓	
Actions			✓		✓		✓		✓		✓	

7. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -
   a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.
   b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
   c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.
   d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

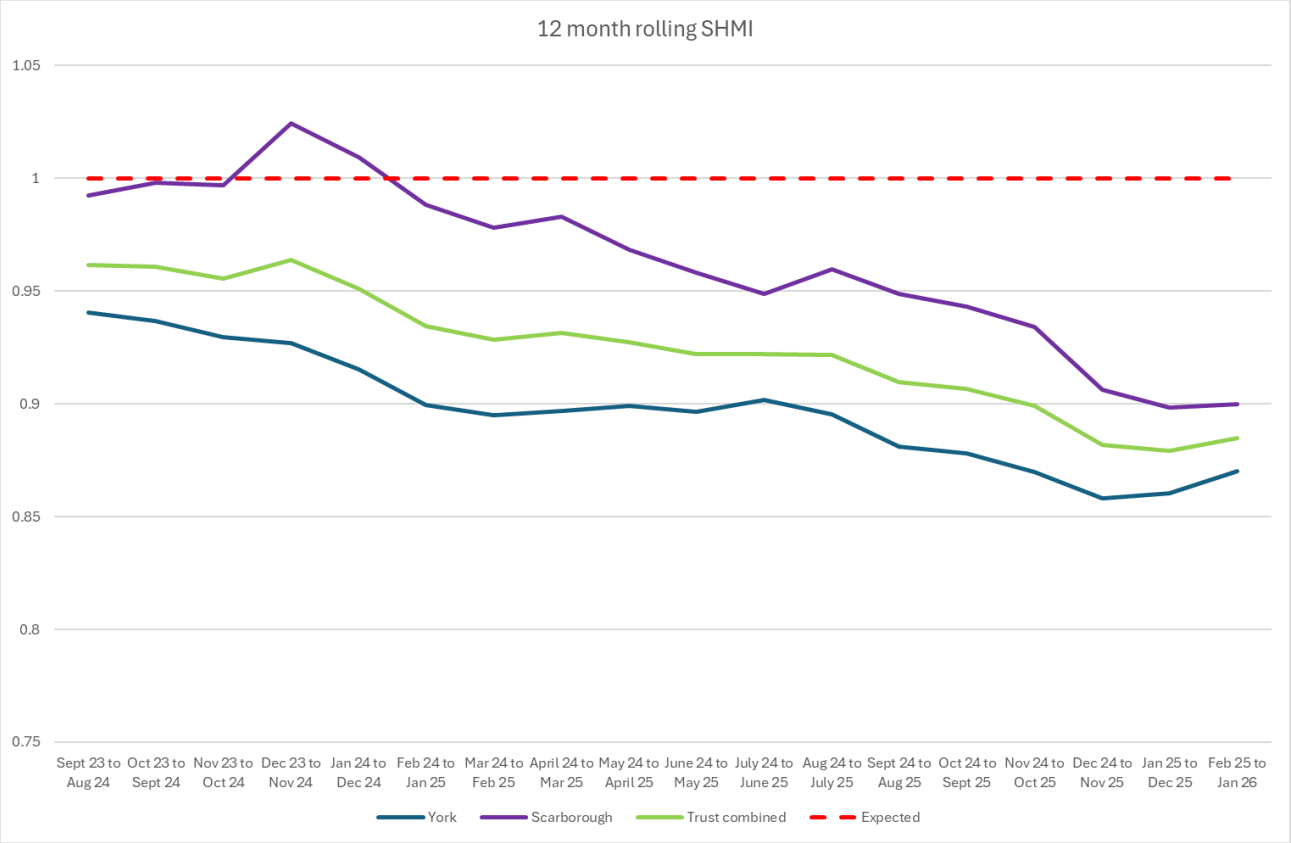
SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

Appendix 1

Figure 1 provides the 12 month rolling SHMI values for the last 18 reporting periods. The dotted red line is the expected value for the SHMI. York is represented by the blue line, Scarborough the purple and the green is the overall Trust value. Over the last 18 reporting periods covering September 2023 to August 2024 up to the most recent February 2025 to January 2026 we have seen a sustained decrease. The most recent reporting period does show a slight increase, but I would be concerned if the SHMI continued to fall as that would prompt us to look at the data as the expected deaths criteria may need revising.

Figure 1: 12 month rolling SHMI values.



Report to:	Trust Board
Date of Meeting:	30 September 2026
Subject:	Responsible Officer Report 2025/26: Annual Medical Appraisal and Revalidation Update
Director Sponsor:	Dr Karen Stone, Medical Director and Reponsible Officer for York and Scarborough Teaching Hospitals NHS Foundation Trust, St Leonard's Hospice and St Catherine's Hospice Scarborough
Author:	Paul Whittle, Appraisal and Revalidation Specialist, Medical Directorate Dr Oliver Prince, Medical Appraisal Lead Rob Newton, Associate Director, Medical Directorate

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

As a Designated Body, the Trust has responsibilities regarding appraisal, revalidation and professional standards of doctors in its employment. The Trust's Medical Director acts as the organisation's Responsible Officer for medical regulation. An increased focus on improving processes and systems in these areas has been put in place by the

Responsible Officer. This report provides a summary of activity for 2025/26. On 31 March 2026 the Trust achieved 83% compliance for medical appraisal.
Recommendation: Trust Board is asked to: • Note the information provided on medical appraisal and revalidation • Note the ambitions and plans for improvement in in these areas • Confirm commitment to supporting the discharge of the duties of the Responsible Officer within the Medical Act.

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

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

Meeting/Engagement	Date	Outcome/Recommendation

Appraisal and Revalidation Update

1. Introduction and Background

Every licensed doctor who practises medicine must revalidate every five years and should have an annual appraisal. The General Medical Council's (GMC) aims for medical revalidation are that it:

- enables licensed doctors to demonstrate that they are up to date and fit to practice
- supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors

To achieve these aims, the GMC requires that all doctors identify the Designated Body (usually their employer) that monitors and assures their practice. As of 31 March 2026, York and Scarborough Teaching Hospitals NHS Foundation Trust was the Designated Body for 846 doctors. The Trust's Medical Director also acts as Responsible Officer for doctors employed by St Leonard's Hospice, St Catherine's Hospice and Brainkind. As of September 2026, the Trust no longer acts as the Designated Body for doctors employed by Brainkind. The Trust also provides appraisal for clinicians registered with the General Dental Council.

Designated Bodies have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations. It is expected that Boards oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisation
- checking there are effective systems in place for monitoring the conduct and performance of their doctors.
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and
- ensuring that appropriate pre-employment background checks are carried out to the required standard.

This report provides information about how these duties have been discharged and improvement actions for the next twelve months.

2. Medical Appraisal

2.1. Appraisal Process

Doctors are assigned an appraiser by the Revalidation Team. Both parties can request a change in cases of conflict of interest. Appraisees usually stay with the same appraiser for three years and must then have a period of at least three years before being appraised by the same appraiser. Appraisals can be completed in person or online. The record of appraisal and supporting documentation is held on an online system called L2P.

