York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 28th October 2026
Time: 9:00am – 12:30pm
Venue: Boardroom, York Hospital



York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 30 September 2026** 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	20	
6.	**Colleague's Story** To consider.	Wendy Gough, Senior OD Practitioner	Verbal	-	9:05
7.	**True North Report** To review the report.	Chief Executive	Report	21	9:15
8.	**Chair's Report** To review the report.	Chair	Report	39	9:25

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	41	9:30
10.	**Clinical Strategy** To approve the strategy.	Chief Executive	Report	To follow	9:45
11.	**Half-Yearly Annual Operating Plan Update** To consider the report.	Chief Executive	Report	78	9:55
12.	**Quality Committee Report** To receive the October meeting summary reports.	Chair of the Quality Committee	Report	To follow	10:10
13.	**Resources Committee Report** To receive the October meeting summary reports.	Chair of the Resources Committee	Report	To follow	10:15
14.	**Well-Led Action Plan Q2 Progress Report** To consider the report.	Chief Executive	Report	104	10:20
15.	**Trust Priorities Report (TPR)** October 2026 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Chief Operating Officer Medical Director & Chief Nurse Chief Culture & People Officer Chief Digital & Information Officer Finance Director	Report	158 165 212 231 242 250	10:30

Item	Subject	Lead	Report/ Verbal	Page No	Time
	Break 11:15				
16.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	272	11:25
17.	**Freedom to Speak Up (FTSU) Quarterly Report** To consider the report.	Freedom to Speak Up Guardian	Report	277	11:30
18.	**Maternity and Neonatal Reports** 18.1 Maternity & Neonatal Voices Partnership Workplan Update – January to July 2026 18.2 Implementation of the National Maternity Early Warning Score across the Trust 18.3 Maternity Incentive Scheme Year 8: Safety Action B Training Trust Selected Checkpoint Assurance Report To consider the reports.	Chief Nurse - Executive Maternity Safety Champion	Report	284 302 308 317	11:40
19.	**Thirlwall Inquiry Report – Summary, Trust Response and Assurance Position** To consider the report.	Chief Nurse	Report	321	11:50
20.	**Patient Experience and Complaints Report** To consider the report.	Chief Nurse	Report	335	12:00
21.	**Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Annual Reports** To consider the reports.	Chief Culture and People Officer	Report	357	12:10
Governance					

Item	Subject	Lead	Report/ Verbal	Page No	Time
22.	**Premises Assurance Model (PAM)** To ratify the submission.	YTHFM Managing Director	Report	375	12:15
23.	**Q2 2026/27 Board Assurance Framework** To consider the report.	Associate Director of Corporate Governance	Report	382	12:20
24.	**Board of Directors and Committee 2026/27 Revised Dates** To consider the report.	Associate Director of Corporate Governance	Report	396	12:25
25.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
26.	**Time and Date of next meeting** The next meeting held in public will be on 25 November 2026 at 9.30am at Scarborough Hospital.				
27.	**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.				
28.	**Close**				12:30

Minutes
Board of Directors Meeting (Public)
30 September 2026

Minutes of the Public Board of Directors meeting held on Wednesday 30 September 2026 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.45pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Ms Rukmal Abeysekera
- 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

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:
- Dr Sarah Dexter-Smith, Chief Culture and People Officer Designate
- Mr Muhammed Patel, Non-Executive Director (NExT placement)
- Mr Martin Hammond, Chaplain (For Item 6)
- Ms Krishna De, Head of Patient Experience and Involvement (For Item 6)
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 15)
- Ms Nicola Lockwood, Head of Children's Nursing *shadowing* Ms Sascha Wells-Munro, Director of Midwifery (For Item 15)
- Ms Susie Kinsella, Community Matron *shadowing* Ms Sascha Wells-Munro, Director of Midwifery (For Item 15)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

DRAFT

Observers:

- Ms Jean Flanagan, Elected Governor – Public
- Mr James Cannon, Appointed Governor – Community and Social Care
- One member of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting and introduced Mr Patel and Dr Dexter-Smith to the Board. He recorded thanks on behalf of the Board to Ms Larcum for fulfilling the role of Interim Director of Workforce and Organisation Development, pending Dr Dexter-Smith's appointment as Chief Culture and People Officer.

2 Apologies for absence

As all directors were present, there were no apologies for absence.

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 29 July 2026 and the extraordinary meeting on 19 August 2026

The Board approved the minutes of the meeting held on 29 July 2026 and the extraordinary meeting held on 19 August 2026 as accurate records of the meetings.

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 10 *Investigate why the number of zero-day length of stay non-elective admitted patients is high*.
Ms Hansen advised that this was still under investigation. The action would remain open.

BoD Pub 11 *Investigate the reasons for the increase in Whole Time Equivalent staff in the NHS staff infrastructure group.*
Ms Larcum reported that an explanatory paper had been presented to the Resources Committee. The increase was due to a change in coding. The action was closed.

BoD Pub 13 *Bring an update to the Board on progress towards a solution towards continuing the work of the Local Maternity and Neonatal System (LMNS)*
Mr Hague explained that a solution had been identified which would support continuation of the LMNS's work on a short-term basis whilst a longer-term solution was sought. The action was closed.

BoD Pub 14 *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.*
Mr Hague explained that a deep dive had been undertaken with the Infection Prevention and Control (IPC) and Microbiology teams which had concluded that the reasons for poor performance were complex, although it had discounted the concern of over-testing. There were issues linked to the culture of the organisation, a lack of attention to basic practices

and to the overcrowding of patients due to operational pressures. The team was refreshing the IPC improvement plan for which ward managers were accountable. There had been good engagement in the work but more robust challenge was needed when colleagues did not comply with standards. 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.*
The due date was deferred to October.

BoD Pub 16 *Ensure that feedback from the apprenticeship survey is shared with the Board.*
This had been shared. The action was closed.

BoD Pub 18 *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.*
This action had been completed.

BoD Pub 19 *Progress actions to strengthen the dissemination of learning across the organisation.*
Mr Hague advised that this would be a long-term ongoing process which would form part of the strengthening of governance under the Continuous Quality Improvement programme. The action was closed.

BoD Pub 20 *Raise the issue of the lack of ethnicity coding with the Health Inequalities lead.*
Ms Hansen advised that this work was ongoing. She noted that there was a lack of ethnicity information accompanying patients who had been referred into the Trust's services. The action was closed.

BoD Pub 21 *Provide an explanation of the difference between Community Response Team (CRT) referrals and 2-hour Urgent Community Response referrals.*
An explanation had been provided to Mr Barkley: Community Response Team referrals were less urgent, with the aim being to provide assessment and care within 24 to 48 hours. The action was closed.

BoD Pub 22 *Investigate the discrepancy between the number of complaints recorded in the narrative as opposed to the graph in the report.*
The discrepancy was an error as it was the total in the graph which was correct. The action was closed.

BoD Pub 24 *Source the evidence of the review of progress against the Fuller report undertaken in 2025 for Miss Smith and Mr Barkley.*
This had been shared and the action was closed.

Miss Smith commented that a further discussion at Board level about the Fuller report would be valuable and she would discuss this first with Executive colleagues.

BoD Pub 25 *Investigate if complaints data relating to delays in treatment can be split into non-elective and elective care.*
Mr Hague confirmed that the data could be split and his team would work with the Datix team to source this information once a new Datix manager had been appointed. The action was closed.

6 Patient's Story

Mr Hammond joined the meeting to present a patient's story, accompanied by Ms De.

Mr Hammond began by explaining the role of the Chaplaincy Service which supported people of all faiths and none through listening, emotional and spiritual care, exploration of beliefs and values, religious support where wanted, and practical support. Their role was person-centred and was not dependent on a patient sharing the chaplain's beliefs. Mr Hammond described the support which had been offered to a patient with a terminal illness to fulfil his last wish, and had involved colleagues from a number of different areas working together.

Mr Hammond described work to increase access and diversity in the Chaplaincy team and there was further discussion on the important work carried out by the team in responding to requests from staff as well as patients.

Mr Hammond was thanked for his informative and uplifting presentation, and he left the meeting with Ms De.

7 True North Report

Miss Smith presented the report. She observed that patient flow through the Trust's hospitals and the prevalence of corridor care was a driver for the metrics in the True North report relating to, for example, the number of complaints received and the responses to the National Staff Survey. There had been a huge focus beginning in September on the elimination of corridor care or "coming off corridors" and this would continue over the coming months. The project involved multiple workstreams and actions which must all be sustained to ensure that the outcomes were embedded. Mr Hague was the Senior Responsible Officer for the work and Miss Smith recorded her thanks to him for his leadership.

Mr Hague advised that the aim was to eliminate corridor care by March 2027. A successful engagement process had taken place during September to understand the challenges and opportunities. The response from colleagues was beginning to change and many were now recognising that the organisation's leadership was taking the project seriously and actively encouraging participation in change. Mr Hague highlighted that there were significant opportunities for positive change and it was vital that momentum was not lost when the leadership and implementation of the programme was devolved to the Care Groups. A number of priorities had been identified, and a workshop was planned for 1 October to set out the next steps. Mr Hague shared some of the opportunities for change, such as new pathways in the Cardiology Service which would save hundreds of bed days.

Returning to the report, Miss Smith advised that elective recovery continued to be challenging, particularly in relation to first outpatient appointments. The new Single Point of Access system would be rolled out in October across ten specialties and whilst this was likely to cause a deterioration in the Referral To Treatment (RTT) position, it was the right course of action for the long term.

Miss Smith highlighted the continued focus on IPC and timely responses to complaints. She reported a significant increase in the number of complaints, many of which were linked to corridor care.

Mr Hawkins reported that the implementation of Tranche 2 of the Nervecentre Electronic Patient Record (EPR) had been successful. The aim was to implement Tranche 3 in June 2027.

Mr Taylor questioned whether Executive Directors were confident about the work to eliminate corridor care based on the fact that a number of key performance metrics had deteriorated in recent months. He asked when the improvements would begin to be in evidence. Miss Smith responded that improvements were dependent on implementing multiple significant changes over time and this work would be a collective responsibility of the Board. Ms Hansen added that the approach to corridor care being led by Mr Hague was transformational, where other process changes to improve performance had been transactional, and as such needed to be given time to embed. She was confident that there would be evidence of improvements. Mr Hawkins added that key metrics for early September were moving in the right direction.

Mr Floyd noted that the Board should also recognise the improvements which were already in evidence in the True North report. He asked whether the corridor care project needed wider system support. Mr Hague confirmed that it did and this was being progressed simultaneously, although there would be more complexity in the longer-term solutions which were needed.

Mr Barkley suggested that Executive Directors consider changing the wording of the True North Urgent and Emergency Care aim to *Reduce the proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero* to “reduce the number of zero length of stays”. He also suggested that the True North workforce aim to *Reduce the monthly sickness absence rate* should be amended to *Improve the attendance rate.*

In relation to the RTT metric, Mr Barkley asked if the proposal for two weeks of RTT clinics in each specialty during Quarters 3 and 4 was being implemented. Ms Hansen confirmed that all specialties had agreed to the plan in principle, but it would need more careful planning in some areas.

8 Chair’s Report

The Board received the report.

Mr Barkley reported that there had been a meeting of the Council of Governors Nomination and Remuneration Committee to discuss recruitment for Non-Executive Director vacancies. The Committee had supported Mr Barkley’s recommendation that Ms Abeysekera would replace Ms Grantham, would relinquish her role as a stakeholder Non-Executive Director appointed by the University of York, and a nomination would be sought for this position. Ms Abeysekera would chair the new Culture and People Committee and Ms Hazelgrave would chair the Resources Committee. Mr Floyd had agreed to chair the Group Audit Committee. These changes would be effective from 1 December.

Mr Barkley advised that he had received enquiries about the Non-Executive Director vacancies and a timeline for recruitment had been agreed.

9 Chief Executive’s Report

The Board received the report.

Miss Smith reflected that the period following the publication of Lady Justice Thirlwall's report had been a difficult time for the NHS although the impact on the families involved in these terrible events would always be first and foremost in everyone's thoughts. Miss Smith advised that some immediate required actions arising from the report had already been completed.

Miss Smith highlighted the recent rating of "Good" following the CQC inspection of the Trust's Maternity Services and noted that the volume of work which had been undertaken to achieve this outcome could not be underestimated. Miss Smith recorded her thanks to Ms Wells-Munro, Director of Midwifery, and the wider leadership team on behalf of the Board. The recommendations in the CQC report would be used to drive further improvement. Miss Smith also reported that the CQC had inspected the Renal Unit at Easingwold for the first time, and this also had been rated "Good".

Miss Smith reported that the Trust had begun its journey of Continuous Quality Improvement (CQI) and underlined the need for commitment to this programme of transformation at all levels. The Trust had partnered with Clever Together to undertake the "Big Conversation". Clever Together would align this work with the CQI programme as it was clear from the experiences of other NHS organisations that a new culture must be embedded for the CQI to succeed. The analysis of the responses to the Big Conversation was close to completion. It was evident that the Trust's values had endured but there was too often a lack of accountability when these values were not lived out in behaviours.

Miss Smith also referenced the Trust's recent mid-year review meeting with the NHS regional leadership team which she had attended with Mr Barkley, Ms Grantham and Mr Bertram. The focus of the meeting had been on finances and quality of care and had been constructive in nature. A formal response was awaited.

10 Quality Committee Report

Dr Boyd summarised the key escalation points from the meetings of the Quality Committee on 18 August and 22 September. At the August meeting, the Committee had received moderate assurance across areas of quality and safety. The Medicine Care Group Senior Leadership team had presented to the Committee and there had been discussion on the Urgent and Emergency Care metrics. The Committee had received updates on Infection Prevention and Control at both the August and September meetings.

Dr Boyd reported that, in September, the Committee had received a paper on Stroke Services and an update on sepsis. A reduced sepsis audit for Quarter 1 was presented but it was anticipated that a full audit would be undertaken in Quarter 2. There had been no increase in reports of any incidents or patient harms during Quarter 1.

Ms Hazelgrave questioned whether metrics related to the Stroke Service should be included in the Trust Priorities Report (TPR). Miss Smith responded that the report to the Board would be refreshed as part of the new integrated accountability framework.

Mr Barkley asked about the reference to a two-step process for testing for C.Difficile infections. Mr Hague explained that the number of tests was higher when compared with other organisations, but further investigation had shown that all testing being undertaken in the Trust was appropriate.

Mr Taylor queried the escalation that long waits to be seen by a doctor as part of the maternity triage process were resulting in women self-discharging. Dr Boyd explained that

anyone choosing to go home rather than wait was followed up by the Service. Ms Wells-Munro would be asked for further assurance when she joined the meeting.

Dr Boyd had escalated that the Community Stroke Service was a particular area of concern and risk. Miss Smith confirmed that there was no commissioned Early Supported Discharge Service. However, the Community Stroke team was exploring opportunities to improve the timeliness and quality of care.

11 Resources Committee Report

Ms Grantham highlighted the main discussion points from the meeting of the Resources Committee on 18 August 2026 which included a focus on the financial position and the Waste Reduction and Productivity (WRAP) programme. The Committee had noted improved performance in Diagnostic and Cancer services.

Ms Hazelgrave had chaired the meeting of the Resources Committee held on 22 September 2026. As usual, the Committee had focussed on progress against the WRAP which was the biggest financial risk for the organisation. Ms Hazelgrave also highlighted the following escalations:

- the sickness absence rate had risen again to 6% against a plan of 4.7%;
- the Committee had undertaken a deep dive of diagnostics, recognising the improved performance;
- the Committee had received and discussed the Winter Plan;
- Mr Hawkins had reported that the increase in the number of Subject Access Requests was exceeding the capacity of the team to respond to them within the statutory deadlines;
- Cancer 62-day performance was at the highest level ever recorded by the Trust;
- the Committee had taken assurance from ongoing work to reduce medical and dental temporary staff spend;
- the cash position was unfavourable and there was still a lack of clarity around the receipt of deficit support funding.

12 Group Audit Committee Report

Ms Hazelgrave highlighted the escalations from the meeting of the Group Audit Committee on 16 September 2026 including details of internal audit reports, and progress towards the 2026/27 external audit. Ms Hazelgrave advised that an audit certificate for the 2025/26 audit had still not been issued as confirmation had not yet been received from the National Audit Office that the group audit of the Department of Health and Social Care had been completed and that no further work was required.

Ms Hazelgrave highlighted that the number of internal audit recommendations which were overdue was the highest for three months and further work to close down actions was required. Ms Hazelgrave observed that the implementation of better “first line” testing of systems and processes by the Trust would eliminate the gaps being identified by Internal Auditors.

The Committee had received an informative presentation from the Freedom to Speak Up Guardian and had noted the significantly improved process in relation to Single Tender Waivers.

Mr Barkley reiterated the importance of completing audit actions by the agreed date, not least as the dates were agreed with the action owners. The Trust risked a Head of Internal Audit opinion of limited assurance if the number of overdue actions was not reduced. Mr Hague assured the Board that nine actions assigned to him had been closed since the Committee met and five would be closed in next two weeks.

13 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen summarised that the position in August reflected improvements in key areas such as Cancer and Diagnostics. Urgent Community Response continued to perform strongly. The number of patients missing appointments remained low and Patient Initiated Follow Up (PIFU) rates were increasing which was positive. Ms Hansen cautioned however that recovery was fragile and inconsistent, and this was reflected in patient access challenges and staff morale. The work to eliminate corridor care would support improvement in both these areas.

Ms Hansen reported that the Emergency Care Standard was below trajectory: patients were waiting far too long in the Trust's Emergency Departments (ED). Discussions were planned with Health and Social Care colleagues regarding changes which would impact on the timely care of patients. Ms Hansen was optimistic that work being undertaken by colleagues in the Medicine Care Group leadership team, with input from specialties, around pathways of care would support improvement.

Ms Hansen reported that the proportion of patients waiting less than 18 weeks for a first appointment was slightly ahead of trajectory, but the waiting list position was concerning. The number of referrals had increased, particularly to Gastroenterology, Respiratory, Paediatric and Pain Management services. Demand for the Pain Management service had been discussed with the ICB, and the Trust was awaiting a go-live date for changes to referral thresholds.

Ms Hansen advised that work to improve performance in diagnostics and to Urgent and Emergency Care pathways was ongoing.

Mr Taylor referred to the scorecard for Children and Young People and to the number of paediatric patients waiting over 12 hours in ED and waiting over 52 weeks for other services, which he noted should be zero. Ms Hansen acknowledged that improvement was needed and advised that work was underway with paediatric ED teams to accelerate pathways. In terms of long waits for appointments, Ms Hansen advised that a "super Saturday" had been used to treat only children in a combination of clinics and another one would be scheduled soon. It was noted that information about the number of children and young people waiting for treatment would be presented to the Resources Committee.

Mr Barkley asked if each of the Care Groups had written escalation protocols in relation to the Cancer Patient Tracking Lists. Ms Hansen would check.

Action: Ms Hansen

Mr Barkley asked what the Emergency Care Standard position was in relation to Type 2 and 3 patients, as only Type 1 was recorded in the TPR.

Action: Mr Hawkins

It was noted that the zero number of attendances recorded for RAFA and SAU was likely to be a data error.

Mr Barkley highlighted the sharp increase in the number of patients with No Criteria To Reside. Ms Hansen agreed and advised that there were issues with transferring patients to Local Authority care.

Quality and Safety

Mr Hague reported that all Health Care Acquired Infections were over trajectory apart from klebsiella bacteraemia. As he had reported previously in the meeting, a deep dive had been undertaken to identify further improvement actions. The number of Category 2 pressure ulcers was also slightly above trajectory and similarly, meetings had been held with the relevant teams. A mattress retrofit was due to be completed during October and 90 new chairs had been delivered.

Mr Hague reported that compliance with the target rate for responses for complaints was off trajectory. Training of colleagues involved in responding to complaints continued but the complexity of complaints was increasing which was adding to the challenge. Mr Taylor questioned whether the number of formal complaints would be reduced if concerns raised by patients and their families were dealt with at earlier stage. Mr Hague confirmed that this approach was strongly encouraged.

Mr Barkley noted the number of complaints related to ED and asked if this was typical and whether there was a difference between York and Scarborough in terms of this figure. Mr Hague would send this information to Mr Barkley.

Action: Mr Hague

Mr Hague agreed with Dr Reece that there was evidence of the use of Artificial Intelligence in the complaints received by the Trust, but the majority of complainants just wanted to be heard, and to ensure that their poor experience would not be repeated.

Dr Stone drew attention to the new scorecard on page 170 which recorded information about research studies.

Maternity

There were no questions or comments on this section.

Workforce

Ms Larcum highlighted the increase in sickness absence rates which, whilst not acceptable, still benchmarked as average against those of other organisations in the region. A revised Sickness Absence Management policy was due to be implemented by the end of October. In response to a question, Ms Larcum explained that sickness absence figures were shared with Care Group leadership teams and were discussed at Care Group performance meetings.

Ms Larcum reported that:

- the annual staff influenza vaccination campaign had begun;
- the turnover rate was reducing and this was contributing to the lack of progress in reducing the number of Whole Time Equivalent staff posts;
- there had been good progress in the recruitment of key medical and dental recruitment;
- there had been a slight increase in the number of Health Care Support Worker vacancies which was being monitored.

Mr Barkley queried a sentence on page 189 of the report: *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* as he was unclear why adjustments to the roster would affect the establishment. Ms Larcum would seek to clarify this for Mr Barkley.

Action: Ms Larcum

Mr Barkley also queried the relatively low level of medical and dental staff training compliance which had fallen to 75%. Ms Larcum advised that Care Groups were being asked to follow this up with individuals to improve the position. Dr Stone added that the resident doctor changeover in August would also have had an impact on the figure.

Digital and Information Services

Mr Hawkins reported that the Trust had increased the number of its licences for Microsoft Co-Pilot to 4000 and a new cross organisation HR advice service was being launched which could be accessed by all Co-Pilot users. Ambient Voice Technology (AVT) continued to be rolled out across services which would support with reducing the backlog of clinicians' letters. The AVT on the Nervecentre EPR platform would be rolled out in Same Day Emergency Care and Mr Hawkins provided further details of how this would operate.

Mr Hawkins also reported that:

- the Data Security and Protection Toolkit had been submitted to NHS England;
- the significant increase in Subject Access Requests was impacting on the morale of the small team; compliance with the statutory deadlines had fallen which was a risk to the organisation;
- there had been short Nervecentre outages resulting from upgrades;
- the number of Freedom of Information requests had fallen slightly;
- 54 information security incidents had been reported and investigated in August.

Mr Hawkins advised that the Trust had reinforced its stance around the confidentiality of patient records, with a zero-tolerance approach to any inappropriate access.

Mr Floyd asked if there was a clear strategy, either at Trust or NHS England level, for the use of Artificial Intelligence (AI). Mr Hawkins confirmed that there was a high-level strategy covering areas such as Radiology imaging. Co-Pilot had been adopted as the Trust's AI tool and the strategic use of AI would be developed once it was clear how it was being used by Nervecentre. Mr Barkley added that NHS England was a strong advocate of the use of Co-pilot and AVT. He proposed that time be set aside at a Board Development Seminar to discuss the AI strategy and opportunities for its use.

Mr Hawkins reported that the Trust was finalising an investment agreement with NHS England for funding to expand the use of AVT.

Mr Taylor asked how the Board could be assured that the Trust was maximising the efficiencies and productivity from new technology. Mr Hawkins responded that the first step was to baseline processes, to understand the targets and for Executive Directors to work together to embed new processes.

Ms Grantham noted that the governance around AI was being established. Mr Hawkins confirmed that an AI and Data Ethics Committee had been created to oversee new uses of AI.

Finance

Mr Bertram reported that, in Month 5, the Trust had a deficit of £14.1m against a plan of £7.8m, a variance of £6.3m. The position had deteriorated in August by £1.8m which was related to the change in the year-end deficit, to £18.5m, which had been agreed with NHS England. Mr Bertram drew attention to the graph demonstrating that the rate of deterioration against the plan had slowed. There was a downward trend in the run rates for both pay and non-pay expenditure.

In terms of delivery of the WRAP programme, £30.4m had been delivered against a target of £67.5m. Mr Bertram reported that the level of delivery had doubled since the same point in the last financial year but this was still insufficient as the gap in WRAP delivery was the main driver of the deficit. Mr Bertram referred to the waterfall chart on page 207 of the report and highlighted three areas of high risk: the WRAP programme gap of £8m, the non-delivery of the expenditure recovery programme at £2.1m and assumed overtrade income of £2.8m.

Mr Bertram advised that, following agreement with NHS England of a £18.5m deficit, the Trust should receive deficit support funding of an equivalent amount over the financial year. As yet, none had been received. Funding for Quarter 1 had not been received due to the late agreement of the financial plan and Quarter 2 funding was still under discussion nationally, although Mr Bertram expected a decision soon. The current £14.1m deficit was causing cash problems for the organisation. The Finance team was actively chasing debtors and was in negotiation with suppliers to accommodate extended payment terms. The ICB had agreed cash support of £3m for the Trust and an emergency cash application was being prepared.

Miss Smith noted that the outputs from colleagues who were supporting the Trust temporarily with its WRAP programme would need to be shared with the Board. It was crucial that the focus now was expanded to long-term financial sustainability as the plan for 2027/28 would need to be submitted by December.

Mr Floyd observed that the Board needed to be fully apprised of the implications of not meeting the financial plan for 2026/27. Mr Bertram responded that these would be set out in the TPR next month.

13.1 NHS Patient Standards

The Board received the report.

Mr Bertram advised that he had already personally thanked the authors for the clear, well-written report. He referred to Section 6 of the report, which was the proposed Trust response to NHS England's minimum standards of patient experience for elective care, and suggested that action 5 to 9 could be undertaken by the Community of Acute Providers as part of a consistent system approach.

14 CQC Compliance Update

Mr Hague presented the report. He reported that there had been a CQC inspection of the Harrogate Renal Unit for which a report was awaited, and he underlined the positive inspections of Maternity Services and the Easingwold Renal Unit which had both resulted in "good" ratings. Finally, Mr Hague referenced the publication of the CQC Inpatient Survey for 2025 from which there was evidence of encouraging improvements, alongside areas for improvement.

15 Maternity and Neonatal Reports

Ms Wells-Munro highlighted key assurances around perinatal mortality reviews, investment and recruitment to strengthen the workforce including the receipt of £200k of non-recurrent funding to support 20 newly qualified midwives and the actions taken following maternity unit diverts which occurred in August.

Ms Wells-Munro advised that there were risks around Maternity Incentive Scheme training requirements and the number of incidents graded as moderate harm or above in August. Key concerns included homebirth provision and the details of this were included in the separate paper under Item 15.5.

Ms Wells-Munro reported that active recruitment to the Service continued and a professional midwifery advocate lead had been appointed in addition to two flow and safety midwives who would manage the operational flow and acuity of the Service to reduce delays to care. A new cohort of Band 5 midwives would begin in post in October.

Ms Wells-Munro responded to the query raised earlier in the meeting about the performance of the maternity triage service. She reported that the waiting times for triage had reduced but as there was no dedicated medical cover for the triage service, the waiting time to see a doctor would continue to be a challenge. There was now a national specification for maternity triage, as specified in the 10 point plan and the paper under Item 15.2 set out what steps were being taken to meet the standards and the investment which would be needed.

Ms Hazelgrave sought clarification on the section in the report on perinatal deaths. Ms Wells-Munro explained that the Board needed to be aware of those which met MBRRACE-UK reporting criteria, of which there were two in June and none in July. She would ensure that the wording of the next report was clearer.

In response to Mr Barkley's question, Ms Wells-Munro explained that Maternity and Newborn Safety Investigations (MNSI) were hosted by the CQC. There were strict criteria under which investigations were undertaken. The MNSI was independent of the Trust and the Service used recommendations from the investigations to inform action plans.

Mr Barkley highlighted the significant increase incidents in July, compared with June. Ms Wells-Munro explained that this was evidence of a good reporting culture and the level of harm was a more important indicator than the number of incidents.

The Board received and noted the following reports.

15.1 Maternity and Neonatal 10 Point Plan Baseline Assessment

15.2 Maternity and Neonatal 10 Point Plan: Board-Level Baseline Assessment Against the NHS England National Maternity Triage Specification

15.3 Saving Babies' Lives Care Bundle

15.4 Maternal Care Bundle Implementation Update and Action Plan

15.5 Homebirth Action Plan in response to National PFD - Progress Update

15.6 Maternity In-House Tobacco Dependency Service

DRAFT

15.7 One-year post implementation review of the Community Midwife for Equitable Health role

16 Safeguarding Annual Report

Mr Hague presented the report, highlighting the increase in demand experienced by the Safeguarding Services teams. The team had undergone a restructuring process, and a named Adult Safeguarding Nurse was now in place. Governance and partnership working across Local Authorities and safeguarding networks was strong. Mr Hague noted concerns around training compliance levels, particularly in relation to Level 3 Safeguarding Children, the Mental Capacity Act and Deprivation of Liberty although compliance had improved since the report was written. There had been new national guidance on which members of staff required this training which had impacted on compliance figures but the introduction of competency-based assessments would have a positive impact on Level 3 Safeguarding Children compliance.

Mr Barkley noted the proportionally high number of babies born into care in the East Riding. Miss Smith observed that the complexity of these cases was an added pressure on resources which were not allocated on this basis.

17 Winter Plan

Ms Hansen presented the Winter Plan and underlined the amount of work undertaken in its development. She cautioned that the winter period was likely to be even more challenging due to increasing demand, resource constraints and issues with partner organisations outside of the Trust's control. The Plan was a progression from last year's, and incorporated feedback from different teams and external partners.

Ms Hansen advised that the approach taken was to prioritise patient flow over the addition of beds, although there remained a risk that additional beds would be needed. The financial envelope for the Plan was £1m but the full cost could rise to £3.6m. In the event that costs rose above £1m, the Trust would need to consider using funds set aside for elective recovery which would impact negatively on the elective recovery plan. Ms Hansen advised that a robust governance structure would be in place to manage the implementation of the Plan on a day-to-day basis. The Board Assurance statements needed to be submitted by the end of the day.

Miss Smith clarified that the Board should only approve the Winter Plan with the resource of £1m which had been included in the budget. The focus would be on reducing admissions as far as possible but there would need to be further discussion if operational pressures were such that the cost agreed was likely to be exceeded.

Ms Hansen confirmed that this was Trust's Winter Plan, but it had been informed by external partners. There was a clear message from regional leads that acute providers should improve flow rather than open more beds.

There was further discussion on some of the details in the plan.

The Board of Directors approved the Winter Plan for 2026/27, subject to it not exceeding £1m financial envelope.

DRAFT

18 Mortality Review (Learning from Deaths) Report

Dr Stone advised that there were no issues arising from the report to bring to the Board's attention. On a positive note, more colleagues had been trained to undertake Structure Judgement Case-note Reviews and these were therefore being completed in a more timely manner.

19 Responsible Officer Annual Report

Dr Stone presented the report which the Board was required to receive annually. She advised that the medical appraisal rate stood at 83%, but this was at a specific point in time. All doctors were being appraised as this was a necessary element of the revalidation process. The Trust's referral rate for revalidation, at 7%, was well below the national average, which was positive. Dr Stone highlighted challenges around the number of trained appraisers and the time to undertake appraisals. This would be factored into job plans going forward.

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

The Board received the report and noted the lack of progress of the work conducted against the action plan since the last report. Ms Hansen explained that this was due to unexpected demands on the small EPRR team in recent months.

21 Culture & People and Digital & Transformation Committees – Terms of Reference

The Board of Directors approved the terms of reference for the Culture and People and Digital and Transformation Committees.

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 28 October 2026 at 9.00am at York Hospital.

DRAFT

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 Priorities 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.	Oct-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. Update 30.09.26: the due date was deferred to October.	Oct 26 from Jul 26	Delayed
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 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 26	30-Sep-26	13	Trust Priorities Report	Check if Care Groups have written escalation protocols in relation to Cancer Patient Tracking Lists.	Chief Operating Officer		Oct-26	On Track
BoD Pub 27	30-Sep-26	13	Trust Priorities Report	Provide information on the Emergency Care Standard position in relation to Type 2 and 3 patients	Chief Digital & Information Officer		Oct-26	On Track
BoD Pub 28	30-Sep-26	13	Trust Priorities Report	Send information to Mr Barkley regarding complaints about ED and the split between York and Scarborough	Chief Nurse		Oct-26	On Track
BoD Pub 29	30-Sep-26	13	Trust Priorities Report	Clarify for Mr Barkley the sentence *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*	Interim Director of Workforce & OD		Oct-26	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

October 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’.

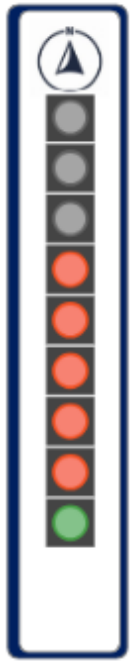
This is the single point of reference to measure our progress.

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)

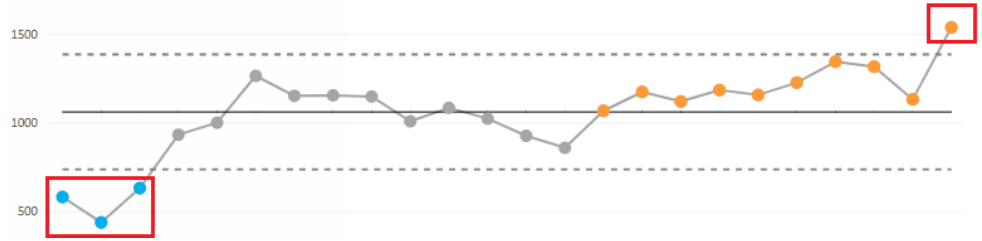
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

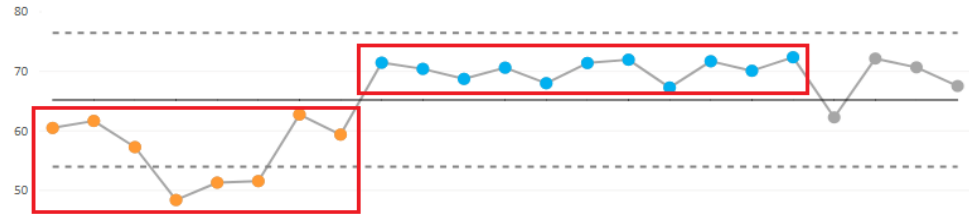
These lines (limits) help to understand the variability of the data and are set to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

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.



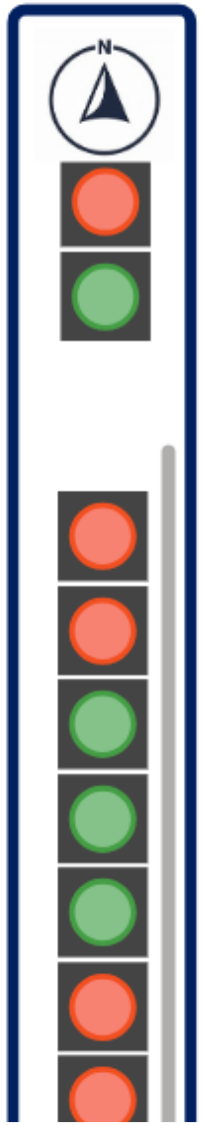
Trend: Counts the number of occasions there is a run of 7 consecutive points going in the same direction.



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

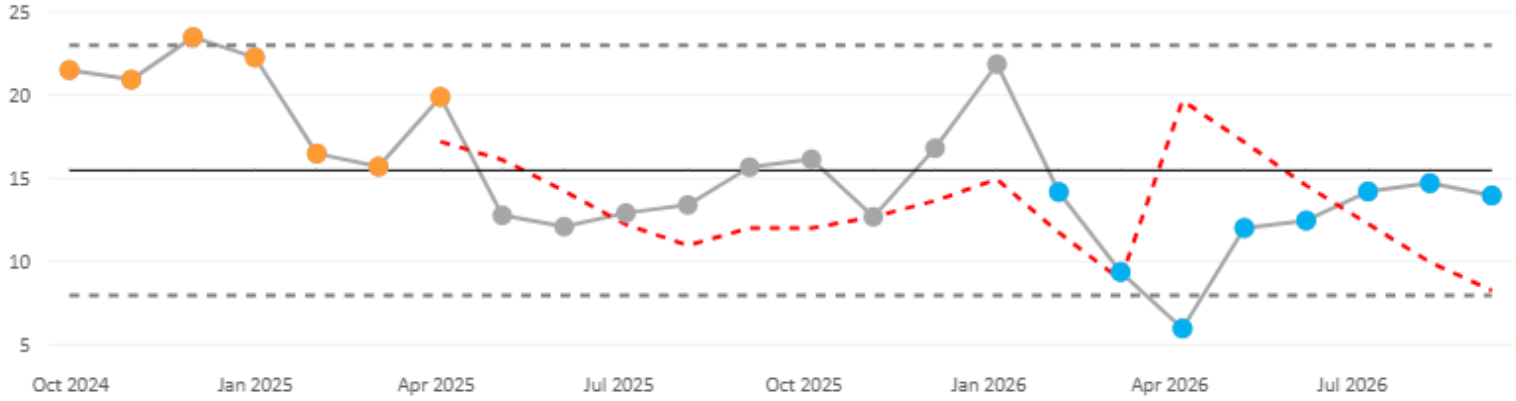
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Target Mar 2027
Value	15.6%	16.1%	12.6%	16.7%	21.8%	14.1%	9.3%	5.9%	12%	12.4%	14.1%	14.6%	13.9%	5%
Trajectory	11.9%	11.9%	12.6%	13.6%	14.9%	11.7%	8.9%	19.6%	17.1%	14.5%	12.2%	9.9%	8.2%	

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?

- Coming off Corridors programme supporting review and improvements to EAU pathways
- Reviewing rota patterns and rosters to align, where possible, medical cover and times of peak demand
- Progressing business case for additional medics

True North Report

Objective Status Down Is Good

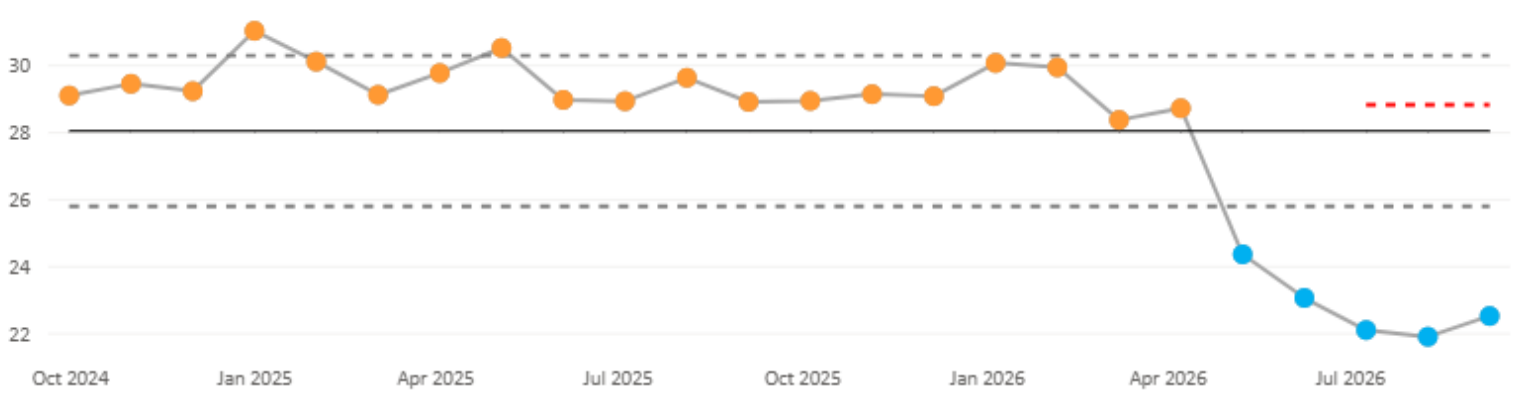
Urgent Emergency Care: Reduce the proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero

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)?

7 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

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Target Mar 2027
Value	28.9%	28.9%	29.1%	29.1%	30.1%	29.9%	28.4%	28.7%	24.3%	23%	22.1%	21.9%	22.5%	28%
Trajectory											28.8%	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?

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

True North Report

Objective Status Down Is Good

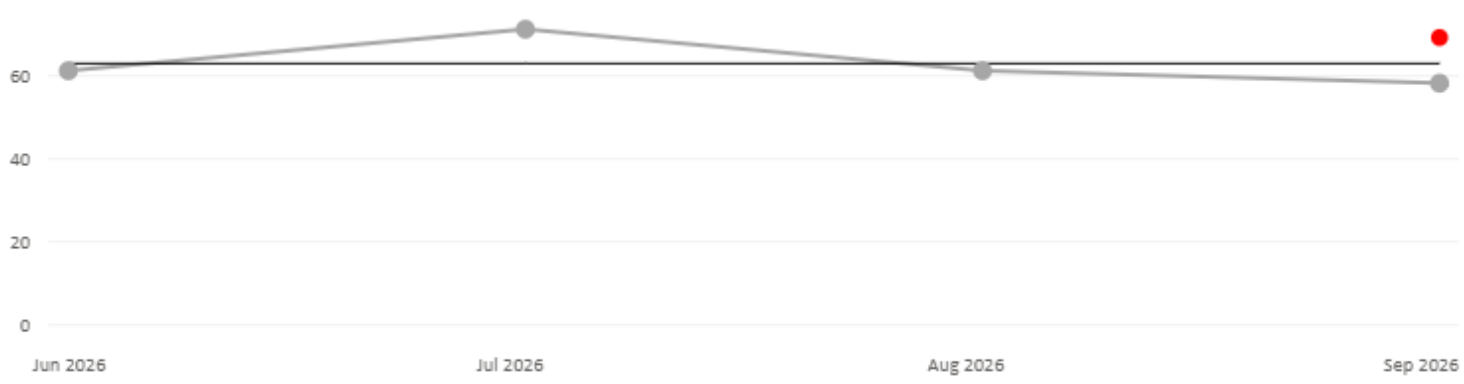
Urgent Emergency Care: Reduce the number of patients treated in non-designated areas

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	Sep-26	Target Mar 2027
Value	61	71	61	58	0
Trajectory				69	

* 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 ⊗ Down Is Good

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	Sep-26	Target Mar 2027
Value	39	25	26	29	0
Trajectory				24	

* 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.

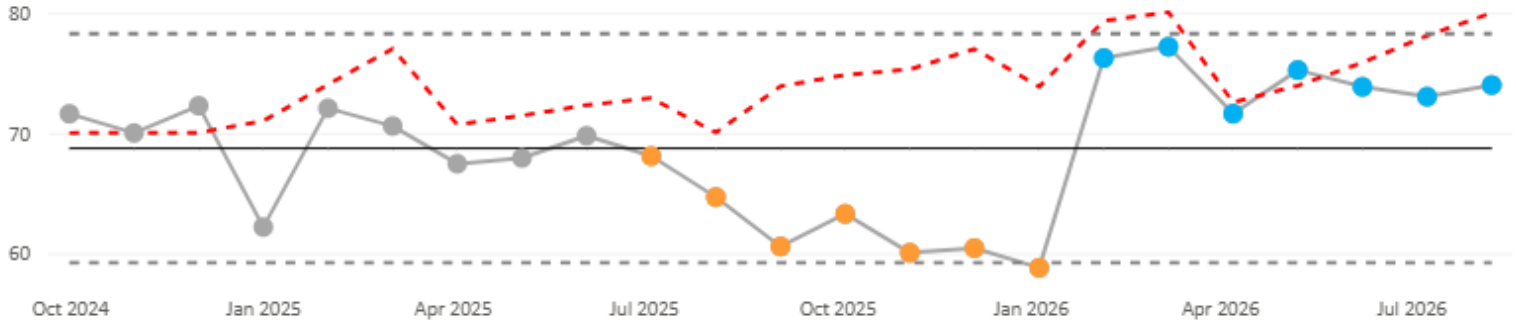
True North Report

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)?