Appraisees are encouraged to have at least one appraisal per revalidation cycle with an appraiser from a different specialty. To this end, Appraisers are allocated according to availability.

System-generated emails and formal reminder letters are sent at set intervals to encourage completion of appraisal. Care Group management teams are provided with monthly appraisal completion data and this forms part of Care Group accountability reporting.

2.2. Appraisers

Dr Oliver Prince, Specialty Doctor (Anaesthetics) is the Trust's Medical Appraisal Lead. Doctors are required to attend appraiser training to become a Medical Appraiser and existing Appraisers are required to attend annual CPD update training.

There are currently 83 active Medical Appraisers within the Trust, of which 74 have dedicated appraiser time in their Job Plan. The overall number of appraisers has remained static from last year despite the recruitment of new appraisers due to doctors retiring, resigning and stepping down from the role. Appraisers are expected to complete 6-10 appraisals per year. It is estimated that 102 Appraisers are required with time assigned in their job plans to facilitate timely appraisal for the 860 doctors who are assigned to the Trust as their Designated Body.

During the past 12 months doctors and dentists have not been able to access timely appraisal due to the shortage in appraiser availability. The shortfall has in large part been filled by Appraisers who go beyond their expected 10 appraisals a year by taking on additional appraisees and responding to individual requests for doctors who need an appraisal at short notice. A streamlined appraisal process, aligned to annual progression reviews for doctors in training, has been introduced for locally employed and bank doctors. These doctors account for 26% of the doctors and dentists requiring an appraisal from the Trust. For locally employed doctors and dentists working at a level below ST3 equivalent, a trained Clinical or Education Supervisor can conduct the appraisal. This streamlined approach was utilised 63 times in the last year with 41 appraisals completed by a trained supervisor and 22 by Appraisers.

Appeals for new Appraisers are regularly communicated to doctors and dentists across the Trust with regular new Appraiser training organised. Care Group Directors and Clinical Directors have been provided with information about the appraiser time made available from their specialties; 13% of senior doctors and dentists are required to be Appraisers to achieve the 102 Appraiser target. Meetings with the Care Group Clinical Directors and Chief Operating Officers are taking place to reiterate the importance of sufficient Appraiser numbers to facilitate timely appraisal and revalidation and highlight departments providing less than 13% of staff as Appraisers. The majority of doctors who are trained Appraisers have been assigned job planned time but there are currently 21 trained Appraisers who have not been able to have time assigned for appraisal, of which 9 are currently working as Appraisers.

2.3. Appraisal Completion Rates

	Number of appraisals	% of appraisals
Total number of doctors with a prescribed connection as of 31 March 2026	846 (up from 738)	
Total number of appraisals undertaken between 1 April 2025 and 31 March 2026	703	83%
Total number of appraisals not undertaken between 1 April 2025 and 31 March 2026	121	14.3%
Total number of agreed exceptions	70	8.2%
Total number of not agreed exceptions	51	6%

The appraisal completion rate has reduced from 84% in 2024/25 to 83% in 2025/26. In 2023/24 the rate was 90% but there has been sustained reduction due to the increasing number of locally employed and bank doctors needing an appraisal, without a corresponding increase in active appraisers.

The number of not agreed exceptions has decreased from 61 in 24/25 to 51 in 25/26. These include people who have been assigned an Appraiser within timescales but have not completed an appraisal.

The change which would make the biggest difference to improving appraisal completion and achieving the target of a minimum of 90% in 2026/27 is more trained Appraisers and more trained Appraisers with job planned time assigned.

2.4. 2025/26 Activities

During the last 12 months the following activity has taken place with regard to Medical Appraisal:

- Commencing of assurance processes of appraiser activity including feedback to the appraiser
- 2 New Appraiser and 7 Annual Update Training sessions.
- Recruitment of 14 new Appraisers. 7 of whom have had time allocated in their job plan.
- Advertisement and promotion of the Appraiser role within new starter and medical leadership programmes.
- 10 Appraisers surpassing a cumulative total of 100 Appraisals
- Communication with Care Group Clinical Directors and Ops Managers to highlight the appraiser shortage and encourage Job Plan amendments for those already trained as Appraisers without additional SPA and encourage clinicians within their Care Group to become Appraisers
- Recognition of appraisers who complete a high number of appraisals through Star Award nominations and letters.
- Introduction of a system to appraise the Physician and Anaesthesia Associates and deliver training on appraisal to the group. The supervisors of these individuals will complete an appraisal proforma.

2.5. 2025/26 Improvement Plan

Objective	Action
1. Increase the recruitment, retention and utilisation of Appraisers	• Increase communication regarding appraiser recruitment and training • Review appraiser contributions in job planning withing specialties and care groups • Meet Care Group leadership to request their support in increasing appraiser numbers across the Trust • Continued recognition of appraisers who complete a high number of appraisals
2. Improve the timeliness and usefulness of appraisal for Locally Employed Doctors	• Incorporate forthcoming national guidance (October 2026) on appraisal process and documentation for Locally Employed Doctors • Raise awareness of bank/locally employed doctor and dentist proforma among Care Group leadership to promote utilisation

	• Encourage senior Resident Doctors who are trained Supervisors to appraise locally employed doctors and dentists.
3. Support the improvement in quality of appraisals	• Introduce a new system of quality assurance of appraiser activity with feedback to individual Appraisers in time to include in their appraisals • Support and educate Appraisers to ensure that doctors and dentists understand what constitutes quality improvement activity • Introduce coaching skills training to Appraiser updates • Update guidance materials relevant to appraisal and revalidation on Staffroom to include research and innovation, career development and quality improvement.
4. Peer Review	• Undertake a peer review in November 2026 with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. Refresh action plan as a result
5. Physician and Anaesthesia Associates	• Ensure all PA and AAs are registered with the GMC by the December 2026 deadline • Educate and support the PAs and AAs in the appraisal process • Establish the GMC requirements for AA and PA revalidation

3. Medical Revalidation

3.1. Revalidation Recommendations

Revalidation recommendations are reviewed weekly by the Deputy Medical Director (Professional Standards) and the Appraisal and Revalidation Specialist. Doctor's portfolios are reviewed as to whether they have sufficient evidence to be recommended for revalidation. Where they have sufficient evidence, a positive recommendation is made to the GMC.

If the doctor doesn't have sufficient evidence at the time of recommendation, then their recommendation may be deferred. On rare occasions, doctors do not engage with the appraisal process despite multiple interventions from the Medical Directorate Team. In these cases, a non-engagement notification is made to the GMC, which is a serious intervention and significant efforts are made to avoid this.

For 2025/26 the deferment rate for the Trust was 7% (down from 8% in 2024/25), compared to a national average of 19%.

The most common reason for deferment is a lack of patient and colleague feedback. This should improve with the recent change in the software used for this feedback. The appraisal and revalidation team continue to set the expectation that feedback should be collected during years two and three of the revalidation cycle.

4. Recruitment and Engagement Background Checks

All doctors employed by the Trust are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including bank and locum doctors.