1 found

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

Occurs

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

Does Not Occur

	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	64.7%	60.6%	63.3%	60%	60.4%	58.8%	76.2%	77.2%	71.6%	75.2%	73.8%	73%	74%	84.3%
Trajectory	70%	73.9%	74.8%	75.3%	77%	73.8%	79.3%	80.1%	72.5%	73.9%	75.9%	78.1%	80%	

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 Q3 26/27.
- Dermoscopy LES extension approved. ICB to support work to improve compliance with LES.
- 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.
- MDT streamlining work commenced with all clinical leads.

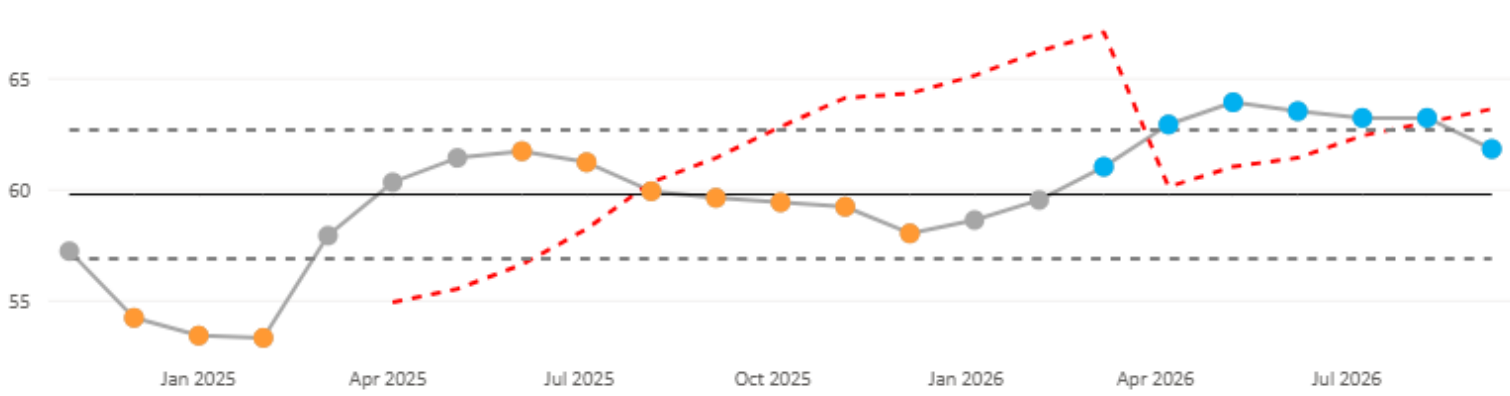
True North Report

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?

Occurs

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

Occurs

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Target Mar 2027
Value	59.6%	59.4%	59.2%	58%	58.6%	59.5%	61%	62.9%	63.9%	63.5%	63.2%	63.2%	61.8%	67.1%
Trajectory	61.4%	62.8%	64.1%	64.3%	65.1%	66.2%	67.1%	60.1%	61%	61.4%	62.4%	63%	63.6%	

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 with focus on OP utilisation.

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.
- Implement additional targeted non recurrent capacity
- Work with ICB to reduce GP demand back to 26/27 planned levels
- Delivery of NHS Focus on First project in October and November.
- Implement 2weeks of RTT clinics per specialty through Q3 and Q4

True North Report

Objective Status Up Is Good

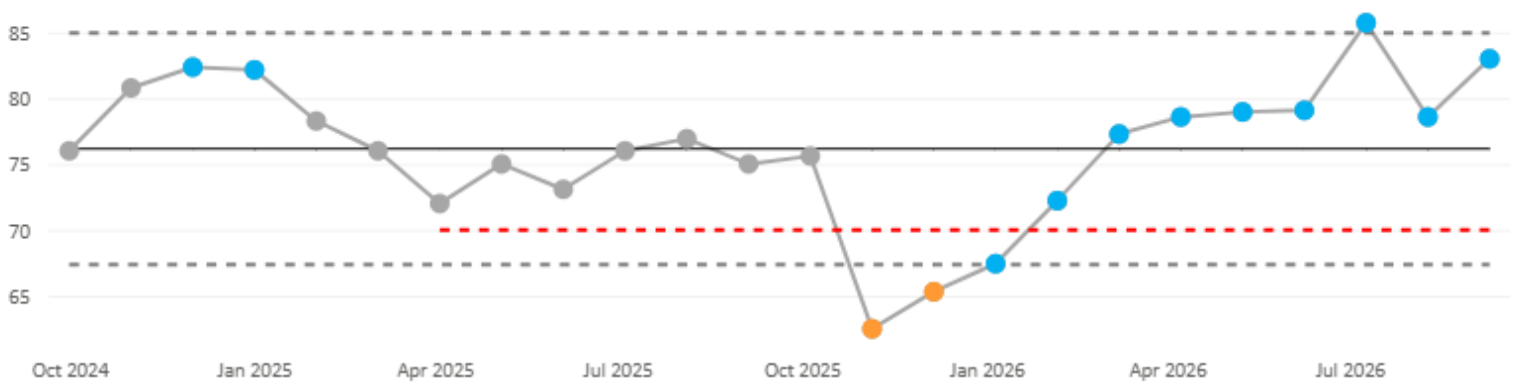
Community: Increase 2-hour Urgent Community Response Compliance

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?

Occurs

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

Occurs

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Target Mar 2027
Value	75%	75.6%	62.5%	65.3%	67.4%	72.2%	77.3%	78.6%	79%	79.1%	85.7%	78.6%	83%	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.

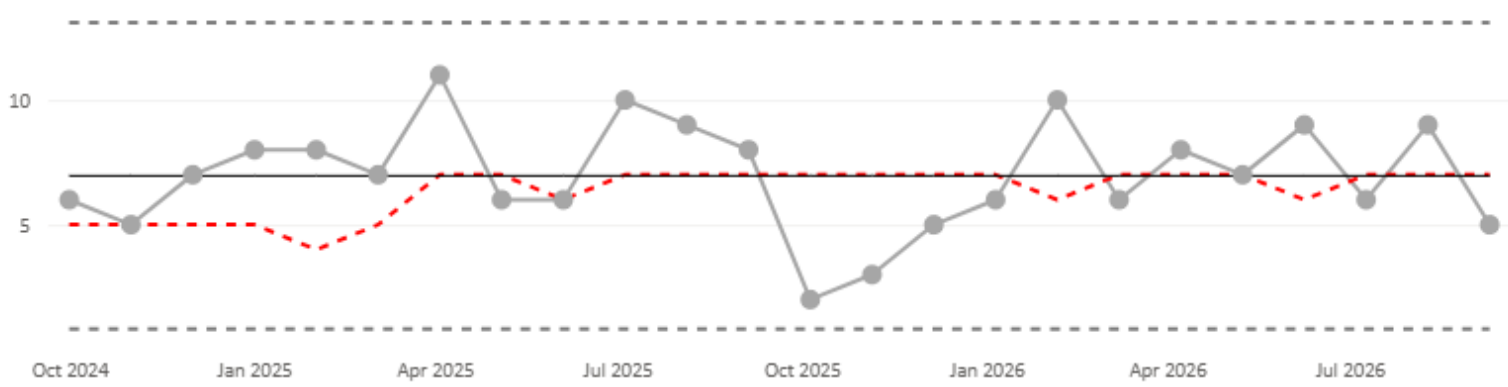
True North Report

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

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

What are the organisational risks?

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

How are we managing them?

- All cases are reported by the IPC team on Datix to the relevant Care Group Handler.
- Cases are managed locally however we are now moving towards a standardised process.
- The IPC team support the care groups to investigate/manage the patients appropriately.
- MSSA 5% reduction on 2025/26 is an agreed Trust 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
- 3 cases over the threshold, year to date, this is an improvement of the position of 5 cases over in August

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

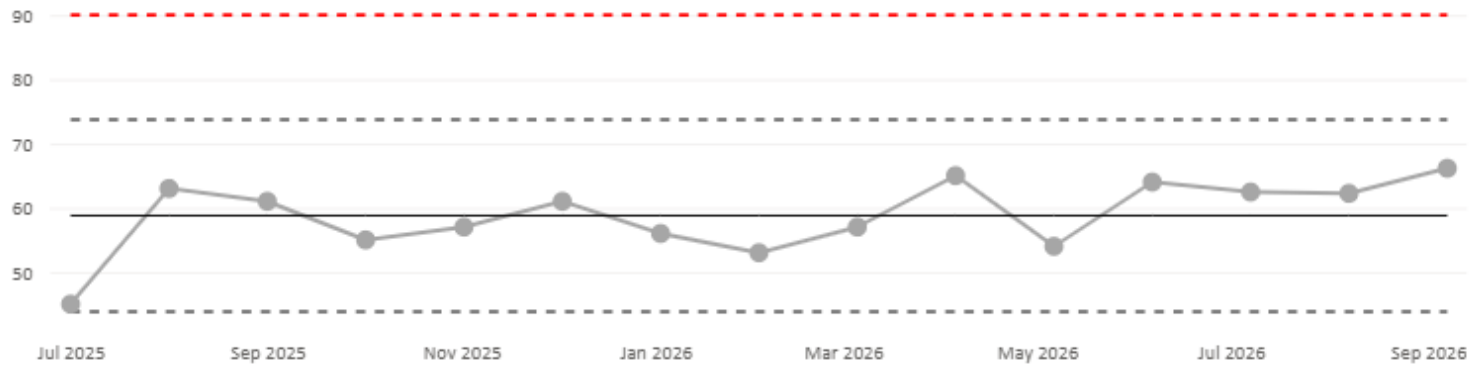
Objective Status Down Is Good

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

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Target Mar 2027
Value	61%	55%	57%	61%	56%	53%	57%	65%	54%	64%	62.5%	62.2%	66.2%	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

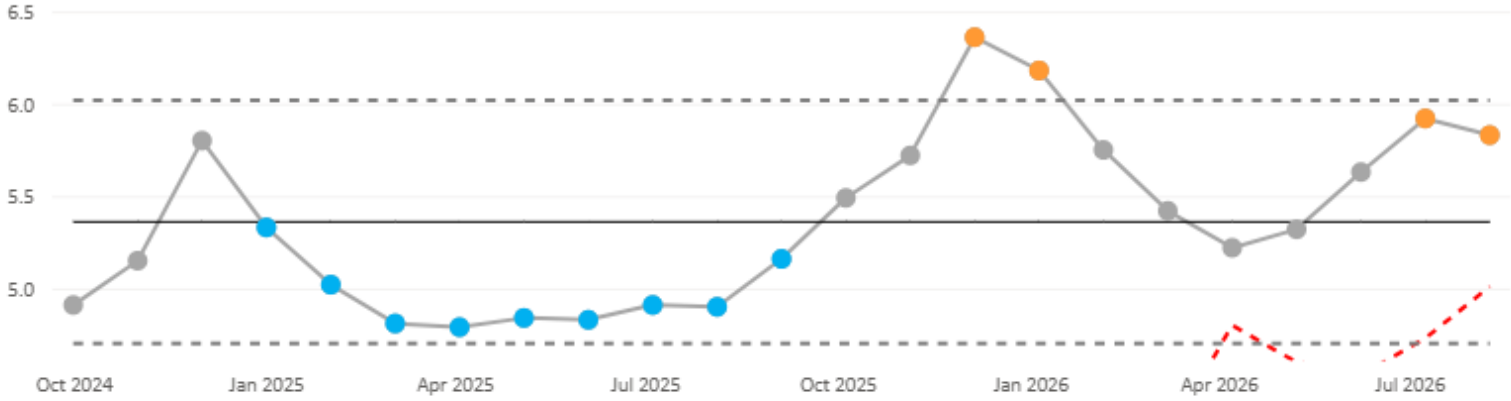
Workforce: Reduce the Monthly Sickness Absence rate

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

Lead Director: Sarah Dexter-Smith

Operational Lead: Lydia Larcum

Committee: Resources



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	4.9%	5.2%	5.5%	5.7%	6.4%	6.2%	5.8%	5.4%	5.2%	5.3%	5.6%	5.9%	5.8%	4.7%
Trajectory	4.2%	4.2%	4.2%	4.2%	4.5%	4.5%	4.5%	4.2%	4.8%	4.6%	4.5%	4.7%	5%	

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.

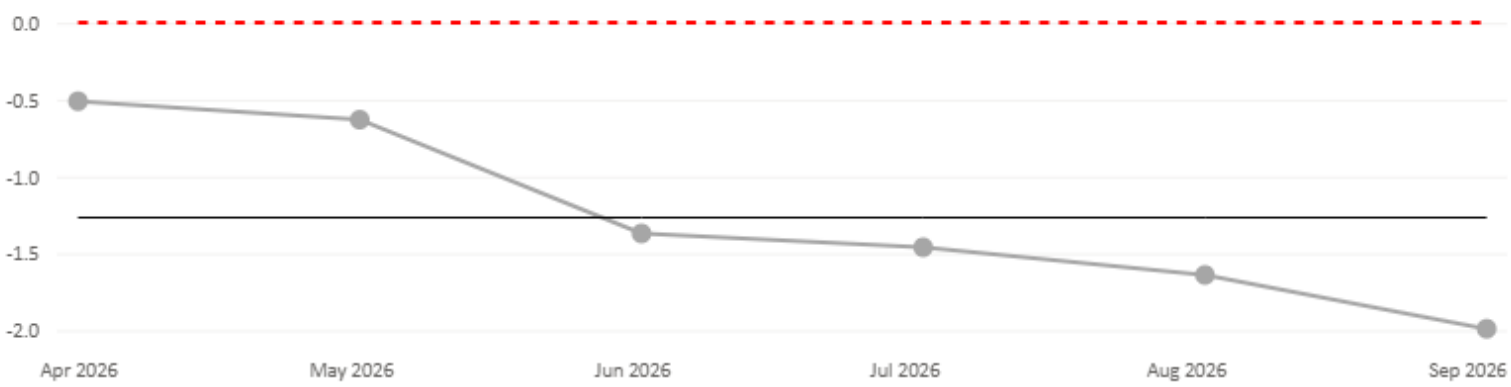
True North Report

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	Sep-26
Value	-0.5%	-0.6%	-1.4%	-1.5%	-1.6%	-2%
Trajectory	0%	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** – The Trust has submitted a cash application to NHSE for November, requesting £8m cash support.

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 £7m short of the YTD target, the deterioration from July is due to 6/12ths of the £4m stretch target in respect of the revised £18.5m deficit plan.
- There is currently a planning gap of £3.6m (5.5% of overall target)
- Of planned schemes still to be delivered, £7.4m WRAP plans are High-Risk, £6.9m Medium Risk and £13.7m 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

- 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.
- Programme activity is focused on Tranche 3, which is expected to go live in June 2027.
- Tranche 3 will include the Patient Administration Service (PAS), theatres, endoscopy, medical device integration, e-consent, and outpatient use of clinical documentation, EPMA & investigations.
- The team are working towards a key design milestone due in mid-October, and the start of detailed planning for the build and test phases.
- There is also key focus on readiness for data migration, which includes significant activity across the organisation to ensure the data migrated will pass quality checks.

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 | September 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	£31,794,232
Delivered	£34,489,202	£24,748,336
Variance	**-£31,296,497**	**-£7,045,896**
Addititional Plans to be delivered		
Planned Low Risk	£13,657,538	£626,636
Planned Medium Risk	£6,860,430	£2,585,917
Planned High Risk	£7,430,510	£283,334
Total Additional Plans	**£27,948,478**	**£3,495,887**
(Planning Gap)/Over delivery	**-£3,348,019**	**-£3,550,009**

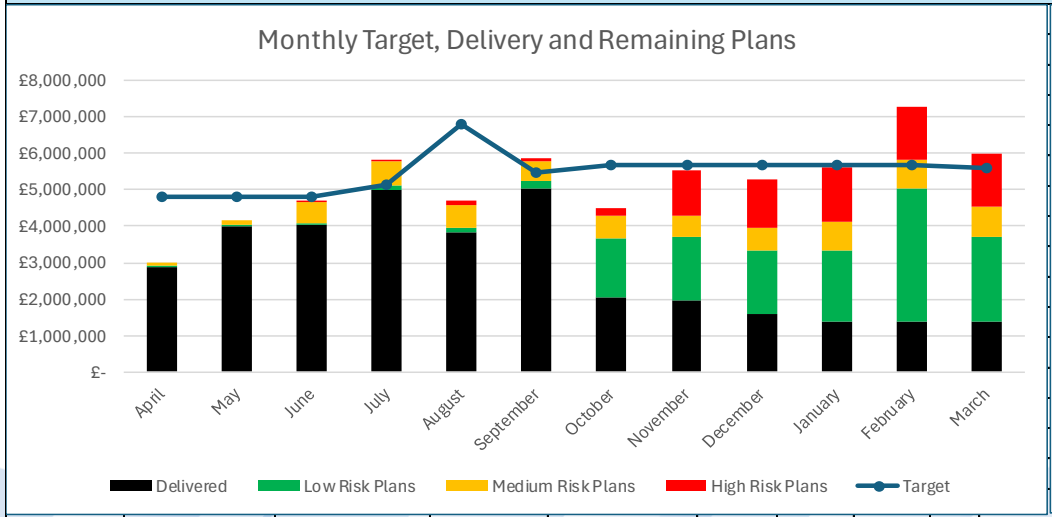
WTE Plan	239.34	**WTE Delivered**	47.91

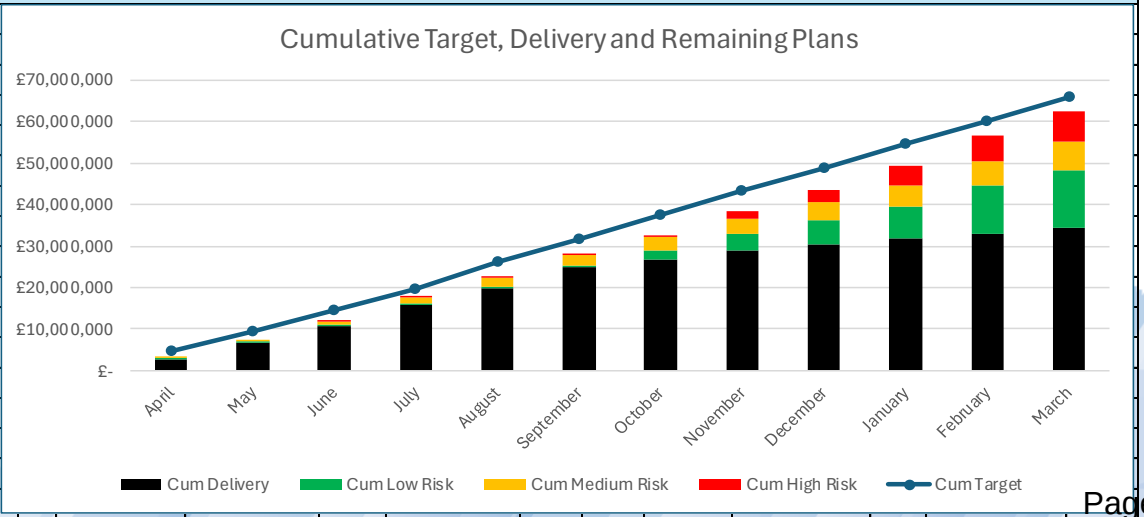
Scheme Governance

Total Number of Live Schemes					**153**				
EQIA Outstanding					56	37%			
Pre-Pipeline					3	2%			
Opportunity					37	24%			
Plan in Progress					9	6%			
Fully Developed					104	68%			
	Plans	**%**	**Delivered**	**%**		**Plans**	**%**	**Delivered**	**%**
Recurrent	£38,875,859	59%	£19,773,243	30%	**Pay**	£28,564,837	43%	£13,979,897	21%
Non Recurrent	£23,561,821	36%	£14,715,959	22%	**Non Pay**	£33,557,481	51%	£20,289,942	31%
Total	**£62,437,680**	95%	**£34,489,202**	52%	**Income**	£315,363	0%	£219,363	0%
					Total	**£62,437,680**		**£34,489,202**	

YTD Period Name	September 2026

In Year Plan Profile





Report to:	Board of Directors
Date of Meeting:	28 October 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 – October 2026

1. I have continued to visit various wards and services at Scarborough and York Hospitals. 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. I have been on holiday for the last two weeks but via MS Teams attended a meeting of the Committee in Common of the Acute Hospital Collaborative in Humber & North Yorkshire. Our Chief Executive also attended. I will circulate minutes of that meeting.

3. I also Chaired a meeting of the Council of Governors Nomination & Remuneration Committee. It was agreed to shortlist 3 candidates to invite to interview which will take place on 30th October. The successful candidate will fill the vacancy succeeding Noel Scanlon.

4. While I was away, Julie Charge, Deputy Chair, attended on my behalf a Chairs and Chief Executive meeting hosted by the Region NHSE leaders. Our Chief Executive also attended.

5. The first meeting of the Task & Finish Group that the Trust established with the Council of Governors to develop proposals for new arrangements for patient and public engagement (in the event of legislation being passed that will eliminate the powers of Councils of Governors) will take place on 22nd October. I will update the Board on the outcome of that meeting.

Martin Barkley
Trust Chair
21.10.26

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	28 October 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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☒ 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:

- Around the Trust
- Our Improvement Journey: 'Better Together'
- Our Big Conversation: Values, Behaviours and Accountability
- 2026 NHS Staff Survey
- Flu Vaccination campaign underway
- Referral to Treatment (RTT) – Focus on Firsts

- NHS England Guidance on Single-Sex Services and Facilities
- Cancer Care and Patient Experience
- SHARC Community Research Grants
- Welcome Dr Sarah Dexter-Smith, Chief Culture and People Officer
- Star Award nominations: September 2026

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. Around the Trust

I want to begin by recognising and thanking colleagues for their continued commitment during what has been an exceptionally challenging period for our urgent and emergency care services.

This month, we have seen significant numbers of patients presenting through our emergency departments, many with flu and Covid, placing considerable pressure on our services and colleagues. During visits to our emergency departments and wards, I saw first-hand the impact these pressures are having on our teams, many of whom are working in extremely difficult circumstances.

This reinforces the urgency of our work to eradicate corridor care, both in our emergency departments and on our wards. As I have said previously, this must remain a collective priority across the Trust. We cannot allow corridor care to become normalised, and we must continue to focus on improving patient flow, reducing delays and ensuring patients receive safe, timely and dignified care.

Alongside this, I have continued to spend time with colleagues across our sites, including a number of Chat and Brew sessions and dedicated conversations with our Specialty and Specialist (SAS) doctors during SAS Week. We also marked Allied Health Professions (AHP) Week, recognising the significant contribution our AHP colleagues make to patient care.

At Malton, I attended a listening event following the fire in July. Colleagues spoke openly about their experiences, including some difficult feedback. These conversations are important, and we must ensure we act on what we have heard and take forward the learning.

I also visited Scarborough Science, Technology, Engineering and Mathematics (STEM) Week, where our colleagues showcased the breadth of careers available across the NHS to around 3,500 young people. The Trust has supported this for the past few years and it is a fantastic way of engaging with younger people in Scarborough about the potential opportunities offered in the NHS. It has also been a pleasure to recognise colleagues through our Star Awards during visits across the Trust.

Spending time with colleagues, listening to their experiences and recognising their contributions remains incredibly important to me. It helps us understand what is working well, where we need to do better and how we can continue to improve.

Later this month, we will hold our annual Celebration of Achievement Awards, which I look forward to sharing more about in my next report.

2. Our Improvement Journey: Better Together

In my previous report, I outlined the work underway to develop and embed a consistent approach to improvement across the Trust. During October, this work has begun to move from mobilisation into practical delivery.

Our approach will be known as *Better Together*, following engagement with colleagues on a name that reflects the importance of working collectively to improve our services. At its heart is the principle that colleagues closest to our patients and services should feel empowered to identify problems, test changes and make improvements.

Our first improvement bootcamps took place earlier this month, bringing together colleagues to begin applying the approach in practice. These combine structured learning, coaching and practical application, helping us develop the skills, behaviours and leadership capability needed to make improvement part of everyday work.

A key part of this work is bringing together our Quality Management System (QMS) and Continuous Quality Improvement (CQI) approach. QMS provides the structures and management processes to understand how services are performing, while CQI provides the methods to identify problems, test changes and learn. Together, they will provide a shared language and consistent approach to improvement across the Trust.

Our partnership with Catalysis, Royal Berkshire NHS Foundation Trust and KPMG continues to support this work, with a focus on developing sustainable improvement capability within our own organisation. Through a ‘see one, do one, teach one’ approach, colleagues will increasingly be supported to lead improvement and develop the skills to coach others.

I have been clear that this must not become another initiative or additional programme for colleagues. Our ambition is for Better Together to become the way we do our daily business, helping teams understand how their work contributes to our priorities and giving them the confidence and support to make improvements.

There is significant work ahead to embed this consistently across the Trust, but I am encouraged by the progress being made and look forward to seeing what we can achieve together.

3. Our Big Conversation: Values, Behaviours and Accountability

Following Our Big Conversation earlier this year, we have completed our review of colleague feedback on our organisational values, behaviours and culture.

The strongest message was that colleagues did not want us to start again. Our values of Kindness, Openness and Excellence remain important to our people and will continue to underpin how we work together and care for our patients.

However, colleagues also told us that the behaviours supporting those values needed to be clearer and more meaningful in everyday practice. In response, we have refreshed all nine behaviours, including replacing ‘Ambitious’ with ‘Curious’ under Excellence, reflecting a greater emphasis on learning, improvement and being open to challenge and new ideas.

This also aligns closely with our Better Together approach to quality improvement.

Importantly, colleagues were clear that our values must be more than words on a page. They need to be consistently demonstrated through our actions, decisions and leadership.

We are therefore developing an accountability compact, setting out what colleagues should expect of one another, alongside what they can reasonably expect from the Trust and its leaders. This includes clear priorities, visible and compassionate leadership, opportunities to speak up and confidence that concerns will be heard and acted upon. Our next priority is to embed the refreshed values and behavioural framework into recruitment, appraisal, development and everyday leadership, alongside progressing the accountability compact.

This is an important part of our wider cultural improvement work. We have listened to colleagues and made changes in response. The challenge now is to ensure our values and behaviours are consistently experienced by our people and reflected in the care we provide.

4. 2026 NHS Staff Survey

The 2026 NHS Staff Survey is now open and will run until 27 November. Last year, 55% of colleagues responded, and we are encouraging strong participation again this year.

The survey provides an important opportunity to hear directly from colleagues about their experiences of working here. The findings will be particularly valuable as we progress our Big Conversation, our refreshed values and behaviours, and wider work to improve organisational culture. We will use the results to understand where progress is being made and where further action is needed.

5. Flu vaccination campaign underway

Our annual flu vaccination programme is now under way as part of our winter preparations and wider work to protect patients, colleagues and maintain the resilience of our services.

This year, we are aiming for at least 65% of eligible colleagues to receive their flu vaccination, compared with 49.4% last year.

At the time of writing, over 3,500 of our eligible colleagues have been vaccinated. Vaccinations are available across our hospital and community sites, and we will continue to monitor uptake and target support where participation is lower.

6. Referral to Treatment (RTT) – Focus on Firsts

Reducing our RTT waiting list remains one of our most significant operational priorities, particularly improving access to first outpatient appointments and reducing long waits for patients.

In response to NHS England's request for all patients waiting over 18 weeks to receive their first outpatient appointment by the end of November, we have launched 'Focus on Firsts', a targeted seven-week improvement approach.

The work focuses on maximising available outpatient capacity, improving scheduling and utilisation, strengthening clinical validation and ensuring timely completion of outpatient

outcomes. Care Groups are being supported to identify opportunities within their services, with daily stand-ups introduced to monitor progress and address barriers quickly.

The scale of our RTT challenge requires a collective response across clinical, operational, administrative and corporate teams. I recognise the significant pressures colleagues are already managing, but improving access and reducing waiting times must remain a priority.

Our focus is on making meaningful progress over the coming weeks and ensuring the improvements achieved are sustained beyond November.

7. NHS England Guidance on Single-Sex Services and Facilities

On 15 October, NHS England issued updated guidance on the provision of single-sex services and facilities, following the introduction of the Equality and Human Rights Commission's statutory Code of Practice in August 2026.

The guidance covers both patient accommodation and staff facilities and asks NHS organisations to review their existing policies, practices and environments to ensure they are consistent with the law and national guidance.

We are reviewing the implications for the Trust, bringing together colleagues from clinical operations, nursing, people and culture, estates and facilities, and other relevant services to identify any changes required.

These are complex and sensitive issues, and it is important that our approach is lawful, proportionate and informed by appropriate expertise, while protecting the privacy, dignity, safety and respect of all patients and colleagues.

We will ensure the Board has appropriate oversight of the review and any actions arising, including the arrangements needed to support colleagues in implementing the guidance consistently and sensitively.

8. Cancer Care and Patient Experience

The Trust has achieved its best-ever results in the latest National Cancer Patient Experience Survey, with patients who received cancer treatment during 2025 rating their overall care an average of 9.02 out of 10, our highest score since reporting began in 2011.

The results reflect the compassionate and personalised care provided by our teams, with 95% of patients reporting that they found their main contact very or quite helpful, alongside significant improvements in how involved families and carers feel in decisions about care.

These results are particularly encouraging because they reflect what matters most - the experience of patients and their families. cancer care involves colleagues working together across many services and disciplines, and I would like to thank everyone who has contributed to this achievement.

I am also pleased to report that the Sir Robert Ogden Macmillan Cancer Care Centre at York Hospital is now open, providing a dedicated space for patients and families from across our Trust footprint to access information, practical advice and emotional support.

The centre represents an important investment in the support we provide to people affected by cancer, recognising that high-quality care extends beyond diagnosis and treatment. It will provide a welcoming environment where patients and families can access support at what can be an incredibly difficult time.

9. SHARC Community Research Grants

I am pleased to report that two community organisations have been awarded funding through the 2026/27 Community Research Grants programme, led by our Scarborough Coastal Health and Care Research Collaborative (SHARC) in partnership with York St John University.

The programme brings together community organisations and university researchers to explore issues affecting local people and develop evidence to improve health and wellbeing in coastal communities.

Sparks Project in Scarborough will explore the impact of its community-based Pop-Up Health Hubs, particularly in communities experiencing health inequalities. Dementia Forward will focus on improving how services and support for people living with dementia on the North Yorkshire coast reflect their needs and experiences.

There was strong interest in the programme, with 13 organisations applying and five developing collaborative research proposals. The two successful projects began in September and will continue until July 2027.

This is a positive example of partnership working to address health inequalities, and the programme will run again in 2027.

10. Welcome to our new Chief Culture and People Officer

I am delighted to welcome Dr Sarah Dexter-Smith, who joined us this month as our new Chief Culture and People Officer.

Sarah brings more than 25 years' experience across healthcare, people leadership and organisational development, most recently as Director of People and Culture at Tees, Esk and Wear Valleys NHS Foundation Trust. As an experienced NHS executive and clinical psychologist, she brings significant expertise in developing compassionate and inclusive cultures, supporting colleagues and strengthening leadership.

Sarah joins us at an important point in our improvement journey and will play a key role in helping us create a culture and working environment where colleagues feel valued, supported and able to provide the best possible care for our patients.

As we welcome Sarah, I would also like to thank Lydia Larcum, who has led our People and Culture work on an interim basis. Lydia has provided important leadership and continuity during a period of significant change, and I am personally very grateful for her commitment and support.

I know colleagues across the Trust will join me in giving Sarah a very warm welcome, and I look forward to working with her as part of our Executive Team.

11. Star Award Nominations

Our monthly Star Awards provide an opportunity for patients and colleagues to recognise individuals and teams who have made a difference by demonstrating our values of kindness, openness and excellence.

It is encouraging to see the consistently high number of nominations received each month, and I know how much colleagues appreciate it when someone takes the time to recognise their contribution. September's nominations are included at **Appendix 1.**

Date: 28 October 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

September 2026

Denise Pooley, Healthcare Support Worker **York** **Nominated by a colleague**

I am nominating Denise for a Star Award in recognition of their exceptional support at a recent Healthcare Support Worker recruitment event. As an experienced HCSW, they played a key role in engaging with prospective candidates, generously sharing their knowledge, skills, and personal experiences of working within the NHS. They spoke openly about their own career journey, providing practical advice, reassurance, and encouragement to those considering a career as a Healthcare Support Worker.

What stood out most was their ability to connect with candidates on a personal level. They took the time to answer questions, address concerns, and share real-life examples of the rewards and challenges of the role. Their honest and enthusiastic approach helped candidates gain a genuine understanding of what it means to work in the NHS and the positive impact they could have on patient care. Several attendees commented on how approachable, inspiring, and informative they were. Their willingness to share their experiences helped build confidence in candidates who may have been uncertain about applying, and their encouragement motivated many to see the NHS as a place where they could develop a meaningful and rewarding career.

By acting as a positive ambassador for both the HCSW profession and the Trust, Denise demonstrated a genuine commitment to supporting the future workforce. Their passion, professionalism, and dedication made a lasting impression on attendees and contributed significantly to the event's success. They are truly deserving of recognition through a Star Award.

Jon Hind, EUC Desktop Engineer **York** **Nominated by a colleague**

Over the last couple of months, Jon and I have been working closely to get the new Zebra printers rolled out across York and its surrounding community sites for Nervecentre Tranche 2. He has worked non-stop, gone everywhere and done everything we've needed done. I can't thank him enough for his help and drive through this rollout.

Tim Barton, EUC Analyst **Scarborough** **Nominated by a colleague**

I would like to personally thank Tim for all the hard work he has put in over on the East Coast in getting us ready to go live with Nervecentre Tranche 2. He has worked nonstop to get all the new printers in place so that we are ready for the new Tranche 2 printing solution. He has looked after the East Coast sites for us and has done everything we have needed to be in a really good position for the go-live and going forward.

Alyson Dawber, Discharge Liaison Officer **York** **Nominated by a colleague**

On 21 August, we did not have a Patient Service Assistant (PSA) on duty - we had only three HCAs, with two patients that needed 1:1 at all times. When Alyson visited the ward and noticed this, she volunteered to help Ward 36 distribute food to the patients during lunchtime. She is amazing and helpful. Although she works in Ward 39, she decided to help on Ward 36 without any hesitation. With this gesture, she supported our team and ensured patients got their food on time.

Yvonne Wadeson, Staff Nurse **York** **Nominated by a colleague**

Yvonne embodies the Trust values in everything she does. She is kind and caring to her patients and colleagues. Yvonne is one of those staff members who, when you see her on shift, you know will run things smoothly. No matter what challenges, you will have someone reliable and supportive to turn to. Her patience, professionalism and dedication make a significant difference to the ward every day. I have learned a great deal from her, and she is an invaluable member of the team and thoroughly deserving of recognition.

Michelle Robertson, Materials Management Officer **York** **Nominated by a colleague**

It is impossible to overstate how much Michelle Robertson means to, and contributes to, the team on SDEC. Michelle is an exceptionally kind, hardworking and conscientious individual who consistently goes above and beyond to support our department. She has spent many hours working closely with the SDEC team to ensure that our ward stock is managed effectively, that stock levels are appropriate, and most importantly, that what we have available genuinely reflects the needs of our patients and staff. Whenever something is needed, missing or simply needs sorting out, Michelle is the first person we turn to. She is incredibly approachable, dependable and proactive, and nothing ever seems too much trouble.

Rather than simply dealing with individual problems as they arise, Michelle takes the time to understand what the department needs and works with us to find practical and sustainable solutions. Michelle's hard work and diligence have undoubtedly saved the Trust significant amounts of money. She has identified and removed unnecessary and erroneous stock, helped ensure that we order only what is genuinely required, and worked hard to maintain appropriate stock levels. This reduces waste while ensuring that essential equipment and supplies are available when our clinical teams and patients need them.

Her contribution goes far beyond stock management. By quietly and consistently making sure that these things are taken care of, Michelle makes the working lives of the entire SDEC team easier and allows clinical staff to concentrate on providing patient care. Much of this work happens behind the scenes and could very easily go unnoticed, but its impact on the smooth and efficient running of the department is enormous.

Michelle can always be relied upon. She is professional, friendly and knowledgeable, and genuinely cares about helping the people she works with. Her dedication to SDEC, her willingness to go the extra mile and the positive difference she makes every day deserve to be recognised. For all these reasons, I believe Michelle Robertson is thoroughly deserving of a Star Award.

Lisa Hodge, Clerical Officer **Selby** **Nominated by colleagues**

Lisa demonstrated exceptional dedication and initiative by successfully managing a significant stock challenge at one of our hubs while simultaneously reorganising the entire office. Achieving all of this in just one day is a remarkable accomplishment that reflects her outstanding work ethic, problem-solving skills, and commitment to excellence. Lisa has only been with the Trust for a short time, but she is already an invaluable team member.

Lisa Clarke, Volunteer **York** **Nominated by a colleague**

Lisa is one of the dedicated volunteers who supports the ICU Reception team. Recently, when reception cover was required at very short notice, Lisa stepped up and provided invaluable support whenever she could. Her willingness to help and the time she gives are greatly appreciated, not only by the reception team but also by the nursing staff, as her assistance allows them to remain focused on patient care rather than being required to answer telephone calls or assist visitors.

Lisa consistently goes above and beyond what is expected of her. She demonstrates exceptional compassion, kindness, and empathy when supporting patients' relatives and visitors, often during some of the most difficult times in their lives. These qualities not only embody the Trust's values but are especially important when supporting families who have lost a loved one.

Bob Farish, Volunteer **York** **Nominated by a colleague**

Bob is one of the dedicated volunteers who supports the ICU Reception team. Recently, when reception cover was required at very short notice, Bob stepped up and provided invaluable support whenever he could. His willingness to help and the time he gives are greatly appreciated, not only by the reception team but also by the nursing staff, as his assistance allows them to remain focused on patient care rather than being required to answer telephone calls or assist visitors.

Bob consistently goes above and beyond what is expected of him. He demonstrates exceptional compassion, kindness, and empathy when supporting patients' relatives and visitors, often during some of the most difficult times in their lives. These qualities not only embody the Trust's values but are especially important when supporting families who have lost a loved one.

George Milner, ACCS ST3-ST8 Emergency Medicine **York** **Nominated by a colleague**

I am nominating George for a Star Award in recognition of the outstanding kindness, openness and excellence he demonstrated in his care of a young person who presented to the Emergency Department extremely distressed and in severe pain because of a known health condition.

George carried out a thorough and compassionate assessment, requested and promptly reviewed the young person's X-ray, and immediately prescribed the medication they required. His knowledge and attention to detail were particularly evident during his examination, with the young person's parents commenting that certain things he had checked, they would usually only expect to be assessed by doctors within their child's specialist team. The parents openly shared how impressed they were with George's thoroughness, knowledge and the timeliness of both the investigation and treatment, particularly as they had previously experienced situations where they had not felt listened to or received the assessment and treatment that they felt their child needed.

George demonstrated:

- kindness through his compassionate approach, reassurance and focus on the young person's comfort
- openness through clearly explaining his assessment and treatment and listening to the concerns of both the young person and parents
- excellence through his thorough clinical assessment, specialist knowledge, prompt decision-making and effective treatment.

Following administration of the medication, the young person's distress and discomfort significantly improved, and the parents again expressed their gratitude for George's care, communication and reassurance. George's actions made a clear and positive difference to the experience of this young person and family, demonstrating the high standard of care and the values we strive to uphold within the Trust.

Chemotherapy Team **Scarborough** **Nominated by a colleague**

I am nominating our amazing Chemotherapy Team for a Star Award. This is in recognition of our hard work, dedication and providing outstanding patient-centred care, and the compassion we show both patients and their families every single day. Our patient numbers have increased massively over the four years I have worked here, and with that has come an enormous increase in workload. Yet despite this, the team continues to give 100% every day. Our patients remain at the heart of everything we do.

Working in Chemotherapy means caring for people during what is often one of the most frightening and difficult times of their lives. Our team provides so much more than just treatment; we provide reassurance, empathy, kindness, emotional support and a listening ear. We regularly go above and beyond what is expected of us. We support not only patients but their families too, recognising that a cancer diagnosis affects everyone around that person. We work incredibly hard, often under significant pressure, and maintain the compassion and care that our patients deserve.

I am incredibly proud to be a part of this team and believe that every member of our Chemotherapy Team deserves to be recognised with a Star Award. The team work tirelessly, cares deeply and makes a real difference every single day.

Matthew White, Healthcare Assistant **York** **Nominated by a colleague**

Today, I had an 84-year-old lady in a wheelchair who was on her own for her appointment. I needed assistance three times with her vulnerability within a few hours. Matty did not bat an eyelid, coming to help me instantly each time I asked. What a guy - so kind and caring with my patient, but also so helpful to me. He works in another department but didn't give a second thought to coming to help. Thank you.

Rebecca Balf, Speech and Language Therapy Clinical Lead **York** **Nominated by a colleague**

Rebecca transitioned into a Band 7 Clinical Lead role in April 2026, having previously been a valued substantive member of the Scarborough team at Band 6. Even before stepping into this leadership position, Rebecca consistently demonstrated initiative and a strong commitment to service improvement, playing a key role in several transformation projects.

Since commencing in post, Rebecca has adapted exceptionally well to the demands of the Clinical Lead role. Throughout probation, Rebecca has shown a clear determination to drive service development across our locality, embracing opportunities to influence change both within the service and across the wider system. This has included active involvement in the Best Start in Life Programme, where Rebecca has developed productive relationships with key partners to support and maximise future service improvements.

More recently, Rebecca has proactively engaged with Cornwall Partnership NHS Foundation Trust to explore Community Assessment Days (CADs) for children and young people, with a particular focus on addressing the significant waiting times within Speech and Language Therapy. Over six weeks, Rebecca worked closely with colleagues in Cornwall, gaining valuable insight and translating this learning into a draft model that could be implemented across the community areas within our service. Rebecca has also carefully considered the practical delivery of CADs and has engaged with key system partners to ensure the model is both achievable and sustainable.

Rebecca, I would like to personally recognise the significant progress you have made in a relatively short period of time. Your energy, enthusiasm and commitment are evident in every discussion we have, but what stands out most is your clear sense of purpose and your unwavering focus on developing services that will make a meaningful difference to children, young people and families. Thank you for everything you have contributed so far, for embracing your leadership role with confidence, and for helping to shape the future of our services while remaining grounded, collaborative and committed to bringing colleagues with you on the journey.

Vicci Anderson, Lead Digital Nurse | **Scarborough** | **Nominated by a colleague**

I am nominating Vicci Anderson for a Star Award in recognition of the exceptional commitment, compassion, and professionalism she demonstrated whilst supporting the Nervecentre Tranche 2 go-live at Scarborough Hospital.

During a period of significant operational pressure within the Emergency Department, Vicci went far beyond the remit of her role. While present to support the digital go-live programme, she recognised that colleagues were under immense pressure and that patients required additional support. Rather than limiting herself to her designated responsibilities, Vicci stepped in to help wherever she could. Throughout the shift, she undertook a full comfort round of patients, providing refreshments, assisting patients to the toilet, and supporting the administration of medications. These actions may seem simple, but at a time of extreme demand they made a meaningful difference to both patient experience and the ability of clinical teams to focus on delivering urgent care.

What makes Vicci's contribution particularly noteworthy is that she demonstrated a genuinely patient-centred approach, seeing beyond job titles and embracing a "one team" ethos. She showed initiative, compassion and a willingness to act when help was needed most. Her actions exemplified the values we strive to uphold across our organisation: putting patients first, supporting colleagues, and working together to overcome challenges.