5. Maintaining High Professional Standards (MHPS)

A weekly Responsible Officer Advisory Group (ROAG) is in place, chaired by the Medical Director and attended by a HR advisor, Deputy Medical Director, an Associate Medical Director and Associate Director (Medical Directorate). This group reviews doctors who require investigation, action or support by the Trust internally or by the GMC or for matters concerning conduct, capability and health. Action is taken in accordance with the Trust's disciplinary policies. Where relevant and appropriate, the Board is updated about cases through the Board's Reportable Issues Log. The Responsible Officer maintains regular contact with the GMC's Employee Liaison Adviser and NHS Resolution Practitioner Performance Advice when appropriate.

In 25/26 there has been a significant volume of MHPS cases which have created a significant workload for the Responsible Officer and the ROAG. A Non-Executive Director has responsibility for overseeing the processes and meets regularly with the RO to receive updates on case management.

Disclosable cases such as those involving investigations under MHPS or referral to the General Medical Council are reporting to the Trust's Quality Committee. In addition to these formal cases with GMC involvement there has remained ongoing issues which are managed within local processes and do not progress to MHPS cases. The ROAG group also has oversight on long term sickness cases and doctors in difficulty.

6. Policy

The GMC publishes 'Good Medical Practice', which sets out the standards of patient care and professional behaviour expected of all doctors in the UK, across all specialties, career stages and sectors. These standards have been updated and updated guidance came into effect on 30 January 2024. The GMC also publish supportive guidance.

The Medical Appraisal Policy was reviewed and approved in August 2025.

Cases involving doctors are managed under the Maintaining High Professional Standards Framework, and the Trust's Conduct and Disciplinary Policy and the Civility, Respect and Resolution Policy. In 2026/27 a local Maintaining High Professional Standards Policy will be written which sets out local delegation responsibilities for the Responsible Officer.

During 2025/26 there has been the continued introduction of professional regulation of Physician Associates and Anaesthesia Associates. The Trust also received the recommendations from NHS England in response to the Independent Review of Physician Associates and Anaesthesia Associates (the Leng Review). PAs and AAs are legally required to register with the General Medical Council by December 2026. Advice and support has been given to those employed in the Trust by Medical Education and the Medical Appraisal Teams and policy will be updated during 26/27.

7. Recommendations

Trust Board is asked to:

- Note the information provided on medical appraisal and revalidation
- Note the ambitions and plans for improvement in in these areas
- Confirm commitment to supporting the progress of this work

Dr Karen Stone
Medical Director
Responsible Officer

Date: September 2026

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April – 31 March

1A – General

The board/executive management team of: York and Scarborough Teaching Hospitals NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	None
Comments:	Compliant – Medical Director
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	
Comments:	Compliant. The Trust requires another 20-30 appraisers to be able to reliably provide timely appraisal and for appraisers to stay within their job planned limits for the number of appraisals completed.

	For managing professional standards the Responsible Officer has a RO Advisory Group which meets weekly consisting of HR support and a Deputy Medical Director, Associate Medical Director and Associate Director. Investigating Officers are appointed as required.
Action for next year:	Increase the recruitment, retention and utilisation of Appraisers Embed tailored appraisal approach for Locally Employed Doctors

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Completion of process review, standard operating procedure and audit tool for the administration of non-training grade starters and leavers to increase assurance about accuracy of prescribed connections. Improved communication with recruitment teams
Comments:	Compliant Improved communication with recruitment teams
Action for next year:	

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	None
Comments:	Compliant – Medical Appraisal Policy reviewed and approved in June 2025
Action for next year	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	To be explored with neighbouring Trusts
Comments:	Peer review is arranged for November
Action for next year:	Complete review

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are

supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Review and embed the process and develop as required
Comments:	Compliant. New 'LED Appraisal' pilot process developed to give LED and locum doctors meet with an appraiser or supervisor, discussing their aspirations and development needs. LED Tutor appointed and involved in induction and CPD.
Action for next year	

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	
Comments:	Compliant. Appraisal is available to all doctors connected to the trust and covers whole scope of work. Appraisers are reminded for the need for this at annual updates and new appraiser training.
Action for next year:	

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	None
Comments:	Compliant – doctors are contacted frequently to understand and address any barriers
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	None
Comments:	Compliant – reviewed 2025
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	N
Action from last year:	• Continued recruitment of medical appraisers and job planning of existing appraisers, • Certificates and star award nominations for appraisers with >100 appraisals • Increase communication regarding appraiser recruitment and training • Review appraiser contributions in job planning withing specialties and care groups • Awareness of appraiser opportunities in new consultant and new specialist programme
Comments:	• During the past 12 months doctors and dentists have not been able to access timely appraisal due to the shortage in appraiser availability. The shortfall has in large part been filled by Appraisers who go beyond their expected 10 appraisals a year by taking on additional appraisees and responding to individual requests for doctors who need an appraisal at short notice. In addition, during this year a streamlined appraisal process has been introduced for locally employed and bank doctors to reduce the demand on trained Appraisers. • Appeals for new Appraisers are regularly communicated to doctors across the Trust with regular New Appraiser training organised. Care Group Directors and Clinical Directors have been provided with information about the appraiser time made available from their specialties; 15-20% of senior doctors and dentists are required to be Appraisers to achieve the 115 Appraiser target. The majority of doctors who are trained Appraisers have been

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	assigned job planned time but there are currently 19 trained Appraisers who have not been able to have time assigned for appraisal.
Action for next year:	• Meetings with Care Groups to review job planned time for Appraisers

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	None
Comments:	Compliant. At least 3 update and 3 new appraiser training sessions established per year.
Action for next year:	None

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	None
Comments:	Compliant. All appraisal input forms are read. Output forms are reviewed using ASPAT. These scores are combined with appraisee scores and given to appraisers. Responsible Officer Report reviewed at Board each September
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	RO to have final sign-off
Comments:	Due revalidations now discussed at monthly team meeting
Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	None
Comments:	Compliant – doctors are informed the same day, and given an action plan where required
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	None
Comments:	Compliant. Clinical governance days regularly scheduled. Governance leads appointed within care groups and governance and accountability established via Quality and Safety structures.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	None
Comments:	Compliant
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	**Y**
Action from last year:	Implementation of new L2P Appraisal software
Comments:	System successfully set up, training given
Action for next year:	None

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to

concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	None
Comments:	Concerns are managed according to national Maintaining High Professional Standards guidance and the Trust's Conduct and Disciplinary Policy and Civility, Respect and Resolution Policy
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Include review of the types of concern and characteristics of doctors in next year's reporting.
Comments:	Reported to Board within Reportable Issues Log and Quarterly Medical Workforce Report
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	Establish mechanism to gain assurance for doctors working in the Trust (typically agency) who have a different RO
Comments:	Compliant. This is regularly done as required between ROs for existing staff and for newly recruited doctors as required.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	None
Comments:	Compliant

Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	None
Comments:	Extensive initiatives in place on this topic across the organisation and reported through other means.
Action for next year:	None