Vicci embodied the very best of our Trust during the Tranche 2 go-live. Her selfless support not only helped patients feel cared for and reassured during a difficult period but also provided practical relief to frontline staff managing significant demand pressures. She is thoroughly deserving of recognition through a Star Award for the difference she made to patients, colleagues and the wider organisation.

Kath Lynch, Switchboard Operator | **Scarborough** | **Nominated by a colleague**

Kath used her experience and initiative when seeing a patient in advanced labour arriving in the car park. She realised the situation and responded using the obstetric emergency bleep, alerting staff to attend promptly. She stated the situation and location perfectly so we could locate the patient quickly and ensure the safety of mum and baby. Thank you for supporting us and patients in times of critical need! You are indeed a star.

Kathreen O'Connell, Senior Healthcare Assistant | **Scarborough** | **Nominated by a colleague**

I am nominating Katie for a Star Award because she deserves recognition for all the hard work and commitment she puts into helping patients and staff. Katie always goes the extra mile to ensure that patients are receiving the best care possible and is always eager to help staff wherever possible. No task is too small or too big for Katie, and she is always up to help with any task given. Katie deserves recognition for all her hard work. Thank you, Katie!

Emer O'Brien, Deputy Sister **York** **Nominated by a colleague**

I am nominating Emer from the Critical Care Outreach Team for the outstanding difference she makes to patients, their families and, importantly, to staff. Emer's clinical skills, knowledge and ability are exceptional, as are her strengths in teaching and supporting others. However, it is her compassion, awareness and kindness in the most challenging moments that truly set her apart.

Recently, Emer attended our ward to review a very unwell patient. On this day, patient acuity was exceptionally high, and staffing was low. The moment Emer walked into the room, I felt an enormous sense of relief — it was as though I could breathe again. She immediately brought a sense of calm, confidence and reassurance to an incredibly pressured situation. She ensured that the patient received timely, appropriate and expert care, but she didn't stop there. Emer recognised that I was struggling with the demands of an extremely busy bay and was visibly overwhelmed. Despite having an extensive caseload of her own and multiple demands on her time, she sat down with my bay of patients, who required cohort nursing, and told me to step away — to take a break, go to the toilet and simply have a moment to breathe. This was far more than she was required to do, but it made a profound difference to me.

When I returned, Emer had engaged the patients in a lively conversation and had helped some of them with their food and drinks. The atmosphere in the bay had completely changed. I was able to return to my patients feeling calmer and more able to manage the rest of the shift. The patients themselves commented to me afterwards about how lovely and caring Emer had been.

This experience perfectly demonstrates why Critical Care Outreach are so valued on our ward. Whenever we need them to attend, it is usually because something has gone wrong and a patient, their family or the staff caring for them are under significant pressure. Yet the moment the team arrive, they bring with them a sense of calm, reassurance and knowledge. They support not only the patient in front of them, but the wider team around that patient.

Emer consistently demonstrates the Trust's values of kindness, openness and excellence through both her actions and her behaviours. Her kindness extends beyond simply providing excellent clinical care; she notices the people around her, recognises when someone needs support and takes the time to help, even when she has countless competing demands of her own. Her openness creates a reassuring environment where staff feel supported rather than judged, and her excellence is evident not only in her clinical practice but in the way she strengthens the whole team around her.

Emer and the Critical Care Outreach Team are an enormous credit to our hospital. I cannot overstate the difference they make to patients, families and staff, often during some of the most difficult moments of a working day. Emer embodies our Trust values and truly goes above and beyond — not because she must, but because she genuinely cares.

Nick Tootell, Domestic Assistant **York** **Nominated by a colleague**

I am nominating Nick, who does the late afternoon/evening cleaning for the Ophthalmology department. Nick has supported the Ophthalmology department for as long as I can remember. He is always friendly, approachable and exhibits the Trust values. He is always keen to help with no request too big or too small. It is a pleasure to see him in the corridor, and I hope he knows how much we appreciate him.

Aston Smith and Ikhtisham Ali, Security Officers **York** **Nominated by a colleague**

From the start of their shift at 6pm on Wednesday 26 August, they have been inundated with jobs in the ED and on wards. They have been going without a break for four and a half hours, non-stop. Their commitment to each job, regardless of how stretched they have been, shows how dedicated to their work they are. They are going from one job to another and then remaining with a mental health patient in between.

I believe this shows them demonstrating the values of kindness, openness and excellence. Showing compassion towards the patients they have come across during their shift, no matter how challenging it has been. For one job, while they were with the mental health patient, they had to deal with a male patient in ED who had assaulted his partner.

Susan Kinsella, Matron **York** **Nominated by a colleague**

Susie Kinsella is an exceptional leader who consistently goes above and beyond her role to ensure women, families, colleagues and services receive the very best support, particularly during times of challenge. Susie demonstrates outstanding initiative, compassion and professionalism, never waiting to be asked before taking action. Her unwavering commitment to safe, high-quality care and to supporting those around her makes her an outstanding leader.

One of the clearest examples of Susie's exceptional leadership was during the Malton fire. As soon as she became aware of the incident, she immediately travelled to the hospital to support her teams. Recognising the potential impact on women and families accessing maternity services, she took swift action to organise an alternative venue within the local community so that the community clinic could continue with minimal disruption. Her calm leadership ensured continuity of care at a time of significant uncertainty and prevented delays to essential maternity services.

Alongside coordinating the relocation of services, Susie provided reassurance and compassionate support to her team, helping them navigate a stressful situation. She then went on to assist colleagues involved in the wider hospital evacuation, placing the safety and wellbeing of others at the centre of every decision. Her actions demonstrated exceptional leadership, resilience and selflessness at a time when they were needed most.

Susie's commitment to improving services extends far beyond emergencies. She continually looks for innovative ways to develop her team and improve the quality of care provided to women and families. Recently, she has opened her own home to enable community midwives to undertake realistic emergency simulation training in a domestic environment. Around 15 members of staff participated, gaining invaluable experience of managing emergencies in a home setting where they routinely provide care. This was entirely above and beyond her normal responsibilities and reflected her determination to provide meaningful learning opportunities. The quality and innovation of this training have since been recognised by NHS Resolution, who have identified it as an example of best practice to showcase more widely. By investing her own time and personal resources, Susie has strengthened the confidence and preparedness of the community workforce, directly benefiting the women and families they care for.

Susie is universally respected for her kindness, integrity and willingness to help others. She leads with compassion, inspires confidence and creates an environment where colleagues feel valued, supported and empowered to deliver outstanding care. Whether responding to a major incident, mentoring colleagues or finding creative solutions to improve education and patient safety, she consistently embodies the Trust's values. Susie is an individual who makes an extraordinary difference every day, and her dedication to women, families and her colleagues makes her truly deserving of this recognition.

Charlotte Shackleton, AHP Team Manager **York** **Nominated by a colleague**

Charlotte was successfully appointed to the Team Manager post on a fixed-term contract in April 2026, having moved from a substantive Band 6 clinical role within our Scarborough team. Since joining the York team, Charlotte has invested time in building strong relationships with colleagues, both individually and across teams. Throughout her probationary period, she has demonstrated exceptional professionalism, commitment, and diligence.

The transition into the role has presented several operational challenges, all of which Charlotte has approached with confidence, professionalism, and a clear commitment to our Trust values. Charlotte is inquisitive, thoughtful, and never hesitant to ask questions to gain a deeper understanding. She is also a strong advocate for both colleagues and patients, consistently contributing positively in every setting.

As your line manager, I would like to express my sincere gratitude for your dedication and hard work since taking on this role. It is a genuine pleasure to work alongside you. Your ability to lead with honesty, integrity, and constructive challenge is both recognised and greatly appreciated. Congratulations on such a successful start in your role and thank you for everything you have contributed so far. I look forward to seeing your continued success and development within the team.

Patient Services Assistant Team **York** **Nominated by a colleague**

The Patient Service Assistant (PSA) role was introduced to the Trust in 2022, primarily to focus on nutrition and hydration for our patients. The role prioritises food and drink service, promoting appropriate meal choice and ensuring that all dietary requirements are met for those in our care. The PSAs are integral and valuable members of our ward teams.

As part of Nutrition and Hydration Week in March this year, the PSA team on G1 offered alternative breakfast menu choices for the patients. This included croissants, bowls with yoghurt, fruit, granola and honey, and ice-cream smoothies, as well as scones for afternoon tea on a Sunday. As this was a big success in Nutrition and Hydration Week, the PSA team wanted to roll this out further, and we agreed to a three-to-four-month trial on the ward. To set this up, the team liaised with catering to cost the additional menu items and organise supply. They have also undertaken a patient survey pre- and post-trial for feedback on the existing and new breakfast offerings.

The feedback has, without a doubt, demonstrated that introducing the extra food items has been a tremendous success, and that it has been extremely well received by the patients. In view of this, the PSAs now intend to continue these choices in the longer term. It is great work that we are sharing within the Care Group and considering rolling out in other areas.

I am very proud of the work that the PSAs have undertaken. They have greatly improved patient experience, enhanced patient nutrition, and shown their commitment to meeting the ongoing and ever-changing dietary needs of our patients. They have devised and led this project themselves and have made a real difference to patient care. The new choices are appealing and have offered variety to an otherwise standard menu. Well done, team.

Ollie Milner, Pathology IT Technician **York** **Nominated by a colleague**

I am nominating Ollie from Pathology IT for a Star Award. Ollie has been fundamental to the build, testing and delivery of Pathology Order Communications within the Trust's new Nervecentre EPR. He has developed a strong understanding of the system and worked with dozens of stakeholders across pathology, clinical teams and digital services to make sure the build was as accurate as possible. The amount of work involved has been huge. Ollie has personally led a large amount of the configuration, testing, troubleshooting and go-live support, all while working to very challenging timescales.

Going live in August is never anyone's idea of a good time, but Ollie has taken it all in his stride. Thanks also need to go to the wider Pathology IT team and colleagues across SHYPS who either supported the build and testing or picked up other work to free Ollie up to focus on Nervecentre. It has very much been a team effort, but Ollie has been at the centre of it throughout. The go-live itself has been a real success. Orders have flowed as expected and, apart from a handful of minor mapping issues, the system has performed exactly as intended. Most of the issues we've seen since have been user-related rather than system-related, which is probably one of the biggest compliments you can pay to the work put in before go-live.

Throughout the project, Ollie has lived the Trust values. He has worked collaboratively with colleagues, shown patience and kindness when supporting users, taken ownership of problems and always been willing to help. He has worked incredibly hard, kept his sense of humour during some very stressful moments, and consistently gone above and beyond to make sure patients and staff got the best possible outcome. There is no doubt that Pathology Ordercomms would not have been delivered as successfully as it was without Ollie.

Maxine Tait, Special School Nurse **Scarborough** **Nominated by a colleague**

Maxine works above and beyond her role as a Special School Nurse. She strives to ensure her work is completed to a high standard and on time. Her priorities are always the children and their families, as well as her work colleagues. Maxine is always positive, and I know I can rely on her and approach her at any point for support. She is dedicated and caring. She will step up and cover other people when needed without hesitation to ensure the service is operating and offering as it should, ensuring patient care continues at a high standard.

Maxine demonstrates the Trust values every time she is on shift. I can't thank her enough for the support she offers to the children and their families we support and the care she offers her work colleagues.

Alexandra Allison, Staff Nurse **York** **Nominated by colleague**

Alex is a valued member of the team on G1. She always shows outstanding commitment, dedication, leadership and an ability to stay positive during the hardest of times, especially when short-staffed. Alex, without doubt, can make some of the hardest days the brightest. She regularly steps up for the team and takes charge, and sometimes even a team of patients on top of that, which is challenging with the high turnover of patients on this ward. She will always try her best to support those around her and assist her colleagues with tasks such as personal care or assistance at mealtimes.

Alex ensures everything runs smoothly during difficult times and will still always put others first before she takes her break. She is always approachable and would be somebody you could talk to about problems. Even if she isn't in charge, she will always be supportive, reassuring and aim to resolve the issue or help you escalate it correctly. She deserves recognition for what she does each day, as she always goes above and beyond for those surrounding her.

Ashley Cowton, Specialist Doctor **York** **Nominated by a colleague**

Ashley is one of our regular anaesthetists assigned to the Preassessment Team. This nomination is from all the nurses who work in pre-op. He is an absolute pleasure to work with. He consistently goes over and above to help solve our patients' problems, even when he is not assigned to the role. We have times without doctor cover during the week, and he has often jumped in to help us sort urgent problems. He is diligent, thorough, kind and clear with his patient care and requests for us to safely prepare our patients for their operations. Thank you, Ashley. We wanted you to know that we appreciate you!

Caroline Dowie, Paediatric Diabetes Administrator **York** **Nominated by a colleague**

I am nominating Caroline Dowie for a Star Award in recognition of her invaluable support with our financial submissions. Caroline is my main contact for Paediatric Diabetes at York and she consistently provides excellent support by responding promptly to queries and providing timely and helpful clarification whenever needed. Her willingness to engage with questions and help resolve issues has been extremely valuable in ensuring that our financial submissions are accurate, complete, and submitted on time.

I particularly appreciate the collaborative approach between Caroline and Joanne Brown, who supports Scarborough. They are always willing to help each other and provide cover when one of them is on leave, which provides valuable continuity and ensures that queries and financial matters continue to be dealt with effectively. Caroline's responsiveness, professionalism, and commitment to supporting me and the Paediatric Diabetes team have made a real difference. I greatly appreciate her continued support and believe she deserves recognition for her valuable contribution.

Joanne Brown, Paediatric Diabetes Administrator | **Scarborough** | **Nominated by Leonis Taenas, colleague**

I am nominating Joanne Brown for a Star Award in recognition of her invaluable support with our financial submissions. Joanne is my main contact for Paediatric Diabetes at Scarborough and she consistently provides excellent support by responding promptly to queries and providing timely and helpful clarification whenever needed. Her willingness to engage with questions and help resolve issues has been extremely valuable in ensuring that our financial submissions are accurate, complete, and submitted on time.

I particularly appreciate the collaborative approach between Joanne and Caroline Dowie, who supports York. They are always willing to help each other and provide cover when one of them is on leave, which provides valuable continuity and ensures that queries and financial matters continue to be dealt with effectively. Joanne's responsiveness, professionalism, and commitment to supporting me and the Paediatric Diabetes team have made a real difference. I greatly appreciate her continued support and believe she deserves recognition for her valuable contribution.

Cath Jespers, General Manager | **York** | **Nominated by a colleague**

I am nominating Cath Jespers for a Star Award in recognition of the outstanding support and commitment she has demonstrated since joining the Family Health Care Group. I have worked closely with Cath on the financial aspects of multiple business cases, often managing several at the same time. Cath has been highly engaged and responsive throughout, quickly adapting to the financial requirements and challenges of each case and working closely with me to ensure the financial information was understood, robust, and addressed appropriately.

What has stood out to me is Cath's determination to get each business case over the line. She has dealt with challenging questions and scrutiny from multiple stakeholders, while remaining focused, constructive, and committed to achieving the right outcome. She has been willing to challenge, listen, understand the financial position, and work through issues rather than allowing difficult questions to become barriers to progress.

While working closely with Cath on the finances, I have also seen first-hand her caring and passionate approach. She genuinely cares about the services and the people she supports, and this comes through in the drive and commitment she brings to each business case. Cath has managed multiple complex pieces of work simultaneously and has shown real determination to see them through to completion. Her responsiveness, collaboration, passion, and drive have made a significant difference, and I believe she is very deserving of recognition through a Star Award.

Mujtaba Bukhari, Specialty Registrar **York** **Nominated by a colleague**

I am nominating Mujtaba for his outstanding teamwork and support. We were very short-staffed on the ward when a patient urgently needed to go for a CT scan and required a staff nurse escort. He overheard our conversation and kindly offered to escort the patient himself. This was far more than a small gesture. Had a nurse needed to leave the ward to accompany the patient, it would have left the ward with even fewer nursing staff and could have compromised the care of our other patients, some of whom were very acutely ill and required close monitoring and support. His willingness to recognise the pressure the nursing team was under and step in to help made a huge difference.

What stood out to me was not only his helpfulness, but the compassion, awareness and consideration he showed towards both the patient and his colleagues. He recognised a difficult situation and stepped in without being asked. I feel he deserves to be recognised for going above and beyond to support both the patient and the wider nursing team.

Rhett Richardson, Staff Nurse, and Greg Horsfall, Specialty Registrar **Scarborough** **Nominated by a colleague**

We came on shift and were handed over a patient who had been slowly deteriorating over the weekend. As soon as Rhett left handover, he went straight to her. We know this patient well, and it was obvious that the condition she was in was not her at all. Rhett trusted his instincts straight away and acted quickly. He contacted the doctor covering Beech that night, who I believe was Greg, and between them they worked incredibly hard to try and turn things around for her. Greg also jumped straight into action. He was taking bloods, prescribing fluids and doing everything he could to stabilise the patient, whilst at the same time having other very unwell patients across the hospital to deal with.

Working on a night shift with limited resources makes situations like this even more challenging, but neither of them lost focus on this patient. What stood out to me most was how well they worked together. They were both calm, focused and determined to get the patient the care she needed, whilst also supporting her family through what was an incredibly frightening situation. They didn’t just accept that this was how the patient was; they recognised that something was seriously wrong and acted on it.

I genuinely believe that the quick thinking, teamwork and dedication of both Rhett and Greg made a huge difference that night. I believe their actions helped save this patient. They both went above and beyond, despite the pressures and limited resources around them, and never lost sight of the person in front of them. I honestly think they deserve to know how brilliant they both were that night and how much of a difference they made to this patient and her family.

Donna Donaldson, Healthcare Support Worker **York** **Nominated by a colleague**

I am nominating Donna for a Star Award in recognition of her outstanding support and commitment during a recent Healthcare Support Worker (HCSW) recruitment event. Donna willingly gave her time to assist at the event, sharing her extensive knowledge, experience, and valuable advice with prospective healthcare support workers. She represented the Trust exceptionally well, engaging with candidates in a warm, professional, and approachable manner. Her enthusiasm for her role and genuine passion for supporting others helped provide candidates with a realistic and inspiring insight into working within our organisation.

Donna went above and beyond by answering questions, offering encouragement, and helping candidates understand the opportunities and expectations of the HCSW role. Her contribution played an important part in creating a positive experience for those attending and demonstrated the Trust's values of kindness, openness, and excellence. Donna's dedication, professionalism, and willingness to support recruitment activities outside of her usual responsibilities make her truly deserving of recognition through a Star Award. She is a fantastic ambassador for the Trust and a valued colleague who consistently goes the extra mile to support both staff and future members of our workforce.

Kerry Stockill, Catering Supervisor **Scarborough** **Nominated by a colleague**

I am nominating Kerry in recognition of her outstanding commitment to the Catering Department, her colleagues and, most importantly, the patients we support. Recently, due to unforeseen circumstances and staff sickness, the Catering team found itself significantly short-staffed, placing additional pressure on the remaining team and increasing the workload at a particularly challenging time. Despite having planned and booked annual leave, Kerry made the selfless decision to cancel her leave to support the department and undertake a weekend supervision role. This was not something Kerry was required to do, but she recognised the difficulties the team was facing and understood the potential impact that staff shortages could have on the smooth running of the service and patient feeding. Rather than putting her own plans first, Kerry chose to support her colleagues and ensure that the department continued to provide a safe, effective and reliable service to our patients.

Kerry’s actions demonstrate the values we want to see within our team. She showed exceptional teamwork, compassion, commitment and a strong sense of responsibility. Her willingness to step forward when the department was under pressure provided valuable support to her colleagues and helped maintain continuity of service during a difficult period. Cancelling annual leave is a significant personal sacrifice, and I feel it is important that Kerry’s contribution is recognised. It is often easy to overlook the additional efforts made by individuals when a service is under pressure, but Kerry’s decision made a genuine difference to the team and demonstrated how much she cares about her colleagues and the service we provide.

Kerry should be extremely proud of the commitment she has shown. Her willingness to put the needs of the service and our patients first, particularly when the team was already under considerable pressure, is a fantastic example of going above and beyond. I would therefore like to formally recognise and thank Kerry for her dedication, flexibility and continued commitment to the Catering Department. Her actions reflect the very best of teamwork and demonstrate the positive difference that one individual can make during a challenging situation.

Yasmin Brown, Staff Nurse **Bridlington** **Nominated by a colleague**

On a busy afternoon in the Outpatient Department, a patient made an unwanted remark towards me at the department reception. I confided in Yasmin about it, and she made sure that I was okay, listened to me and asked how it made me feel. She also made sure both the patient and the consultant they were due to see were aware of the nature of the comments. Yasmin always goes above and beyond for all in her team, patients and others in the hospital. She truly is a wonderful nurse and is a credit to the profession.

Gill Dean, Staff Nurse **Bridlington** **Nominated by a colleague**

On a busy afternoon in the Outpatient Department, a patient made an unwanted remark towards me at the department reception. I confided in Gill about it, and she made sure that I was okay, listened to me and asked how it made me feel. She also made sure both the patient and the consultant they were due to see were aware of the nature of the comments. Gill has always gone out of her way to make sure we all feel looked after and that everyone in the department is taken care of.

Faye Newton, Staff Nurse **Scarborough** **Nominated by a colleague**

Faye puts her absolute all into ensuring patients are prepared for their surgery. As Faye's line manager, I was contacted by the deputy waiting list manager to tell me just how awesome Faye is and how she goes the extra mile to not only help patients but also the teams she works with.

Amy-Louise Petch, Midwife, and Emily Price, Student Midwife **Scarborough** **Nominated by a colleague**

I am nominating Amy (Midwife) and Emily (Student Midwife) for a Star Award following the birth of my baby girl at Scarborough Hospital on 27 July 2026. I came into Scarborough Hospital on the morning of my induction because my baby was measuring small. I was feeling quite anxious, as you often hear horror stories about inductions, and my first labour had not been the positive experience I had hoped for. I had really wanted this birth to be a “healing” experience, but I arrived feeling that perhaps this was no longer possible because I needed an induction.