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	None
Comments:	Compliant
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	None
Comments:	Compliant
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	None
Comments:	Addressed as part of MHPS and professional standards processes alongside other initiatives.
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	None
Comments:	Various initiatives in place on this topic across the organisation and reported through other means.
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	None
Comments:	Various initiatives in place on this topic across the organisation and reported through other means.
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	None
Comments	Compliant
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Y
Action from last year:	None
Comments:	Compliant
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not

restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	
Comments:	Compliant. Regular attendance at RO meetings,
Action for next year:	Continued attendance and engagement with regional networks. Exploration of peer review

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .
All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	846
Total number of appraisals completed	703
Total number of appraisals approved missed	51
Total number of unapproved missed	40
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	92*
Total number of late recommendations	3
Total number of positive recommendations	86
Total number of deferrals made	6
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	
Total number of trained case managers	
Total number of concerns received by the Responsible Officer[2]	19
Total number of concerns processes completed	12
Longest duration of concerns process of those open on 31 March (working days)	164
Median duration of concerns processes closed (working days)[3]	52.5
Total number of doctors excluded/suspended during the period	3
Total number of doctors referred to GMC	4
Total number of appeals against the designated body's professional standards processes made by doctors	1
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	118 (non-training)
Total number of new employment checks completed before commencement of employment	118
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
*There has been an error identified within the data provided on the General Medical Council online system so the number of revalidations completed and deferrals have had to be collated manually, and there may be some room for error in this internal data collection.

Actions still outstanding
Current issues
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).
Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	York and Scarborough Teaching Hospitals NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.
[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.
[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Item 20

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Emergency Preparedness, Resilence and Response Core Standards Annual Assurance – Action Plan Progess
Director Sponsor:	Accountable Emergency Officer - Claire Hansen
Author:	Head of EPRR – Richard Chadwick

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The Emergency Preparedness, Resilience and Response Core Standards Annual Assurance process was completed in January 2026. The Board of Directors approved the assurance submission of 82% of the standards being fully compliant on 28 January 2026 which achieved an organisational grading of PARTIAL.

An action plan has been developed to remediate the partially and non-compliant standards and this report is the third in 2026 to chart the progress of work against that action plan.

The assessment in September 2025 of the 62 standards resulted in 82% being classified as fully compliant and the organisational grading improving to PARTIAL compliance. It is assessed that by September 2026, when the annual assurance is required to be submitted

to NHS England, that the organisational grading will remain at PARTIAL compliance which is a reassessment of the predicted grade from previous reports in 2026 due to the slippage in progress.

A further progress report will be submitted to the Resources Committee in December 2026.

Recommendation:

The Board is requested to note the lack of progress of the work conducted against the action plan since the last report.

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	18 August 2026	Noted

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS – ACTION PLAN PROGRESS REPORT

1. Introduction and Background

NHSE conduct an annual assurance of the Emergency Preparedness Resilience and Response Core Standards. There are 62 core standards that are grouped into the 10 domains of: Governance, Duty to Risk Assess, Duty to Maintain Plans, Command and Control, Training and Exercising, Response, Warning and Informing, Cooperation, Business Continuity and Chemical, Biological, Radiological and Nuclear. The overall assurance organisational grading is determined as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

2. Current Position

The annual assurance for 2025-2026 reported the following:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	1	3	0
Cooperation	4	3	1	0
Business Continuity	10	9	1	0
Hazmat/CBRN	12	8	4	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	51	11	0

This is a fully compliant rating of 82% against total standards and therefore is an improvement on the 2024-2025 NON-COMPLIANT organisational rating to PARTIALLY compliant.

The annual assurance programme for 2026/2027 has now been finalised as follows:

HNY Core Standards 2026 Timeline (Revised)	
Core Standards letter received	1st July 2026
Revised process discussed with providers	13th July 2026
Health Assurance Group Meeting (Sign off revised process)	29th July 2026
Initial self-assessment submission	31st August 2026

Peer Reviews	September 2026
Health Assurance Group Meeting	11th September 2026
Final self-assessment submission **Hard deadline for evidence submission (for Tier 3 standards)**	30th September 2026 (Previously 30th October 2026)
ICB EPRR team to meet with providers to assess Tier 2 standards, finalise evidence review and feedback	To be completed by end of September 2026
ICB EPRR Team to review any evidence for Tier 3 standards not already reviewed and provide feedback	To be completed in advance of AEO meetings w/c 12th and 19th October
ICB and Provider AEO meetings	w/c 12th and 19th October 2026 (previously November). Final positions agreed and amended returns submitted to ICB EPRR Team if different from those submitted at the end of September.
NHSE NEY request dip-sample information	w/c 19th October 2026
Health Assurance Group Meeting	21st October 2026
Deadline for ICBs to send full assurance returns to NHSE	30th October 2026
Deadline for ICBS to submit dip-sample evidence to NHSE	2nd November 2026
Dip-sample check and challenge (if required)	w/c 16th November 2026
LHRP Confirm and Challenge	23rd November 2026
Regional Sign off – ICB, Provider and Regional Returns	26th November 2026
Executive Committee	2nd December 2026
Resource Committee	15th December 2026
Trust Board	27th January 2027

3. Action Plan Progress

The action plan to remediate the partially and non-compliant standards is at Appendix 1. Using the progress to date on the action plan it is assessed that the change to gradings against the annual assurance reported position as of Aug 26 would be:

Domain	RAG	Aug 25	Feb 26	May 26	Aug 26
Governance	(G)	5	5	**Completed**	5
	(A)	1	1		1
	(R)				
Risk Assessment	(G)		**Completed**		
	(A)	2			
	(R)				
Duty to Maintain Plans	(G)	9	10	10	10
	(A)	2	1	1	1
	(R)				
Command & Control	(G)	**Completed**			
	(A)				
	(R)				
Training & Exercising	(G)	**Completed**			
	(A)				
	(R)				
Response	(G)	**Completed**			
	(A)				
	(R)				

Domain	RAG	Aug 25	Feb 26	May 26	Aug 26
Warning & Informing	(G)	1	1	1	1
	(A)	3	3	3	3
	(R)				
Cooperation	(G)	Completed	3	3	**3**
	(A)		1	1	1
	(R)				
Business Continuity	(G)	8	9	9	9
	(A)	2	1	1	1
	(R)				
CBRN / HAZMAT	(G)	8	8	9	9
	(A)	4	4	3	3
	(R)				
% of standards assessed as fully compliant		77%	82%	85%	84%

4. Points to Note On Progress

It should be noted that there has not been any progress in compliance this quarter. This is due to the finite resources in the small Emergency Preparedness, Resilience and Response Team and competing priorities that have detracted from core business.

Notes on progress for those actions still not fully compliant are below and are unchanged since the last report.

- **Governance.** Standard 5 relates to the organisation having sufficient resources to ensure it can fully discharge it's EPRR duties and remains AMBER. Sufficient resources relate to number of staff assigned to the portfolio, the resources to implement an effective On Call framework and the finance available to update, service, calibrate and repair Emergency Preparedness, Resilience and Response equipment.