From the moment I met Amy and Emily, they completely changed how I felt. They immediately put me at ease, and as my labour progressed, I genuinely felt as though I was chatting with friends rather than being treated as just another patient. They took the time to explain everything clearly, answered every question I had and made sure I understood what was happening. What stood out most to me was how much Amy wanted me to feel in control of my own birth. She gave me advice and guidance but never made me feel that decisions were being made for me. She supported my choices and helped me feel confident in my ability to birth my baby. They went above and beyond to support the birth I wanted. They even arranged for me to change rooms so that I had the option of using the birthing pool if I wanted to. They also took the time to explain and demonstrate the science behind different aspects of labour, which was genuinely fascinating and helped me understand what was happening to my body.

My induction/labour was intense, but despite this, I truly feel that Amy and Emily gave me the healing birth experience I had hoped for. Three weeks later, I am still on a high from my birth, and I honestly believe that is because of the care, encouragement and support they gave me. They made me feel listened to, respected, informed and, most importantly, in control. I never felt like “just another patient”. All the other staff I briefly encountered on Labour Ward and Hawthorn Ward were also brilliant, but Amy and Emily made such a lasting impression on me that I wanted to formally recognise them.

Thank you, Amy and Emily, for helping me turn what I had been dreading into such a positive and empowering experience. You gave me the birth I had hoped for and memories that I will treasure forever. I would genuinely consider doing it all again – something I never thought I would say after my first birth! They absolutely deserve to be recognised with a Star Award.

Michael Komla Azaglo, Deputy Charge Nurse **York** **Nominated by a colleague**

After having received treatment over four weeks with IV antibiotics, my veins became increasingly difficult to cannulate, so I had a midline fitted. Michael was the only employee on Ward 11 who was able to draw blood from my midline. He is excellent and the most competent nurse. Michael is so kind and caring and works tirelessly to be consistently excellent for his patients. Being cared for by such a competent nurse makes a difference. Thank you, Michael. You are a legend!

Endoscopy Unit **Scarborough** **Nominated by a colleague**

I had an appointment at Scarborough Endoscopy Unit for gastroscopy and colonoscopy. I was terrified of having the gastroscopy, but all the staff were amazing, from reception to discharge. All staff were friendly and went out of their way to put me at ease. I would like to sincerely thank them all for making things easier for me. You are all a credit to your professions.

Maternity Unit **York** **Nominated by a patient**

We want to say a massive thank you to the maternity team, mentioning in particular:

- Vicky on triage, who was so calm and comforting when we in the middle of a panic spiral
- Chris Page, who went above and beyond to do all he could to prevent major surgery; all the team in theatre who helped deliver our baby and kept us calm in what could have been a very stressful situation
- Scarlet, who, despite how busy the ward was, really took the time to explain and comfort me during the night when I was feeling vulnerable and a little lonely - she also went the extra mile even at the end of her shift
- Hannah, who spent absolutely ages helping me express and feed my son when we had difficulties getting breastfeeding established and was always smiling and encouraging even when we were struggling
- A special mention to all the ladies on the night shift - no job was too small, no request was too silly, no question was too daft.

Our biggest thank you must go to Georgia and Alisha. You were amazing, supporting us through the entirety of labour and delivery. It was so reassuring to know I was so obviously in safe pairs of hands. In theatre, both of you were so comforting and supportive. When I was receiving my spinal injection, I was scared, and my husband couldn't be with me at that time. Alisha took hold of my hand and made me feel like everything was going to be alright. After our son was born, Georgia took the time to make sure we were comfortable with our baby and gave us the best toast we've ever had.

Abbie Foley, Staff Nurse **York** **Nominated by a patient**

I work for the Trust, and I visited as an outpatient to the early pregnancy assessment unit. My visits to this department were followed by bad news. However, Abbie was there for my second visit; she talked me through my options and was kind and understanding. I also have a needle phobia and required a blood test. Abbie was so gentle and got a private room ready for me to make it as easy as possible for me.

Abbie also popped in on my following visit a few days later, despite working in another clinic that day. Abbie really went above and beyond despite the circumstances of my visit and was just wonderful. Thank you so much; your great work needs recognising.

Mukuka Chileshe, Locum Doctor **York** **Nominated by a patient**

I am nominating Mukuka for a Star Award for making me feel well informed and cared for during my time in ED. I was in severe pain, and when Mukuka brought me in to speak with him, he was caring and open and made me feel listened to. Mukuka explained everything he was doing during my examination and why, which was extremely refreshing because, as a patient, you do not always understand what is happening. I was told what was being ruled out and why, and then what my next steps were going to be and why.

It seems simple why I am so happy, but these explanations mean so much. It gave me the trust and clarity needed that I would be cared for. Thank you so much, Mukuka, for taking care of me and being such a kind and warm person for people in distress.

Hearing aid repairs **York** **Nominated by a patient**

What a great service from the team repairing hearing aids. I contacted them regarding my damaged hearing aid. I received a speedy response with concise and clear instructions about how to send my hearing aid in for repair. I then received a call the day I'd dropped it off to say it had been repaired and would be available the following morning for me to collect. I received similarly clear instructions about collection from reception at York Hospital. A great service considering that I'd anticipated days, possibly weeks, of waiting.

Lisa Laverick, Clerical Assistant **York** **Nominated by a patient**

I had an issue with medication that needed an instant response. Lisa started working through the history and got back to me very quickly with a result that put me at ease. She was very polite and professional.

Holly West, Staff Nurse **York** **Nominated by a patient**

I came in due to self-harm and have dissociative identity disorder. I was presenting as a different personality, and Holly addressed me as such, which is validating and makes me feel safer. She really made me feel seen, looked after and safe. She facilitated me getting fresh air with staff to help me cope, checked in on me, and printed out word searches, etc., as distractions.

She also kept me well informed about what was happening and kept a close eye on me when I wasn’t feeling safe in myself despite a very busy shift. Her demeanour was kind, caring and smiley. I felt very well looked after. You can tell she truly cared and it wasn’t just a job.

William Lea, Specialty Doctor **York** **Nominated by a patient**

I had concerns about a procedure and asked to speak with someone. William came and spoke to me away from others. He went back to the beginning of what had been happening instead of rushing through with the immediate issue and took time to talk with me, give me information that I asked for and answer my questions. He listened and explored with me long enough that I got to the bottom of what had been bothering me. Something I hadn't realised had been sitting with me for approximately 30 years!

He showed real understanding and empathy and gave me an idea of what I could do going forward about this issue that had been bothering me. At the end of our discussion, I felt fully informed to decide on my treatment. Had he not been the way he was, I would have felt much more anxious or not had the advised treatment at all.

Michelle Shore, Midwife **York** **Nominated by a patient**

I had my baby at York Hospital, and the midwife looking after me was Shelly Shore, along with a student midwife. My birth didn’t go to plan, and I needed a C-section. I had previously mentioned that I was very anxious about giving birth this time, as I had a traumatic experience with my last birth. Shelly and the other midwife did not leave my side all the way through labour and the C-section. She explained everything that was happening and looked after my family and me all through our journey.

I have previously had bad experiences which caused anxiety, but Shelly and the other midwife have changed my whole outlook on things. I can’t thank them enough. Please recognise them for their hard and lovely work.

Nasser Ayoubi, Associate Specialist **York** **Nominated by a patient**

I saw Nasser Ayoubi on Monday evening for an impacted earring. I had been passed around various people and hospitals all day, so I was very anxious and in tremendous pain. Mr Ayoubi has got the most incredible bedside manner and put me at ease. He spoke so calmly and gently and gave me so much confidence that he would be able to help me within minutes. He came to see me on the ward before he went home, and did a wonderful job reassuring me before my surgery the next morning.

My surgery was a success, so much so that I was discharged after a few hours and didn't need any pain medication. What a fantastic colleague he is, and someone who deserves to be recognised not only for their clinical ability but for their humanity and kindness.

Susan Cowley, Midwife **York** **Nominated by a patient**

I came into Triage with concerns in the evening. Sue instantly made me feel at ease and reassured. She explained the full plan and why we were doing each step. She asked questions and ensured I understood the information and was happy before we proceeded. I am a first-time mum with diagnosed anxiety, panic disorder and autism. All of which is detailed in my health passport and birth plan. Sue clearly had read through this very thoroughly and ensured she helped me in a way that truly calmed me and that I understood.

I easily get panicked and overwhelmed, and I can't thank her enough for the way she approached helping me. Both my partner and I were amazed by how she made me feel. She really went above and beyond and read about me as a person and what helps me.

Labour Ward **Scarborough** **Nominated by a patient**

We welcomed our first baby boy into the world on Monday. We could not have asked for a more positive and supportive team throughout the whole process, from the team of midwives, the nurses, and anaesthesiologists, to the healthcare assistants, community health workers, paediatricians, and more. Everyone went above and beyond to make sure my birth partners and I felt comfortable, respected and dignified.

A special thank you to Fern and Becky, who did not leave my side during their entire shifts and made sure I felt supported during the entirety of my labour and also looked after my birth partners. I will never forget my experience, and I will be forever grateful for the people who helped me along the way. Everyone was so incredible; thank you all so much.

Clare Sanders and Emily Riley, Midwives **York** **Nominated by a patient**

I went into labour on Sunday morning with my second baby. Upon arriving at triage at around 11.15am, Chloe was the first midwife we came across and, just like them all, she was absolutely brilliant. She confirmed I was 6cm dilated and that I wouldn't be going home, which was a huge relief to both me and my husband!

When arriving on the labour ward, after opting for a water birth, I was greeted by Clare and Emily. They looked after us so well - they were so thorough, attentive and reassuring throughout. They made the whole experience so wonderful for us. We welcomed our baby boy, Sebby, within 90 minutes of arriving in the room, and Clare and Emily were just wonderful before, during and after his birth. We felt so well cared for and supported every step of the way.

I will always be so grateful to the team of midwives at York for helping me deliver both of my boys and for giving us the best possible experiences. I really wanted to take the time to recognise Clare Sanders and Emily Riley for the amazing care they gave us. Thank you so much for everything.

Katie Collins, Midwife **York** **Nominated by a patient**

I can't thank Katie enough for delivering my baby. She was amazing, putting me at ease and being wonderful.

Kerry Jozefowicz, Midwife **Scarborough** **Nominated by a patient**

I had a precipitous labour with my second-born. I had an episode of psychosis straight after the birth. Kerry spoke with me all night, calmed me down, made adjustments to my care, allowed me to stay in the labour room, allowed my mum to come in and set her up a bed, and took care of my newborn when I couldn't face having him in the room. She did a lot more, but I struggle to talk about it as I still find it traumatic. I can't thank her enough, and she deserves to be recognised.

Maple Ward **Scarborough** **Nominated by a patient**

I am nominating Maple Ward for the warmth, kindness and genuine care they showed me when I was admitted to hospital. Being admitted to hospital is scary and daunting for anyone, but I think when you work in the hospital yourself, it feels even harder. You know the environment, and you know the staff, so suddenly being the patient instead of the person looking after someone else is a strange and vulnerable feeling.

Sharji, IJ and Matt, along with Mandy, Wendy, Mel and Freya, were amazing with me. They were so busy, but they still made the time to check on me, talk to me, comfort me and just be there when I really needed someone. They made what was genuinely the hardest day and night of my life a little bit easier. I especially want to mention Freya, who is bank staff. She was there throughout the whole night and was just so lovely. She sat with me, listened to me and made me feel like I wasn't on my own. Sometimes it's the little things that mean the most, and her kindness really did mean so much to me.

I'd had a traumatic experience with another member of clinical staff and got to the point where I just wanted to leave. I was very upset and overwhelmed, but the staff on Maple were so patient with me. They helped calm me down, didn't judge me and gave me the space I needed, while still making sure I was okay. I know how busy wards are and how much pressure staff are under, which is why I don't think their kindness should go unnoticed. They could have just carried on with everything they had to do, but instead they took the time to look after me as a person, not just another patient. I honestly can't thank them enough. They made a heartbreaking experience feel a little less painful, and I will always remember the kindness they showed me. They really deserve to be recognised for it.

Claire Riley, Deputy Sister **York** **Nominated by a relative**

Claire was leading the care for my mum. They were short-staffed, and she was swiftly moving from one interaction to another. She kept a lovely, kind demeanour throughout it all and was able to field my many questions and requests (I have a habit of asking a lot).

Honey Dineen, Midwife **York** **Nominated by a relative**

Our son was born, through some difficulty, on an afternoon in August. All the midwifery team were excellent and supportive. We will always be grateful for your exemplary hard work.

After the birth, our son struggled to establish feeding. Honey was extraordinarily supportive of us. She was completely upfront with us about our need to stay longer on the ward than perhaps we wanted. Honey was exactly the person we needed in that moment. The following morning, Honey was kind and helpful to us. I feel amazingly lucky to have our son and my wife supported by someone like her.

Benjamin Hawley, Staff Nurse **Scarborough** **Nominated by a relative**

My mum is currently on Oak Ward and has been for quite a while. Things have changed quite considerably for my mum with her condition while she has been on Oak Ward. I have struggled with dealing with this, but Ben, even though he hasn't always been the nurse looking after my mum, has found time to ask me how mum is doing and how I am doing and coping with everything. He is never too busy to offer his support or answer questions. He is lovely with my mum and always takes time to check in on her when passing, despite her not always being a patient on his bay.

Christopher Smith, Patient Services Assistant **York** **Nominated by a relative**

Chris was always so kind and friendly; he really took his time and care with the patients. I noticed it when visiting my mother-in-law. He's greatly missed when he's not here.

Hannah Churchill, Healthcare Support Worker **York** **Nominated by a relative**

Hannah was very cheerful and helpful to a variety of people and was totally aware of what needed to be done, including simple things that make a difference, such as getting chairs or blankets for people. She went out of her way to assist patients and those with them in any way she could, to try to make the stay in the department more bearable.

Don Sumilang, Acute NIV Specialist Nurse **York** **Nominated a relative and a colleague**

Nomination 1

I wanted to take this opportunity to commend the practice of Don Sumilang. My mum has been in Ward 34 for the past three weeks and has generally had excellent care. However, the care from Don has been exceptional. Don has made my mum feel safe, and when you are feeling vulnerable and dependent on others, this cannot be underestimated. He did this by being a consummate professional, using his clearly extensive knowledge and skill to provide excellent care. He always made sure that mum understood what was happening and why, managing her care and advocating for her when required. His calm and reassuring manner made a huge difference to how she felt; she felt heard, and when things weren't clear, he took time to explain and reassure.

I have been a registered nurse for years, and my expertise is advanced practice with a background in critical care, and I was impressed and thankful for Don's clinical knowledge and skill. I was with my mum one evening when she was deteriorating, and Don intervened to support her when it was clear that other staff needed support. His intervention prevented further deterioration, and I was very grateful for his timely intervention and direction.

Nomination 2

Don is always very helpful during periods of high workload. He always treats patients with care, compassion and kindness. He puts the patients' best interests first, deals with unwell patients, and remains calm. He supports families with his knowledge and takes the time to explain the plan for the patient. He also supports colleagues during hard and stressful times. He supports the ward when it becomes busy by helping with different jobs. Don's hard work never goes unnoticed! We are very appreciative of him. He never fails to put smiles on our faces.

Olivia Swain, Deputy Sister **York** **Nominated by a relative**

Liv is a fantastic nurse. Willow (my daughter) is extremely nervous around the nurses, but because of how kind and caring Liv is, she has managed to bring Willow out of her shell when she is an inpatient. She always makes time to come to see us when we are in, and seeing and speaking to her puts me at ease. She is kind, caring and compassionate, and her bedside manner is impeccable. No question or need is too much.

Each time she has looked after Willow, it has been and is, such a relief to have her caring and looking after Willow. Liv is wonderful, and she will go so far and make so many more parents and children feel at ease with her nursing. Keep being wonderful and the best nurse, Liv; you deserve this Star Award more than anyone!

Cath Stone, Patient Services Assistant **York** **Nominated by a relative**

My mum was sent to SDEC from her GP surgery. All the staff were wonderful, very efficient and caring. Cath was so supportive, kind and caring towards my mum and myself at this worrying time. She worked with a smile on her face, and nothing was too much trouble. She is a credit to the department, as all the staff were.

Zanele Gaule, Staff Nurse **York** **Nominated by a relative**

I am nominating Zanele from the Endoscopy Department for a Star Award for the exceptional kindness, compassion and care she showed to both my auntie and me. My auntie had been admitted to hospital following an attempt to take her own life, following the devastating death of her husband, with whom she had shared a long life. She was grieving an enormous loss and was incredibly vulnerable, frightened and overwhelmed.

From the moment Zanele became involved in her care, she treated my auntie with such patience, dignity, compassion and understanding. There was no judgement, only kindness. She took the time to explain everything clearly, never made us feel rushed, answered our questions and, most importantly, continually reassured my auntie when she was scared and struggling. At what was undoubtedly one of the darkest and most difficult times of her life, having somebody show her that level of humanity and compassion meant more than I can put into words. Sometimes it is not just the medical care that people remember, but the way somebody made them feel during one of the worst moments of their life. She genuinely left an imprint on both of us, and we have spoken about her kindness since.

I don't think she will ever fully realise how much her patience, reassurance and humanity meant to us that day. When someone is grieving such an enormous loss and has reached a point where life has become too much, being treated with genuine kindness and dignity matters enormously. We are incredibly grateful that she was there. She is an absolute credit to the Endoscopy Department and to York Hospital, and I would really like her kindness, compassion and the difference she made to us both to be recognised. Thank you for making an incredibly difficult and frightening day a little bit easier. We will both remember your kindness for a very long time.

Loz Brough, Patient Services Operative **York** **Nominated by a relative**

I am nominating Loz from Ward 24 for a Star Award. Overall, the care my auntie has received on Ward 24 has been wonderful, but there are a couple of members of staff who have really shone, and Loz is absolutely one of them. They’re the type of person my auntie needed around her to try lift her spirits after losing her husband. What a guy! He is genuinely such a lovely person. Kindness and positive energy seem to radiate from him, and you can see the difference he makes when he walks onto the ward. He is friendly, attentive and caring towards not only the patients, but their relatives and friends too. He takes the time to speak to people, makes patients smile and has a brilliant sense of humour.

During what can be frightening, sad and uncertain times for patients and their families, having somebody who can bring a little bit of light and laughter into the room is incredibly special. Nothing seems like too much trouble for him, and you can see that he genuinely cares about the people he is looking after. He goes above and beyond, and that doesn't go unnoticed.

People like Loz can completely change someone's experience of being in hospital. His warmth, humour and kindness have certainly made a difference to ours. Loz, thank you for being you and for bringing so much positivity to Ward 24. You are an absolute credit to York Hospital and thoroughly deserve to be recognised.

Adele Fearn, Healthcare Assistant **York** **Nominated by a relative**

I am nominating Adele from Ward 24 for a Star Award for the kindness, compassion and time she gave to my auntie. My auntie has recently lost her husband, with whom she shared a long life, and was admitted to hospital following an attempt to take her own life.

Understandably, she has been going through an incredibly dark and difficult time. After spending an afternoon with Adele, however, we saw such an uplift in her. They had been singing and dancing along to the radio, talking and spending time together, and it was genuinely lovely to hear. At a time when my auntie has had very little to smile about, Adele managed to bring some happiness and normality back into her day. More importantly, my auntie felt able to talk to Adele. She spoke so highly of her afterwards and was genuinely grateful to have had somebody she felt comfortable opening up to.

When somebody is grieving and struggling to see a way forward, being able to smile, sing, dance and talk for an afternoon might sound like something small, but to their family it is enormous. Seeing even a little glimpse of that person coming back means more than I can explain. Adele gave my auntie some light during an incredibly dark period of her life, and as her family, we are extremely grateful for that. Thank you, Adele, for giving her your time, for listening to her and for making her smile. Your kindness made a genuine difference to her, and she hasn't forgotten it.

Karen Dennis, Staff Nurse **York** **Nominated by a relative**

I am nominating Karen from the Endoscopy Department for a Star Award for the kindness and compassion she showed me during an incredibly difficult time. My auntie had been admitted to hospital following an attempt to take her own life after the devastating death of her husband, with whom she had shared a long life.

While my auntie was having her camera procedure, Karen took the time to speak to me and, more importantly, to listen. I was trying to hold everything together and be there for my auntie, while naturally carrying a lot of emotions myself. Karen gave me the time and space to talk about what had happened and what we were going through. She listened with genuine kindness, empathy and absolutely no judgement. She didn't need to have all the answers or make the situation better - sometimes you simply need somebody to listen, and that is exactly what she did for me. It may have seemed like a small gesture to her, but at such an emotional and overwhelming time, it meant a great deal to me. Her kindness gave me a little bit of comfort during an incredibly difficult day, and I won't forget that.

Karen is a credit to the Endoscopy Department and to York Hospital. I would really like her to be recognised for the compassion she showed not only as a healthcare professional, but simply as one person showing kindness to another when it was needed most. Thank you, Karen, for giving me your time and for listening. It genuinely meant more than you probably realised.

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

My six-year-old son was in the ED with a broken arm. The care given by the whole team was fantastic, but particularly from Jason, who acted as both a healthcare professional and as a children's entertainer, putting my son at ease with his warmth, kindness and magic tricks! We were there for four hours under observation, and Jason must have been in to see us about 10 times to check in, offer snacks and drinks, and entertain my son with jokes and tricks. He also put a cast on my son's arm and chaperoned us back and forth from X-ray. All of this was done with care for the patient at the heart of it. I have never had such a brilliant experience in a hospital. Jason is a real credit to the NHS and York Hospital, and I hope that he receives this recognition.

Lottie Gilham, Staff Nurse **Scarborough** **Nominated by a relative**

Lottie has looked after my mum on Oak Ward over the last few weeks. Lottie has always gone above and beyond to keep us updated on the ever-evolving changes in my mum's condition. She explains things in an easy-to-understand manner. She is methodical, hardworking, conscientious and good-humoured. She treated my mum with kindness, understanding, and compassion and was very patient with her. I felt very reassured when Lottie was looking after my mum.