  Previous reports in 2026 assessed that resources were sufficient to continue improvement against the core standards action plan. Continued Team involvement in managing planned and unplanned incidents over the last 6 months has resulted in a reassessment of progress and it is now assessed that the year end grading will remain the same as last year. This reassessment warrants Standard 5 being re-graded as AMBER (Partially Compliant) since the May 26 report and this results in a 1% reduction in the % of standards assessed as fully compliant

  A gap analysis will be submitted to the Accountable Emergency Officer to quantify the gap between resource and capability and to articulate any mitigation required to tolerate gaps.
- **Duty to Maintain Plans.** All the plans held by the EPRR Team will be reviewed this year. One plan, Countermeasures (Standard 14) remains in draft. The plan outlines how the Trust will deliver the provision of vaccination and prophylaxis to staff and patients and will support local authorities in a mass vaccination and/or prophylaxis plan. The local authority plans are very immature and are being considered this year which will then allow the completion of the Trust plan. It is expected this plan will be published in 2026.
- **Warning & Informing.** A draft Major Incident Communications Plan has been written and has been reviewed by the Director of Communications. There is work required to determine and document how communications will be issued to staff and the general public out of hours after which the plan will be ready for endorsement and publication. This plan will be published this year and will ensure compliance with all standards in this domain (Standards 33, 34 and 36).
- **Business Continuity.** The Assurance of Commissioned Providers and Suppliers standard requires assurance through evidence of that business continuity plans are in place for all our providers and suppliers. The number of suppliers and providers to the Trust is significant

and work has begun with the Deputy Director of Procurement to work through the critical providers and suppliers to gain assurance. It is expected that this work will take at least 12 months. The number of Commissioned Providers and Suppliers who do have appropriate Business Continuity plans is yet to be identified and will be reported at the next progress report.

- **Chemical, Biological, Radiological and Nuclear / Hazardous Material.** The Training Resource (Standard 63) will be completed this year as the Chief Instructor for Chemical, Biological, Radiological and Nuclear implements the national training curriculum from Yorkshire Ambulance Service. A programme of exercising the Chemical, Biological, Radiological and Nuclear capabilities for both sites is set for this year and, dependant on the availability of staff, this will be completed by October 2026.

5. Residual Risks

The residual risks to the completion of the action plan are as follows:

- **Emergency Preparedness, Resilience and Response Team Resources.** The Emergency Preparedness, Resilience and Response Team consists of 2 WTE staff members and a 3/5 a week share of a further WTE post. The "implied responsibilities" that do not contribute directly to core standard compliance include managing incidents; supporting Trust change programmes; coordinating safe implementation of back log maintenance and IT upgrades and supporting the planning of resilience initiatives. The time involved in this work has doubled since 2023 and is therefore detracting from the time available to implement the core standards action plan.
- **Staff Availability.** The development and implementation of plans and then the testing of them through training and exercising relies on the availability of clinical and nursing staff. When individual training programmes are designed, there is a reliance on colleagues being made available for those events. Mitigation measures for this risk include:
    - Training and exercising are targeted at senior managers and clinicians to minimise disruption on the shop floor. Where operation procedures are required to be tested then longer lead in times to roster staff to activity are considered.
    - Work is ongoing to develop training packages that can be delivered on Learning Hub to minimise the time staff take to conduct training and prevent disruption to services. Experience this year has indicated that although the opportunities for individual training have been provided online and in person, the take up from colleagues has been at best limited. This has improved with the introduction of portfolios of evidence of completion of training for Health Commanders and conducting a formal audit process.
    - Activity conducted when responding to incidents is being recorded on logs to minimise the need for training and exercising events.

6. Summary

Significant progress has been made in 2025 however the pace of improvement in 2026 has stalled as the Emergency Preparedness, Resilience and Response Team has been distracted from core business responding to incidents and reinforcing resilience within the Trust. This has resulted in a reassessment of the final compliance position for this year to be remaining at PARTIAL compliance.

A separate paper to review mitigation available to get progress back on track is being produced and if this is not possible due to resources it may result in the grading remaining the same as last year's. Further assessment of the position is underway. A report detailing the final position of the Trust for this year's assessment will be with the Resources Committee in December 2026.

Date: 12th August 2026

Appendix 1 – EPRR Core Standards Action Plan – Current Non-Compliant Standards

Ref	Domain	Standard name	Standard Detail	ICB Final Grading 2024	ICB Final Grading 2025	Trust Action 2025	Trust Action 2026	Actionee	Target Date	Remarks / Updates
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	A	A	2 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	1 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	RC	Q2 - 26	2 - (08/04/25) - RC to speak to KH and see how this can be taken forward in light of Trust challenges and the political NHSE landscape.
14	Duty to Maintain Plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	R	A	8 - Capture specific Countermeasures Training in the central training log. (R) 9 - Write a new policy to consider mass vaccination and issue of prophylaxis. (A)	2 - Capture specific Countermeasures Training in the central training log. (R) 3 - Write a new policy to consider mass vaccination and issue of prophylaxis. (A)	CR RC	Q4- 25 Q2 - 26	1 (19/11/25) - Draft plan to be circulated internally and externally to achieve final draft. To Executive Committee in early 2026.
33	Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	A	17 - Determine 24/7 Comms capability and include in Incident Comms Plan (A)	5 - Determine 24/7 Comms capability and include in Incident Comms Plan (A)	RC	Q4 - 26	17 (08/04/25) - Included in draft with Comms Team. 17 - (05/06/25) - Chaser sent to LB. 5 - (19/11/25) - RC to meet Comms Team to finalise draft.
34	Warning and Informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	A	A	18 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (G) 19 - Write Incident Comms Plan (A)	6 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. 7 - Write Incident Comms Plan (A)	Comms Team RC	Q4 - 25 Q4 - 25	18 (08/04/25) - RC to include a comms slide in induction training, familirisation training and C2 training. 19 (08/04/25) - With Comms team for comment. 19 - (05/06/25) - Chaser sent to LB. 6 & 7 - (19/11/25) - RC to meet Comms Team to finalise draft.
36	Warning and Informing	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	A	20 - Write Incident Comms Plan (A)	8 - Write Incident Comms Plan (A)	RC	Q4 - 25	20 - (05/06/25) - Chaser sent to LB. 8 - (19/11/25) - RC to meet Comms Team to finalise draft.
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	A	A		9 - Engage with Exec PAs to ensure availability of AEO	RC	Q4 - 25	
53	Business Continuity	Assurance of Commissioned Providers / Suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	33 - Review required of process and included in Trust BC Plan. (A)	12- Review required of process and included in Trust BC Plan. (A)	CR	Q3 - 26	33 (14/07/25) - Meeting programmed with IW and review post that meeting. 12 (19/11/25) - Number of contracts significant. Will capture new contracts going forward and work through historial contracts at best effort.
59	Hazmat/CBRN	Decontamination Capability Availability 24/7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	A	A	40 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A) 41 - Amend CBRN Plan to include guidance provided in CBRN Audit (G)	13 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A)	EC-S	Q3 - 26	40 (08/04/25) - Manual process in place whilst automation is explored. 13 (19/11/25) - EC-S to get comptency added to Health Roster.
63	Hazmat/CBRN	Hazmat/CBRN Training Resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	A	47 - CI CBRN to comply with guidance provided in CBRN audit.	16 - CI CBRN to comply with guidance provided in CBRN audit.	EC-S	Q3 - 26	16 (19/11/25) - EC-S to action and report to RC quarterly.
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	A	50 - Complete actions as per CBRN Audit guidance. (R)	17 - Complete actions as per CBRN Audit guidance. (R)	EC-S	Q3 - 25	17 (19/11/25) - LIVEXs planned for both sites in Jun 26.

Report to:	Board of Directors
Date of Meeting:	30 September 2026
Subject:	Culture and People Committee and Digital and Transformation Committee: Terms of Reference
Director Sponsor:	Martin Barkley, Trust Chair
Author:	Martin Barkley, Trust Chair

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes
☐ No
☒ Not Applicable

Executive Summary:

Following the Board Development Seminar discussion on 22 July 2026, terms of reference have been developed for two new committees of the Board: the Culture and People Committee and the Digital and Transformation Committee.

The proposed Culture and People Committee will provide dedicated Board-level assurance on delivery of the Trust's Culture and People Plan, strategic workforce requirements, organisational culture, staff experience, equality, wellbeing, leadership and relevant workforce risks.

The proposed Digital and Transformation Committee will provide dedicated Board-level assurance on the Trust's Digital Strategy, digital-enabled transformation, the Electronic Patient Record programme, continuous improvement, information governance and relevant strategic risks.

The terms of reference set out each Committee's purpose, authority, duties, membership, quoracy, meeting frequency, reporting arrangements, annual effectiveness review and indicative work plan. Both Committees will report directly to the Board of Directors.

Recommendation:

The Board of Directors is asked to:

1. approve the Terms of Reference for the Culture and People Committee;
2. approve the Terms of Reference for the Digital and Transformation Committee;
3. establish both Committees as standing committees of the Board, reporting directly to the Board of Directors; and
4. note that each Committee will review its effectiveness and Terms of Reference at least annually and submit an annual report to the Board.

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

Meeting/Engagement	Date	Outcome/Recommendation
Board Development Seminar	22 July 2026	Initial discussion paper presented on the proposed establishment and remit of the two Board committees.

Culture and People Committee and Digital and Transformation Committee: Terms of Reference

1. Purpose

This paper seeks formal Board approval of the Terms of Reference for the Culture and People Committee and the Digital and Transformation Committee, following the earlier discussion of the proposed committee structure at the Board Development Seminar on 22 July 2026.

The proposed Committees are intended to strengthen dedicated Board oversight and assurance in two strategically important areas while providing clear accountability, escalation and reporting arrangements to the Board of Directors.

2. Culture and People Committee

The Culture and People Committee will act on behalf of the Board in relation to people and culture strategy, implementation, impact, assurance and escalation. Its remit includes the Culture and People Plan, strategic workforce needs, Trust values and culture, statutory and regulatory employer obligations, equality and diversity, staff health and wellbeing, freedom to speak up, leadership and management development, workforce metrics and relevant Board Assurance Framework and Corporate Risk Register risks.

The Committee will meet every two months. Its proposed quorum is three members, comprising at least two Non-executive Directors and one Executive Director. The Committee Chair will report key issues and decisions to the next Board meeting held in public. The terms of reference are provided at appendix 1.

3. Digital and Transformation Committee

The Digital and Transformation Committee will act on behalf of the Board in relation to digital and transformation strategy and assurance. Its remit includes delivery of the Digital Strategy, digital-enabled transformation, the Electronic Patient Record programme, the Trust's systemic approach to continuous improvement, information governance, data security, the digital project portfolio, capital expenditure and relevant Board Assurance Framework risks.

The Committee will meet six times each year on a bi-monthly basis. Its proposed quorum is three members, comprising at least two Non-executive Directors and one Executive Director. The Committee Chair will report key issues and decisions to the next Board meeting held in public. The terms of reference are provided at appendix 2.

4. Governance and assurance arrangements

Both Committees will be standing committees of the Board and will operate within the Trust Scheme of Delegation. Each will undertake an annual effectiveness assessment, review its Terms of Reference at least annually and present an annual report to the Board. The attached indicative work plans provide a basis for planned

assurance reporting and may be refined by each Committee as its work programme develops.

5. Recommendations

The Board of Directors is asked to:

1. approve the Terms of Reference for the Culture and People Committee;
2. approve the Terms of Reference for the Digital and Transformation Committee;
3. establish both Committees as standing committees of the Board, reporting directly to the Board of Directors; and
4. note that each Committee will review its effectiveness and Terms of Reference at least annually and submit an annual report to the Board.

Terms of Reference for: Culture and People Committee	York and Scarborough Teaching Hospitals NHS Foundation Trust
Authors Name: M. Barkley	
Contact Name: Chief Culture and People Officer	
Scope: Trust-wide	**Trust Priorities: Creating a great place to work, learn and thrive; Well-led**
Keywords: Culture; people; workforce; equality, diversity and inclusion; staff experience; wellbeing; leadership	**Replaces: People & Culture Committee V1**
To be read in conjunction with the following documents: Trust Strategy; Culture and People Plan; Standing Orders; Scheme of Delegation; Board Assurance Framework; Corporate Risk Register	

Unique Identifier: CPC	**Review Date: September 2026**	
Issue Status: Final	**Issue No: 2**	**Issue Date: 16 September 2026**
To be Authorised by: Board of Directors	**Authorisation Date: September 2026**	
Document for Public Display: Yes		

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Officer responsible for archive: Corporate Directorate	

People and Culture Committee - Terms of Reference

1	**Status**
1.1	The Culture and People Committee is a standing committee of the Board of Directors. It acts on behalf of the Board in relation to people and culture strategy, implementation, impact, assurance and escalation.
2	**Purpose of the Committee**
2.1	The purpose of the Committee is to gain assurance, on behalf of the Board of Directors, that the Trust is making acceptable progress towards delivery of the Culture and People Plan and the strategic objective of creating a great place to work, learn and thrive, while contributing to the objective of being well-led.
2.2	The Committee oversees the relevant well-led domains and NHS Oversight Framework assessment, operating within applicable regulatory, legal and national oversight frameworks, including leadership and management expectations and NHS staff standards. In carrying out its duties, members and attendees will act in accordance with the Trust values of Kindness, Openness and Excellence.
3	**Authority**
3.1	The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference, seek information from any employee, and obtain appropriate professional advice, subject to the Trust's Scheme of Delegation and other approved governance arrangements. The Committee may make recommendations to the Board of Directors on matters within its remit. Its powers, in addition to those vested in Executive members in their own right, are set out in the Trust's Scheme of Delegation.
4	**Legal requirements of the committee**
4.1	The Committee will obtain assurance that the Trust complies with its statutory, regulatory and contractual obligations as an employer.
4.2	The Committee will obtain assurance regarding compliance with the Equality Act 2010, including the Public Sector Equality Duty.
4.3	The Committee will keep abreast of changes in employment law and regulation, draw significant risks and implications to the Board's attention, and obtain assurance on the appropriateness of management's mitigating actions.
4.4	The Committee will work within relevant national oversight and workforce frameworks, including requirements relating to freedom to speak up, workforce equality and diversity, medical revalidation, safe working and NHS staff standards.
5	**Role and duties**