Sadly, my mum doesn't have a good outlook, and we are looking to bring her home as her life draws to a close, but I, along with my family, are very grateful to Lottie. She has stood out, along with another nurse (whom I have also nominated), for their kindness both with my mum and with myself, as I've had a hard time dealing with and accepting the reality of my mum's condition.

Ward 15 **York** **Nominated by a relative**

My dad had a nasty fall on a Friday night and was admitted to Ward 15 for observations. This was the first time my dad had been admitted to hospital for something serious, and it was a scary time for my mum and me.

Everyone on Ward 15 was so incredibly helpful and nice while we visited. Any questions we had, they got us answers and kept us updated. My dad ended up staying on Ward 15 for three weeks, so we got to know the team, and they always made us feel welcome and chatted with us. When my dad started to feel better, he also had some good chats with the team. A shoutout to Merin, who chatted to my dad about Indian culture, as before the fall, Dad was researching Indian spices and curries to make a curry that uses authentic spices and techniques.

Another special shoutout to the team that handled my dad's seizure when he was on the ward. My mum found my dad not responding on the toilet. HCA Liam was walking past, and I shouted to him, He jumped straight in, got Beckie, the charge nurse on duty, and they both got right in and called all the necessary people who were there in seconds to get my dad back to bed and look at him. The student nurse/HCA doing the nursing apprenticeship was also amazing. I knew this was a great training moment, but she kept coming over to make sure Mum and I were okay and updating us with what she could while also learning and getting stuck in. She will make a great nurse. Steve, Karen and another lady (sorry, I can't remember her name) who came round and did the teas, coffees and food were so lovely and always stopped for a chat. Also, special shoutouts to Olivia, Katie, Merin, Emma, and Rachael. They all looked after my dad and did amazingly well.

If I ever get admitted to hospital, I would want to be looked after by the team on Ward 15. I can't thank them enough for what they did for my dad and for us. Dad is also planning to bake some cakes for them when he's better. They deserve all the recognition for what they do on such a busy ward.

Bill McIntyre, Patient Services Operative **York** **Nominated by a visitor**

Billy is a joy to see on the ward. We've been visiting for the past three weeks, and every day we have seen Billy lighten the mood in the bay. His kindness shines through, and he is patient with people, especially when it comes to my mum, who still hasn't quite worked out how the menus work. Thank you, Billy.

Item 11

Report to:	Trust Board
Date of Meeting:	28th October 2026
Subject:	Annual Operating Plan Update – Quarter Two
Director Sponsor:	Clare Smith, Chief Executive
Author:	Tilly Nightingale, Head of Strategy and Planning

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The Annual Operating Plan (AOP) 2026/27 established three organisational priorities, supported by four multi-year enabling programmes. This paper provides the first quarterly assurance report following approval of the final AOP and sets out the position at the end of Q2.

The report brings together Senior Responsible Officer assessments of progress against the three organisational priorities, including performance against agreed trajectories, delivery of key milestones, risks and mitigating actions. The updates have been considered by Resource Committee, which advised that the levels of assurance are

reflected in its Committee escalation reports provided to Board at each meeting. Quality Committee has provided specific assurance and exceptions for Coming off Corridors, which are reflected in this report and the detailed update at Appendix 1.

The Q2 position is mixed. There is evidence of progress in delivery across the organisational priorities, although this has not yet translated consistently into improvement across all agreed outcome measures. Coming off Corridors and Leadership, Values and Behaviours are assessed Amber, while significant performance pressures remain within Outpatient Transformation - Planned Care.

The report also provides an update on the four multi-year enabling programmes: Clinical Strategy, Electronic Patient Record - Nervecentre, Continuous Quality Improvement / Better Together and Living Within Our Means. Assurance for these programmes is drawn from their established programme, Executive and, where appropriate, Board committee governance arrangements.

Alongside delivery of the 2026/27 AOP, work with KPMG through the Continuous Quality Improvement programme is developing the Trust approach to strategy deployment, priority setting and delivery. This work has commenced with the Executive Team and will inform a different, more systematic approach to organisational priorities, delivery and assurance for 2027/28. The agreed AOP arrangements remain in place for 2026/27.

Recommendation

Trust Board is asked to:

- Receive the Q2 position against the 2026/27 Annual Operating Plan.
- Consider the assurance provided through the SRO updates, Resource Committee escalation reports and established programme governance.
- Note the Quality Committee assurance and exceptions for Coming off Corridors, including the need for continued scrutiny as winter demand increases and transformation is delivered through existing resources.
- Note the material exceptions and recovery actions, particularly the Red and Partial assurance position for Living Within Our Means.
- Consider whether any additional assurance, support or intervention is required.

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
Resource Committee	20th October 2026	The levels of assurance are reflected in the Committee escalation reports provided to Board at each meeting.
Quality Committee	20th October 2026	Coming off Corridors: assured by the breadth of

		engagement and planned monthly reporting. Not assured about increasing winter demand and the transformation required from existing resources. Potential future dashboard reporting; matters escalated through the Committee report.

Annual Operating Plan – Quarter Two Update

1. Introduction and Background

The Annual Operating Plan 2026/27 sets out the Trust's three organisational priorities for the year:

- Coming off Corridors
- Timely Care
- Leadership, Values and Behaviours.

These priorities are supported by four multi-year enabling programmes:

- Clinical Strategy
- Nervecentre - Electronic Patient Record (EPR),
- Continuous Quality Improvement (CQI)
- Living Within Our Means.

Together these form the Trust delivery framework for 2026/27, linking immediate organisational priorities with the longer-term transformation required to sustain improvement.

The AOP committed to quarterly reporting to Board, bringing together performance against agreed measures, progress against delivery milestones, key risks and mitigations, and matters requiring escalation or Board attention. The purpose is not to duplicate existing programme, performance or committee reporting, but to provide a consolidated view of delivery, impact, risk and assurance.

- where delivery is against the commitments made in the AOP
- whether planned activity is being delivered
- whether this is translating into the intended impact
- areas which remain off trajectory
- the actions being taken in response
- the assurance and scrutiny applied through the relevant governance arrangements.

As the final AOP was approved during Q1, this is the first quarterly delivery and assurance report and provides the position at the end of Q2.

2. Q2 Overview of Priorities: Delivery and Assurance

Detailed Q2 assurance updates for each of the three organisational priorities are provided at Appendix 1. These set out the SRO assessment of overall delivery, performance against agreed trajectories, progress against key milestones, risks and mitigating actions, and matters requiring escalation or Board attention.

Coming off Corridors is assessed Amber. Programme mobilisation is complete, governance and priority workstreams are established and Emergency Department corridor-care episodes reduced during Q2. However, inpatient corridor-care episodes increased and overall improvement is not yet statistically significant.

Timely Care - non-cancer planned care is assessed Red. The total waiting list increased from July to September. At the end of Q2, 18-week RTT performance was off trajectory and more patients than planned trajectory were waiting more than 52 weeks. Progress has been made in strengthening specialty recovery plans and RTT governance, improving clinic utilisation in some specialties, expanding PIFU and progressing Single Point of Access. However, referral growth, outpatient capacity, workforce gaps, estate delays and reduced recovery funding continue to constrain delivery. The March total waiting-list trajectory is forecast to be achieved, but the 52-week and 18-week standards are not.

Timely Care - cancer is assessed Amber. The Trust continued delivery of its Cancer Performance Improvement Strategy across operational grip, demand management, tumour-site transformation, diagnostic recovery, digital improvement and workforce resilience. Faster Diagnosis Standard performance has improved and the Trust remains the highest-performing provider in Humber and North Yorkshire across the Faster Diagnosis, 62-day and 31-day standards. At the end of Q2, the 31-day standard was above trajectory, while Faster Diagnosis and 62-day performance remained below trajectory. Delivery of the 2026/27 trajectory remains achievable but high risk because of referral growth, diagnostic constraints, workforce fragility, variation between tumour sites and delayed capital programmes.

Leadership, Values and Behaviours is assessed Amber. Programme activity has progressed, including the Big Conversation and development of the refreshed Values and Standards of Behaviour Framework, although sickness absence remains above trajectory and has not yet demonstrated the intended programme impact.

2.1. Overall, the Q2 position shows progress in delivering the agreed programmes and interventions, but this is not yet consistently reflected in the outcome measures. The assurance provided to Board therefore considers delivery against the commitments made in the AOP, the extent to which this is translating into intended impact, and the risks, mitigating actions and governance oversight in place.

2.2. Committee assurance

Resource Committee considered the Q2 reports for Coming off Corridors, Leadership, Values and Behaviours, and Outpatient Transformation. The Committee recorded the same position for all three reports: “The levels of assurance are reflected in the Committee escalation reports provided to Board at each meeting.”

The Resource Committee position is therefore not repeated as a separate programme-by-programme assurance judgement in this report. Board should read the detailed

SRO updates at Appendix 1 alongside the Resource Committee escalation report for the relevant meeting.

Quality Committee considered Coming off Corridors and provided specific assurance and exceptions. The Committee was assured by the breadth of engagement in developing the plans, while recognising that this had taken place over a relatively short period and that future monthly reporting would be required. The Committee was not assured about the position entering winter, given increasing demand and the scale of transformation required from existing resources. Future dashboard reporting was identified as a potential development, and these points were escalated through the Committee report.

Priority	Resource Committee position	Quality Committee position
Coming off Corridors	Assurance reflected in the Committee escalation report to Board.	Assured by the breadth of engagement in developing the plans and the intention to report monthly to Quality Committee. Not assured about the position entering winter, with increasing demand and transformation required from existing resources. Potential future dashboard reporting; matters escalated through the Committee report.
Outpatient Transformation - Planned Care	Assurance reflected in the Committee escalation report to Board.	Not applicable – report is not received by Quality Committee
Leadership, Values and Behaviours	Assurance reflected in the Committee escalation report to Board.	Not applicable – report is not received by Quality Committee

3. Q2 Enabling Programme Update

Detailed Q2 updates for each of the four multi-year enabling programmes are provided at Appendix 2. These set out delivery against the commitments in the AOP, the evidence supporting the reported position, benefits and impact, key risks and mitigating actions, governance arrangements and matters requiring Board attention.

This section provides an overarching summary of the position across the four programmes rather than repeating the detailed evidence contained in the individual updates.

3.1. Clinical Strategy Development and Early Implementation

RAG: Green | Reasonable assurance on foundation-year delivery

The AOP identified 2026/27 as a foundation year for the Clinical Strategy, focused on establishing clinical ownership, developing and testing pathway redesign, identifying opportunities for early implementation and putting in place the mechanisms required to support change.

During Q2, development of the Clinical Services Strategy continued towards Board consideration. Frailty has been identified as the first strategic pathway priority, with the Social Finance Trailblazer providing early enabling work for partnership-based frailty

pathway development. The Trust Board Strategic Planning Event on 21 October supports further testing of the emerging direction and transition into implementation planning.

The approach to implementation is also becoming clearer through the development of Better Together and the Strategic Planning Framework. The Clinical Strategy will be implemented as a Strategic Initiative within this framework, linking its priorities to accountable delivery, performance review and the Trust's developing daily management system. This is intended to ensure that delivery of the Clinical Strategy is integrated with the Trust's wider strategy deployment and improvement approach, rather than operating as a separate programme of work.

The Q2 position therefore demonstrates progress in establishing the strategic framework and the mechanisms through which it will be delivered, alongside early work to enable implementation. Future assurance will focus increasingly on prioritised pathway change, clear ownership and delivery arrangements, and measurable impact.

3.2. Electronic Patient Record

RAG: Green | Reasonable assurance

The EPR programme has continued to progress during Q2, with the successful implementation of Tranche 2 representing the principal delivery milestone during the period. Following go-live, the programme has moved into optimisation and adoption, supported by continued training, digital readiness and digital champion activity. Planning and design for Tranche 3 is also underway towards the planned June 2027 implementation.

This represents good progress against the commitments made in the AOP, which identified continued rollout, optimisation, expansion of functionality and adoption, and ongoing training and digital champion support as the principal areas of delivery during 2026/27. The specific commitment for Tranche 2, anticipated in late August 2026, has been achieved.

The focus is now increasingly moving from implementation to benefits realisation. EPR functionality is intended to support patient flow and bed management, more coordinated outpatient and diagnostic pathways, improved access to information and staff experience. However, implementation of the functionality alone does not demonstrate that these benefits have been realised. Continued assurance will therefore need to draw increasingly on adoption data, operational outcomes and validated productivity and financial benefits.

Benefits are monitored through EPR programme governance, with relevant financial, productivity and efficiency benefits also linked to the Waste Reduction and Productivity Programme. The programme is supported by established governance arrangements including programme management, clinical and operational design, resilience and Executive oversight.

Overall, the Q2 position supports a Green assessment and reasonable assurance. The principal milestone due during the period has been delivered and the wider 2026/27 commitments are progressing. The next assurance test will increasingly be whether this delivery is translating into the intended organisational benefits.

Further evidence of delivery against the individual AOP commitments is provided at Appendix 2.

3.3. Continuous Quality Improvement: Better Together

RAG: Green | Reasonable assurance

The CQI programme is delivering against its Q2 foundation and mobilisation commitments. Key progress includes appointment and mobilisation of the strategic delivery partner, workforce engagement relating to values and behaviours, establishment of Better Together as the Trust's improvement methodology and continuing development of the Quality Management System and programme roadmap.

The programme has therefore established important elements of the infrastructure and approach required by the AOP. However, implementation of the methodology or mobilisation of the strategic partner are not, in themselves, evidence of improvement outcomes.

The next phase of assurance will increasingly focus on adoption and impact, including consistent use of Better Together, organisational capability, evidence of improvement against priority outcomes and delivery of measurable productivity and financial benefits.

The AOP provides for CQI assurance through formal programme management and monthly reporting to Executive Committee, including progress against milestones, risks, benefits trajectory and capability transfer.

Overall, the Q2 position supports a Green assessment and reasonable assurance that the foundation and mobilisation commitments are progressing. The next assurance test will increasingly be whether the developing Quality Management System and Better Together approach are being embedded consistently and translating into measurable improvement and benefits.

3.4. Living Within Our Means

RAG: Red | Partial assurance

The approved financial plan changed after the AOP was written. The AOP referenced a £22.646m deficit and £61.6m WRAP requirement. The final plan agreed with NHS England is an £18.5m deficit before Deficit Support Funding and a £65.7m WRAP requirement. The Q2 position is assessed against the latest approved financial plan while retaining visibility of the original AOP commitments.

At the end of September, the adjusted year-to-date deficit excluding DSF was £18.4m against a planned £9.2m deficit, an adverse variance of £9.2m. The variance deteriorated from £6.3m at Month 5 to £9.2m at Month 6. Delivery of the approved £18.5m year-end deficit is currently the best-case scenario; the mid-range forecast is £30.5m and the worst-case forecast is £45.5m.

WRAP remains the principal financial delivery risk. Month 6 delivery was £24.7m against a cumulative target of £31.8m, a £7.0m shortfall. Full-year savings delivered were £34.5m against the £65.7m requirement. The shortfall has partly been managed through deferred investment and other non-recurrent measures, which do not reduce the underlying cost

base. Finance has subsequently reported that the WRAP programme is now fully planned, which is a significant post-Q2 milestone; assurance now depends on conversion into recurrent delivery.

Agency expenditure was £0.5m favourable to the Month 6 plan, but bank expenditure was £5.8m adverse, leaving combined bank and agency spend £5.3m adverse to the Q2 trajectory. Medical and dental staffing remains the principal operational pay pressure.

There is clear visibility of the adverse position, established financial governance and specific recovery actions. However, material delivery gaps remain and the evidence does not support reasonable assurance that the AOP financial outcomes will be achieved. The position is therefore Red with Partial assurance.

4. Overall Assurance and Next Steps

The Q2 report provides a consolidated view of performance, delivery progress, risk and mitigating action across the organisational priorities and enabling programmes. Resource Committee assurance is reflected through its escalation reports to Board. For Coming off Corridors, Quality Committee provided additional assurance on the breadth of engagement and the planned monthly reporting route, while highlighting concern about increasing winter demand and the transformation required from existing resources.

The overall position demonstrates that programme activity is progressing, but intended outcomes are not consistently being achieved. This is most material within planned care and financial recovery. The Board should therefore consider not only the reported RAG positions, but the evidence, governance and recovery actions supporting them.

Work with KPMG through the CQI programme continues in parallel to develop the Trust future approach to strategy deployment, priority setting and delivery for 2027/28. This does not change the agreed AOP governance and reporting arrangements for 2026/27.

Appendices

Appendix 1: Organisational Priority Q2 SRO Assurance Updates.
Appendix 2: Multi-Year Enabling Programme Q2 Updates.

Date: 20/10/26

APPENDIX ONE: Organisational Priority Q2 SRO Assurance Updates

ANNUAL OPERATING PLAN 2026/27 – Q2 UPDATE

COMING OFF CORRIDORS - QUARTERLY SRO ASSURANCE UPDATE

Priority Name	SRO	Quarter	Reporting Date
Executive Sponsor	Chief Nurse	2	20th October 2026

1. OVERALL DELIVERY ASSESSMENT

Overall RAG	Executive summary, maximum 100 words
AMBER	Q2 is rated Amber. Programme mobilisation is complete and the five priority workstreams, governance and trajectories are in place. ED corridor-care episodes reduced from 71 in July to 58 in September, 11 below trajectory. Inpatient episodes increased from 25 to 29, five above trajectory; nevertheless, total September episodes were 87 against a trajectory of 93. Average corridor-care duration is reducing, indicating early benefit, but improvement is not yet statistically significant. Delivery confidence is moderate and dependent on timely Q3 implementation, Care Group accountability and protected senior clinical and operational capacity.

2. PERFORMANCE AGAINST AGREED METRICS

Metric	Q2 target / trajectory	Current position	Direction of travel	RAG
Average number of corridor care episodes: ED	69	July: 71 August: 61 September: 58	Improving: 71 to 58; September 11 below trajectory	**Amber**
Average number of corridor care episodes: Inpatient	24	July: 25 August: 26 September: 29	Deteriorating: 25 to 29; September 5 above trajectory	**Red**

3. DELIVERY PROGRESS AND KEY MILESTONES

Significant achievements this quarter	Delayed or off-track milestones	Key milestones due next quarter
• Organisation-wide engagement, workshops, drop-ins and direct observations completed, generating a consolidated evidence base for improvement. • Five priority workstreams agreed: ward/board rounds and criteria-led discharge; site management and escalation; EAU; SDEC/ambulatory pathways; and Internal Professional Standards. • Programme governance, Q2–Q4 trajectories and the Signal dashboard established; corridor spaces risk assessed and the highest-risk spaces identified for closure.	• Inpatient corridor-care episodes increased from 25 to 29, five above trajectory. This may reflect pressure transferring from ED or increased turnover as corridor stays shorten; the cause is not yet confirmed and will be monitored through Q3. • The targeted improvement phase begins in Q3; current ED improvement therefore provides early assurance but not yet evidence of sustained system impact. • Delivery remains contingent on protected senior clinical and operational capacity and consistent Care Group ownership.	• Close the highest-risk corridor spaces; any exceptional reopening will require executive on-call approval. • Implement Care Group ward-to-board reporting, including delivery, outcome, risk and exception measures. • Commence targeted improvement across all priority workstreams and monitor impact from October. ○ Pilot revised ward and board rounds and criteria-led discharge, supported by NerveCentre functionality. ○ Complete reviews of EAU, SDEC, ambulatory and direct pathways, and launch Scarborough EAU rapid improvement activity.

• Corporate risk register and Board Assurance Framework updated to reflect corridor care as an organisational priority.		○ Implement a revised site management and escalation model. ○ Align Internal Professional Standards with National Clinical Operating Standards.

4. KEY RISKS AND MITIGATING ACTIONS

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Protected senior clinical and operational capacity is not consistently available, creating a risk to the pace and quality of Q3 design, testing and implementation.	• Named clinical and operational leads are in place for each workstream, supported by visible SRO oversight. • Care Groups are required to prioritise and release capacity for pathway review, testing and implementation. • Delivery and exceptions will be monitored through ward-to-board and Quality Management System reporting. Residual risk: Q3 milestones and benefits may slip if capacity is not protected.	**Amber**	Chief Nurse / Care Group Clinical Leads
Competing organisational priorities may constrain engagement and delivery capacity, reducing the pace and consistency of workstream implementation.	• Workstreams are being co-designed and tested locally to secure ownership and minimise additional operational burden. • Coming Off Corridors is being embedded in handovers, governance forums and ward-to-board reporting. • The Deputy COO and Programme Manager will map priority programmes and role impacts to identify and resolve capacity conflicts. Residual risk: competing demands may delay delivery or weaken adoption.	**Amber**	Chief Nurse / Care Group Leadership

5. COMMITTEE ASSURANCE, ESCALATIONS AND EXCEPTIONS

Relevant Board sub-committee(s)	Material assurance or exception	Date considered
Quality Committee Resource Committee	**Assurance:** mobilisation, governance, trajectories and workstream ownership are established. ED episodes reduced from 71 to 58 and total September episodes were below trajectory. **Exception:** inpatient episodes increased from 25 to 29, five above trajectory, and the improvement is not yet statistically significant. Analysis to be undertaken in Q3 to understand causal factors. **Required oversight:** committees should maintain scrutiny of Q3 implementation pace, inpatient flow, protected capacity, Care Group accountability and evidence of sustained benefit. Care Off Corridors: Quality Committee comments: (1) **Assured by:** the wide engagement of the plans, albeit over a small period of time with provision to report to the Quality Committee in future on a monthly basis. (2) **Not assured about:** it was recognised that this was an evolution of planning and with Winter rapidly approaching with increasing demand and the transformation required on existing resources. (3) **In future** potentially dashboard reporting. (4) The above escalated to report.	20th October 2026

	Resource Committee comments: 'The levels of assurance are reflected in the Committee escalation reports provided to Board at each meeting.'	