5.1	The Committee's role and duties are to: • Gain assurance that the Trust understands its strategic workforce needs, including wellbeing, culture, recruitment, retention, people development and organisational capacity, and oversee plans for delivery. • Gain assurance that Trust values are practised across services and at all levels of the organisation. • Gain assurance that staff health and wellbeing is effectively promoted and supported. • Gain assurance that arrangements for raising concerns, including the Freedom to Speak Up Guardian function, meet national expectations and have staff confidence. • Gain assurance that appropriate action supports transformation of services and teams where issues are identified. • Gain assurance that effective and inclusive arrangements are in place to communicate with and involve staff. • Gain assurance that leaders and managers are appropriately recruited and trained, with an inclusive and evidence-based approach to development. • Gain assurance that arrangements support and maintain good employee relations, including with recognised trade unions and professional bodies. • Gain assurance that appropriate training and supervision is in place for all staff. • Assess delivery through the Culture and People dashboard and other appropriate metrics. • Taking account of agreed risk appetite and tolerances, identify and escalate significant risks to the Board of Directors. • Review the scope, impact and management of relevant Board Assurance Framework and Corporate Risk Register risks, including the delivery and effectiveness of mitigation plans.
5.2	The Committee will review and make recommendations to the Board of Directors on: • Changes to the staffing establishment and workforce planning, including financial and staffing implications. • Findings of external staffing or culture reviews and management responses. Where quality issues or concerns are identified, the Committee will take advice from the Quality Committee. • The efficacy of management actions to address workforce equality and diversity, including pay gaps, WRES, WDES, SOWES and implementation of the NHS Equality Delivery System.
5.3	The Committee is accountable to the Board of Directors. It will maintain effective relationships with the Quality Committee and other Board committees where matters overlap, and will escalate significant risks, decisions and assurance concerns through the Chair's report and other agreed reporting routes.
6	**Membership**

6.1	Membership is as follows: • Non-executive Director - Committee Chair • Non-executive Director - Committee Vice-Chair / member • Additional Associate Non-executive Director or Non-executive Director - member • Chief Culture and People Officer - Executive lead and assurance/escalation provider • Chief Nurse - Executive member The Chair will ensure that attendees promote equality, diversity and inclusion.
6.2	Any Executive or Non-executive Director may attend a Board committee meeting by virtue of office and will assume full member rights. An interim postholder will be treated as a member for the period in which they hold the relevant interim position. An Executive Director who is unable to attend may delegate to a Deputy Director, with the deputising arrangement made clear at the meeting. A Non-executive Director who is unable to attend may delegate to another Non-executive Director, with the deputising arrangement made clear at the meeting. The Chief Executive and Trust Chair are invited and reserve the right to attend any meeting.
6.3	In attendance, in an advisory capacity as required: relevant members of the Culture and People team and, at the Chair's discretion, individuals invited for specific work plan items, such as the Freedom to Speak Up Guardian or Staff Side Chair.
7	**Quoracy**
7.1	The minimum number of members required for a quorate meeting is three, comprising at least two Non-executive Directors and one Executive Director. If the Committee Chair is absent and the meeting is otherwise quorate, another Non-executive Director will chair. Deputies do not count towards quoracy unless representing the member under formal acting-up arrangements, in which case the deputy is deemed a full member. A non-quorate meeting may proceed unless the Chair decides otherwise. Any decisions must be reviewed at the next quorate meeting and recorded in the minutes.
8	**Duties of the Chair**

8.1	The Chair of the Committee shall be responsible for: • Agreeing the agenda in partnership with the Chief Culture and People Officer; • Directing the meeting, ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion; • Ensuring the agenda is balanced and discussion is productive; • Giving direction to the secretariat and checking the draft minutes; • Ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee; and • Attending the Annual Members' Meeting to respond to any stakeholder questions on the Committee's activities and shall provide a quarterly update to the Council of Governors on the work of the Committee.
9	**Frequency of meetings**
9.1	Meetings will normally be held every two months. Separate meetings may be held if required by the Board of Directors. The Committee Chair, in consultation with the lead Executive Director, may request additional meetings where necessary to discharge the Committee's responsibilities.
9.2	Any member may request an urgent meeting. The Chair will normally call an urgent meeting to consider the specific matter unless it can be addressed more expediently through another appropriate route.
9.3	Voting is at the discretion of the meeting Chair. Decisions will be determined by a majority of Executive and Non-executive Directors present and voting. Where votes are equal, the person presiding will have a second or casting vote.
10	**Administrative support**
10.1	The Corporate Directorate will provide the Committee Secretariat, including arranging meetings, preparing agendas, circulating papers and drafting minutes. Papers will be made available at least five days before scheduled meetings. The Secretariat will maintain an action log, attendance register and a log of items reviewed during each 12-month period.
10.2	Draft minutes will be approved by the meeting Chair and shared with Committee members. The final record will be agreed at the next quorate meeting. The Committee Chair will provide an update of key issues and decisions to the next Board of Directors meeting held in public.
11	**Monitoring Effectiveness and Compliance with Terms of Reference**
11.1	The Committee Chair will ensure that the Committee undertakes an annual effectiveness assessment. The outcome and any remedial action will be reported to the Board of Directors, and the Chair will oversee completion of agreed actions. The Committee will present an annual report to the Board of Directors setting out its work against the duties in these terms of reference and recommendations where action or improvement is required. Member attendance will be disclosed in the Trust's Annual Report.

12	**Review of Terms of Reference**
12.1	These terms of reference will be reviewed by the Committee at least annually and presented to the Board of Directors for ratification. The Committee is a standing Board committee and is not time limited.

Author	M. Barkley
Owner	Chair of the Culture and People Committee (Non-executive Director)
Date of Issue	September 2026
Version #	2
Approved by	Culture and People Committee, subject to ratification by the Board of Directors
Review date	September 2027

Annex 1: Indicative Committee Work Plan

Item	Frequency
Board Assurance Framework - Great Place to Work	Every meeting
WRES Annual Report	Annually
WDES Annual Report	Annually
EDI action plan progress	Alternate meetings
NHS Equality Delivery System Annual Report	Annually
Gender Pay Gap Report	Annually
Ethnicity Pay Gap Report	Annually
Medical Revalidation	Annually
Modern Slavery Declaration	Annually
National Staff Survey Report	Annually
Staff Survey Action Plan progress	Alternate meetings
Freedom to Speak Up	Every meeting
Freedom to Speak Up Annual Report	Annually
Guardian of Safe Working	Alternate meetings
Resident Doctors 10-point plan progress	Every meeting
Pulse Survey results	Three times a year
Inclusive culture report	Twice a year
Health and wellbeing	Alternate meetings

Item	Frequency
Staff Network report	Every meeting
Leadership and management development progress	Alternate meetings
Progress against NHS standards	Alternate meetings
Staff training reports	Alternate meetings
Workforce performance metrics, including WTE, bank, agency, sickness absence, vacancies, turnover, disciplinary matters and grievance timescales	Every meeting
Feedback from LNCC and JNCC	Every meeting
Culture and People policies update	Every meeting

Terms of Reference for: Digital and Transformation Committee	NHS York and Scarborough Teaching Hospitals NHS Foundation Trust
Authors Name: M. Barkley	
Contact Name: Chief Digital and Information Officer	
Scope: Trust-wide	**Trust Priorities: Timely, responsive, safe, accessible and effective services; great place to work, learn and thrive; transformation; well-led**
Keywords: Digital; transformation; continuous improvement; information governance; electronic patient record; strategic risk	**Replaces: Digital Sub-Committee Terms of Reference**
To be read in conjunction with the following documents: Trust Strategy; Digital Strategy; Standing Orders; Scheme of Delegation; Board Assurance Framework; Corporate Risk Register; Information Governance Policy	

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Digital and Transformation Committee - Terms of Reference

1	**Status**
1.1	The Digital and Transformation Committee is a standing committee of the Board of Directors. On behalf of the Board, it contributes to setting strategy in relation to digital and transformation.
2	**Purpose of the Committee**
2.1	The Committee is responsible for supporting a Trust-wide systemic method of continuous improvement and the Trust's Digital Strategy and its effective implementation, leading to transformational improvements in efficiency and effectiveness and improved staff job satisfaction and patient experience.
2.2	The Committee is the primary mechanism through which the Board gains assurance regarding its strategic ambitions for digital transformation and embedding a systemic approach to continuous improvement. It seeks assurance on the systems, processes and people in place to deliver transformational improvement against the relevant strategic objectives.
3	**Authority**
3.1	The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any member of staff. All staff are directed to co-operate with requests made by the Committee. Its powers, in addition to those vested in Executive members in their own right, are detailed in the Trust's Scheme of Delegation.
4	**Legal requirements of the committee**
4.1	The Committee will operate within all applicable statutory, regulatory and contractual requirements relevant to digital, transformation, information governance and continuous improvement.
4.2	The Committee will oversee relevant information governance and data security requirements, including assurance on actions to achieve compliance with the Data Security and Protection Toolkit.
4.3	The Committee will receive information governance reports relating to data breaches and incident investigations and seek assurance on the adequacy of associated actions.
4.4	The Committee will receive relevant internal audit reports relating to digital and transformation and oversee management responses within its remit.
5	**Role and duties**

5.1	The Committee's role and duties are to: • Oversee delivery of the programme to embed a systemic method of continuous improvement across the Trust with progress reports. • Oversee delivery of the Trust's digital-enabled transformation ambitions set out in the Trust Strategy and Digital Strategy. • Assess strategic risk within the Committee's remit through the Board Assurance Framework. • Review progress in implementing the Digital Strategy. • Receive an update on the Electronic Patient Record project at every meeting. • Review the programme report covering all digital projects. • Review risks and issues associated with achieving the Digital Strategy. • Receive updates on digital and information policies and procedures. • Review capital expenditure against plan. • Make annual digital budget recommendations to the Board.
5.2	The Committee will recommend action or improvement to the Board of Directors on any matter within its remit and will escalate key issues and decisions through the Committee Chair's report.
5.3	The Committee is accountable to the Board of Directors. It will maintain effective relationships with other Board committees where matters overlap, including through appropriate referral, assurance and escalation arrangements.
6	**Membership**
6.1	Membership is as follows: • Non-executive Director - Committee Chair • Non-executive Director - Deputy Chair / member • Non-executive Director - additional member • Chief Digital and Information Officer - Executive lead and assurance/escalation provider • Director of Quality, Improvement and Patient Safety - member • Other Executive Directors or Deputy Executive Directors as agreed with the Chief Executive - member
6.2	Any Executive or Non-executive Director, including an Associate Non-executive Director, may attend by virtue of office. An interim postholder will be considered a member while holding the relevant interim position. An Executive Director may delegate to a Deputy Director, and a Non-executive Director may delegate to another Non-executive Director; the deputising arrangement must be clear at the meeting. The Chief Executive and Trust Chair are invited and reserve the right to attend any meeting. At the Committee Chair's discretion, other individuals may attend in an advisory capacity for specific work plan items.
7	**Quoracy**

7.1	The minimum number of members required for a quorate meeting is three, comprising at least two Non-executive Directors and one Executive Director. If the Committee Chair is absent and the meeting is otherwise quorate, another Non-executive Director will chair. Deputies do not count towards quoracy unless representing a member under formal acting-up arrangements. A non-quorate meeting may proceed unless the Chair decides otherwise. Any decisions must be reviewed at the next quorate meeting and recorded in the minutes.
8	**Duties of the Chair**
8.1	The Chair of the Committee shall be responsible for: • Agreeing the agenda in partnership with the Chief Digital and Information Officer • Directing the meeting, ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion; • Ensuring the agenda is balanced and discussion is productive; • Giving direction to the secretariat and checking the draft minutes; and • Ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.
9	**Frequency of meetings**
9.1	Meetings will be held six times each year, on a bi-monthly basis. Separate meetings may be held if required by the Board of Directors.
9.2	Any member may request an urgent meeting. The Chair will normally call an urgent meeting unless the matter can be addressed more expediently through another appropriate route.
9.3	Voting is at the discretion of the meeting Chair. Decisions will be determined by a majority of Executive and Non-executive Directors present and voting. Where votes are equal, the person presiding will have a second or casting vote.
10	**Administrative support**
10.1	The Corporate Directorate will provide secretariat support, including arranging meetings, preparing agendas, circulating papers, drafting minutes and maintaining the action log and attendance record.
10.2	The Committee Chair will agree the agenda with the Chief Digital and Information Officer, direct the meeting in accordance with Trust values, ensure balanced and productive discussion, give direction to the secretariat, check draft minutes and ensure sufficient information is presented to the Board. The Chair will report key issues and decisions to the next Board meeting held in public.
11	**Monitoring Effectiveness and Compliance with Terms of Reference**

11.1	The Committee Chair will ensure that the Committee undertakes an annual effectiveness assessment. The outcome and any remedial action will be reported to the Board of Directors, and the Chair will oversee completion of agreed actions. The Committee will present an annual report to the Board outlining its work against these terms of reference. Members' attendance will be disclosed in the Trust's Annual Report.
12	**Review of Terms of Reference**
12.1	These terms of reference will be reviewed by the Committee at least annually and presented to the Board of Directors for ratification. The Committee is a standing Board committee and is not time limited.

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Annex 1: Indicative Committee Work Plan

Item	Frequency
Board Assurance Framework relating to innovation and transformation	Every meeting
Information Governance Policy review	Annually
Committee Annual Report	Annually
Digital Strategy progress review	Alternate meetings
Electronic Patient Record project update	Every meeting
Digital budget recommendations to the Board	Annually, November
Digital projects programme report	Every meeting
Risks and issues associated with achieving the Digital Strategy	Alternate meetings
Digital and Information policies and procedures update	Every meeting
Internal audit reports relating to digital and transformation	Annually
Data Security and Protection Toolkit compliance actions	Alternate meetings
Information governance reports on data breaches and incident investigations	Every meeting
Continuous quality improvement programme progress	Every meeting

Capital expenditure against plan	Every meeting
Escalation report to the Board	Every meeting
Review of Terms of Reference	Annually