6. BOARD ATTENTION OR DECISION REQUIRED

Type	Request to Board
Note and Support	The Board is asked to: note the Amber Q2 assessment, including ED improvement and the adverse inpatient variance; support continued executive sponsorship and protected senior clinical and operational capacity for the Q3 priority workstreams; hold Care Groups to account for delivery, inpatient flow and ward-to-board exception reporting; and require assurance in Q3 that improvement is sustained, statistically supported and delivering reduced corridor-care exposure.

ANNUAL OPERATING PLAN 2026/27

OUTPATIENT TRANSFORMATION – PLANNED CARE (NON-CANCER) - QUARTERLY SRO ASSURANCE UPDATE

Priority Name	SRO	Quarter	Reporting Date
Executive Sponsor	Chief Operating Officer	2	20th October 2026

1. OVERALL DELIVERY ASSESSMENT

Overall RAG	Executive summary, maximum 100 words
Red	The total waiting list increased from 56,760 in July to 58,713 in Sept, while long waits and first outpatient access remained significant pressures. During Q2, Care Groups reviewed all specialty actions to strengthen delivery and ensure alignment to the 6 RTT priorities. Work continued to deliver outpatient reform through increasing PIFU, increasing outpatient clinic utilisation and decreasing DNA rates. Implementation of Single Point of Access (SPoA) continued with 10 specialties identified and clinical workshops undertaken with each specialty. GIRFT baseline self-assessments were commenced. However, referral growth, outpatient capacity, workforce gaps, estate project delays and reduced recovery funding continue to constrain progress. Current forecasts achieve the March total waiting list trajectory, but not 52-week or 18-week standards.

2. PERFORMANCE AGAINST AGREED METRICS

Metric	Q2 target / trajectory	End of Q2 position	Direction of travel	RAG
18-week RTT performance	RTT performance: 62.4%	57.7% (unvalidated)	Deteriorating	R
52-week RTT waits	52 week RTT waits: 529	1,316 (unvalidated)	Deteriorating	R
PIFU rates	PIFU: 5.85%	5.1%	Improving	A
% of patients who have their 1st OP attendance within 18 weeks	% of 1st OP >18wks: 63.6%	62.3%	Deteriorating	R

3. DELIVERY PROGRESS AND KEY MILESTONES

Significant achievements this quarter	Delayed or off-track milestones	Key milestones due next quarter
• Detailed specialty recovery plans completed and consolidated into six Trust-wide RTT priorities. • Reduce the longest waits • Increase first outpatient access • Deliver outpatient transformation and reduce avoidable follow-up demand • Improve productivity and delivery of planned activity • Manage GP referral demand growth • Strengthen governance, validation and enabling infrastructure • Additional Colorectal and Upper GI capacity approved in September. • Clinic utilisation improved in several specialties, including Dermatology and Rheumatology • PIFU, validation and specialty pathway redesign progressed.	• Total waiting list increased to 58,713 in September • 1,316 patients were waiting over 52 weeks; current plans do not achieve the zero trajectory. • 18-week performance remains below trajectory at 57.7% • First outpatient activity and capacity remain insufficient • Capital schemes and recruitment in key specialties remain delayed; programme arrangements are in place to monitor delivery and delays.	Plans to bring off track performance back in line with performance trajectories by December 2026. • Implement Single Point of Access (SPoA) for 10 specialties in October. • Deliver the Q3 two-week RTT-only activity initiative. • Introduce additional new-patient capacity within consultant clinics. • Implement approved Colorectal, Pain and Upper GI recovery activity. • Scope and agree the clinical validation requirements • Improve visibility of chronological scheduling and reporting to understand outlying specialty processes. • Deliver the 7-week intensive improvement project 'focus on firsts' in line with NHSE initiative.

• RTT governance strengthened through weekly PTL reviews and monthly Delivery Board oversight. • SPoA project progressed with clinical workshops undertaken in all 10 specialties.		• Implement PIFU in audiology, a high-volume specialty. • GIRFT operational and clinical lead to peer review all specialty GIRFT baseline assessments.

4. KEY RISKS AND MITIGATING ACTIONS

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Insufficient outpatient capacity - March RTT trajectories not achieved	Increase activity; optimise clinic utilisation, develop chronological scheduling tool to improve scheduling discipline. All specialities first appointment demand and capacity validated as part of 27/28 planning - Impact: More appointments and treatments; reduced long waits	Red	Claire Hansen
Referral growth above plan – increase waiting lists, long waiters	ICB to agree referral threshold for pain and for implementation and retrospective application to Pain total waiting list. Implementation of SPoA. Impact: Reduces avoidable referrals and list growth	Amber	Claire Hansen
Workforce gaps in key specialties – reduces capacity and efficiency	Targeted recruitment, locum and insourcing support. Impact: Stabilises capacity in pressured specialties	Amber	Claire Hansen
Reduced recovery funding	Prioritise funding to highest-risk specialties and productivity schemes. Impact: Protects delivery of priority activity	Amber	Kim Hinton / Sarah Barrow

5. COMMITTEE ASSURANCE, ESCALATIONS AND EXCEPTIONS

Relevant Board sub-committee(s)	Material assurance or exception	Date considered
Resource Committee	***August Resource Committee – RTT Improvement & Recovery Update Report*** ***October Resource Committee – RTT Improvement & Recovery Focused Review*** The Committee has received assurance through the RTT Improvement and recovery focused review and update reports,. Performance improvement remains achievable but high risk. Key areas requiring continued oversight include demand growth above plan, diagnostic capacity constraints, workforce resilience, delivery of elective reform transformation and focus on first project. Resource Committee comments: • 'The levels of assurance are reflected in the Committee escalation reports provided to Board at each meeting.'	20 October 2026

6. BOARD ATTENTION OR DECISION REQUIRED

Type	Request to Board
None / Note / Decision / Escalation / Support	The Board is asked to note the RTT position against plan, noting the improvements in PIFU, clinic utilisation during Q1 and Q2. Note NHSE focus on firsts initiative in October and November and Trusts response of a seven week intensive project including two weeks of RTT OP clinics for each specialty. Note that delivery of the 2026/27 RTT trajectories remains achievable but high risk. The Board is asked to support continued prioritisation of Activity Related Performance funding as agreed in planning, diagnostic recovery programmes and workforce investment.

Completion principle: Use existing programme, performance and committee reporting. Focus on exceptions, delivery confidence, risks and decisions. Do not reproduce detailed reports. Keep to one or two pages max.

ANNUAL OPERATING PLAN 2026/27

OUTPATIENT TRANSFORMATION – PLANNED CARE (CANCER) - QUARTERLY SRO ASSURANCE UPDATE

Priority Name	SRO	Quarter	Reporting Date
Executive Sponsor	Chief Operating Officer	2	20th October 2026

1. OVERALL DELIVERY ASSESSMENT

Overall RAG	Executive summary, maximum 100 words
Amber	During Q2 the Trust continued delivery of its Cancer Performance Improvement Strategy focused on six strategic themes: operational grip, demand management, tumour-site transformation, diagnostic recovery, digital improvement and workforce resilience. Sustained improvement has been achieved in FDS performance, with the Trust maintaining its highest sustained position since introduction of the standard and remaining the highest performing provider in Humber and North Yorkshire across FDS, 62-day and 31-day standards. Delivery of the 2026/27 trajectory remains achievable but high risk due to referral growth exceeding plan, diagnostic constraints, workforce fragility, variation between tumour sites and delayed capital programmes.

2. PERFORMANCE AGAINST AGREED METRICS

Metric	Q2 target / trajectory	End of Q2 position	Direction of travel	RAG
Faster Diagnosis Standard	80% (Aug trajectory) 81.4% end of Sept trajectory	Aug: 74%	Improving	A /R
31 day standard	96%	Aug: 97.9%	Stable	G
62-day standard	73.8%	Aug: 71.1%	Improving	A

3. DELIVERY PROGRESS AND KEY MILESTONES

Significant achievements this quarter	Delayed or off-track milestones	Key milestones due next quarter
• Sustained FDS performance above 73% for five consecutive months, the highest sustained position achieved since introduction of the standard. • Trust remains highest performing organisation in Humber and North Yorkshire Cancer Alliance for FDS, 62-day and 31-day standards. • Cancer Performance Improvement Strategic Plan developed with six improvement themes and tumour-site recovery plans. • £956k Cancer Alliance investment secured to support workforce development, diagnostics, pathway redesign and additional capacity. • Pathway transformation progressed across multiple tumour sites including one-stop clinics, straight-to-test pathways, virtual review processes and MDT redesign.	• FDS performance remains below the level required to achieve annual trajectory and constitutional compliance – actions in place to deliver by March 27. • Diagnostic constraints in endoscopy, CT/MRI and histopathology continue to impact pathway timeliness – Actions identified further to the Rutter review for Q3 and Q4. • Referral growth of 11% exceeds operational plan assumptions and continues to place pressure on services – discussions ongoing in ICB contract management board • Capital schemes for CT, MRI and diagnostic infrastructure remain delayed - programme arrangements in place to monitor delivery and delays. • Automated Cancer PTL tool for operational teams to support PTL management	• Tumour site specific: Implement tumour-site transformation actions including COLOFIT, one-stop clinics, virtual reviews and MDT redesign. Implement joint Head and Neck MDT arrangements with Leeds and Hull. • Progress diagnostic recovery plans for endoscopy, CT/MRI and histopathology. • Strengthen PTL management and operational grip through standardised governance arrangements across all care groups.

• Strengthened governance through twice-weekly PTL oversight, monthly Cancer Delivery Board and formal escalation processes.	• High-volume pathways including Breast, Skin, Colorectal, Lung and Gynecology remain below required trajectories – refreshed action in August 26 for Q3/Q4 delivery.	

4. KEY RISKS AND MITIGATING ACTIONS

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Higher volume tumour sites deteriorate and/or do not improve performance at required rate, impacting Trust overall position	At pace implementation of Cancer Performance Improvement Strategy and tumour-site recovery plans	R	Claire Hansen
Demand growth exceeding plan, with referrals increasing 11% year-on-year	Strengthen NG12/GIRFT referral compliance, referral vetting, capacity and demand modelling and system-wide demand management. Impact: reduces unnecessary demand and improves alignment of capacity with referrals. Dermoscopy LES resolved with ICB for further year.	A	Cancer Site Clinical Leads
Inconsistent PTL management and administrative delays impacting performance	Standardised PTL governance, twice-weekly oversight meetings, digital solutions and administrative improvement programmes. Impact: reduces avoidable breaches and improves operational control.	A	ACOOs
Diagnostic constraints across endoscopy, CT/MRI and histopathology affecting pathway timeliness	Deliver diagnostic recovery programme, maintain cancer prioritisation, improve diagnostic visibility and progress capital investments. Impact: reduces diagnostic delays and breach risk.	A	Claire Hansen

5. COMMITTEE ASSURANCE, ESCALATIONS AND EXCEPTIONS

Relevant Board sub-committee(s)	Material assurance or exception	Date considered
Resource Committee	***August Resource Committee - Cancer Strategic Improvement & Recovery Plan*** ***October Resource Committee - Cancer Progress Report*** The Committee has received assurance through the Cancer Performance Improvement Strategy and tumour-site recovery plans. Performance improvement remains achievable but high risk. Key areas requiring continued oversight include demand growth above plan, diagnostic capacity constraints, workforce resilience, delivery of tumour-site transformation and progression of capital schemes supporting diagnostic recovery. Resource Committee comments: 'The levels of assurance are reflected in the Committee escalation reports provided to Board at each meeting.'	20th October 2026

6. BOARD ATTENTION OR DECISION REQUIRED

Type	Request to Board

Note	The Board is asked to note the progress made against the Cancer Performance Improvement Strategy and recognise that delivery of the 2026/27 cancer trajectories remains achievable but high risk. The Board is asked to support continued prioritisation of cancer pathways, diagnostic recovery programmes, workforce investment and tumour-site transformation to sustain improvement towards constitutional standards by March 2027.

ANNUAL OPERATING PLAN 2026/27

LEADERSHIP, VALUES AND BEHAVIOURS - QUARTERLY SRO ASSURANCE UPDATE

Priority Name	SRO	Quarter	Reporting Date
Executive Sponsor	Interim Director of Workforce and OD	2	20th October 2026

1. OVERALL DELIVERY ASSESSMENT

Overall RAG	Executive summary, maximum 100 words
Amber	Delivery of the Leadership, Values and Behaviours programme remains on track, with significant progress made during the quarter through completion of the Big Conversation and review of findings with senior leaders. A refreshed Values and Standards of Behaviour Framework has been developed in draft, alongside plans for an Integrated Accountability Framework to support implementation and align with the forthcoming CQI Model. However, an Amber rating is maintained as key outcome measures within the Annual Operating Plan, particularly sickness absence, are currently deteriorating and have yet to reflect the intended benefits of the programme. Sustained implementation will be required during 2026/27 and 2027/28.

2. PERFORMANCE AGAINST AGREED METRICS

Metric	Q2 target / trajectory	Current position	Direction of travel	RAG
Staff Survey metrics (raising concerns sub-score, % recommending place to work, % recommending place to receive care) are annual and reported in Q4				
Sickness absence rate (quarterly)	5.2%	5.7% (AUG)	Deteriorating	R

3. DELIVERY PROGRESS AND KEY MILESTONES

Significant achievements this quarter	Delayed or off-track milestones	Key milestones due next quarter
• Big Conversation held with colleagues – more than 12,500 contributions received • Values and Standards of Behaviour Framework drafted and tested with Leaders and against KPMG-Catalysis Behaviours and NHS Leadership & Management Framework • Introduced new sickness reporting enhancements, alongside Care Group absence management plans	• Delivery of programme on-track • Sickness absence milestones off-track.	• Launch of Values and Standards of Behaviour Framework • Launch of Integrated Accountability Framework • Introduction of the Leadership & Management Self-Assessment Tool • Launch of updated Sickness Policy

4. KEY RISKS AND MITIGATING ACTIONS

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Colleagues may become sceptical of future engagement activity if they do not see practical changes resulting from the feedback they have provided. This could reduce trust, engagement and participation in future improvement work.	• Launch the Values and Standards of Behaviour Framework and Integrated Accountability Framework during Q3. • Publish clear "You Said, We Did" communications linked to specific themes raised by colleagues. • Prioritise a small number of visible actions where colleagues can see evidence of change. • Maintain visible executive and Care Group leadership engagement.	A	Interim Director of Workforce and OD

New frameworks and expectations are introduced, but leaders and managers lack the skills, confidence or support required to apply them consistently.	• Deliver CQI training for senior leaders. • Launch the Leadership & Management Self-Assessment Tool. • Redesign the Leadership & Management development offer. • Review Leadership 360 arrangements and appraisal processes to reinforce expectations.	A	Interim Director of Workforce and OD

5. COMMITTEE ASSURANCE, ESCALATIONS AND EXCEPTIONS

Relevant Board sub-committee(s)	Material assurance or exception	Date considered
Resource Committee	Resource Committee comments: 'The levels of assurance are reflected in the Committee escalation reports provided to Board at each meeting.'	20th October 2026

6. BOARD ATTENTION OR DECISION REQUIRED

Type	Request to Board
None / Note / Decision / Escalation / Support	State clearly what the Board is asked to note, decide or support, including the recommendation.

APPENDIX TWO: Multi-Year Enabling Programme Q2 Updates.

Clinical Strategy Development and Early Implementation

SRO	Q2 RAG	Assurance
Clinical Strategy Implementation Lead	**Green**	**Reasonable**

1. 26/27 AOP commitment and Q2 delivery

AOP commitment	Q2 position / evidence	Assessment
Establish clinical ownership and agency and support clinicians and operational teams to take greater ownership of pathway design and delivery	The Clinical Services Strategy has progressed to a policy-aligned draft for Board approval. Clinical leadership and team-led pathway redesign are explicit conditions for implementation.	**In delivery**
Develop and test pathway redesign and identify priority areas where change can be implemented early	Frailty has been identified as the first strategic pathway priority. The Social Finance Trailblazer provides early enabling work for partnership-based frailty pathway development.	**In delivery / priority identified**
Test pathway improvements around patient need, earlier decision-making and reducing duplication and delay	The draft strategy describes a value-to-patients decision framework and a clinical model based on whole pathways closer to home, prevention, digital enablement and generalist capability.	**Framework proposed; testing to follow**
Build mechanisms to support change, including data and analytics, aligned enabling functions and simpler governance	The draft identifies trusted data, aligned workforce, digital, estates, diagnostics and capital decisions, simpler governance and a single management system as conditions for delivery.	**Scope Developing**
Prioritise relationship development and create conditions for sustainable improvement	The developing model is based on work with neighbourhood teams, primary care, community providers, mental health, social care, local authorities and voluntary-sector partners.	**Scope Developing**
Progress the strategy through engagement and Board consideration	A Trust Board Strategic Planning Event is scheduled for 21 October 2026 to socialize the emerging direction and support implementation planning before Board consideration.	**On track**

2. Overall programme update

Development of the Clinical Services Strategy progressed substantially during Q2, moving to a policy-aligned draft setting out the Trust clinical ambition, strategic shifts, decision framework and proposed clinical model. Frailty has been identified as the first strategic pathway priority and will be used to test the clinical, data, governance and engagement methods through which future pathway change will be delivered. The Social Finance Trailblazer provides early enabling work for partnership working and frailty pathway development while the wider strategy is finalised.

The next stage includes the Trust Board Strategic Planning Event on 21 October 2026, followed by consideration of the Clinical Strategy at Trust Board, supporting further testing of the direction and transition into implementation planning.

3. Benefits and impact

At Q2, the strongest evidence relates to development of the strategic framework, identification of frailty as the first priority pathway and early work to create the conditions for implementation. It is too early to evidence service-level outcomes attributable to the strategy. Future assurance should demonstrate pathway change and measurable improvement, supported by agreed baselines, delivery ownership, governance and benefit-realisation measures.

4. Key risks and mitigating actions

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Strategy not yet translated into an agreed implementation plan	The October event and subsequent Board consideration will support implementation planning. Residual risk: delivery remains conceptual without clear sequencing, ownership and milestones.	Amber	Clinical Strategy Implementation Lead
Insufficient clinical and operational capacity	Clinical ownership and authority are explicit within the developing strategy. Residual risk: implementation pace may be constrained without protected capacity.	Amber	Clinical Strategy Implementation Lead with MD and COO
Dependencies across partners and enabling functions are not aligned	Implementation planning will identify dependencies. Frailty and the Trailblazer provide an early opportunity to test partnership arrangements.	Amber	Clinical Strategy Implementation Lead
Benefits and outcomes lack agreed baselines	The developing strategy specifies outcome-led design. Confirmation is required that the benefits-realisation framework and reporting arrangements are in place.	Amber	Clinical Strategy Implementation Lead, CCIO & DoF

5. Governance route and assurance

Governance forum / route	Assurance or exception	Date considered / frequency
Council of Governors	Development and challenge of the emerging strategy and implementation approach	9th September 2026
Board Development Session	Development and challenge of the emerging strategy and implementation approach	23rd September 2026
Trust Board Strategic Planning Event	Planned testing of the emerging direction, priorities and transition into implementation planning.	21 October 2026
Trust Board	Consideration of the Clinical Services Strategy for approval	27th October 2026

Overall, the evidence supports reasonable assurance that the Clinical Strategy foundation-year commitments are progressing. Assurance on implementation and benefits will need to strengthen following Board consideration and development of the implementation plan.

6. Board attention or decision required

Type	Request to Board
Assurance / Note	Take reasonable assurance that the foundation-year commitments are progressing; note frailty as the first strategic pathway and the Social Finance Trailblazer as early enabling work; and note that future assurance will focus increasingly on implementation, pathway delivery and measurable outcomes.

Electronic Patient Record (EPR) - Implementation and Benefits Realisation

SRO	Q2 RAG	Assurance
Chief Digital and Information Officer	**Green**	**Reasonable**

1. AOP commitment and Q2 delivery

AOP commitment	Q2 position / evidence	Assessment
Progress Tranche 2, expected in late August 2026	Tranche 2 has been implemented and the programme has moved beyond go-live into optimisation and adoption.	**Delivered**
Progress towards Tranche 3 implementation, expected in June 2027	Planning and design activity has commenced and the programme continues to report against the June 2027 milestone.	**On track**
Undertake ongoing optimisation following go-live	Structured optimisation activity is underway following implementation and stabilisation of the deployed functionality.	**In delivery**
Expand functionality and increase adoption across services	Further functionality has been deployed through Tranche 2, supported by continuing clinical and operational engagement. Adoption is being monitored as the system becomes embedded.	**In delivery**
Continue training and digital champion support	Training, digital readiness activity and digital champion support remain in place to support staff and reinforce adoption.	**In delivery**

2. Overall programme update

The EPR programme has made significant progress during Q2, with successful implementation of Tranche 2 representing the principal milestone specifically due within the period. Following go-live, the programme has moved into optimisation and adoption while maintaining progress towards Tranche 3 implementation in June 2027.

Training, digital readiness and digital champion support remain in place, further functionality has been deployed and adoption is being monitored as EPR becomes embedded across services.

3. Benefits and impact

The AOP identifies EPR as an enabler of the three organisational priorities. Its intended contribution includes improved visibility of patient flow and bed management, more coordinated outpatient and diagnostic pathways, reduced duplication and improved staff experience through access to a single integrated patient record.

The capability to support these benefits is increasingly in place, but implementation alone does not demonstrate that the anticipated benefits have been realised. Future assurance will increasingly need to demonstrate service-level adoption, operational outcomes and measurable workflow, productivity and financial benefits.

Relevant financial, efficiency and productivity benefits are monitored through programme governance and tracked through WRAP, providing a route for validation against agreed baselines, trajectories and named ownership.

4. Key risks and mitigating actions

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Sustained adoption and consistent use across services	Training, digital readiness, clinical engagement, digital champion support and service-level adoption monitoring. Residual risk: deployed functionality may not translate consistently into workflow and service improvement.	Amber	EPR programme / service leads
Operational capacity to support optimisation and Tranche 3	Structured optimisation workstreams, programme planning, critical-path reporting and readiness assessment. Residual risk: competing operational pressures may affect pace or readiness.	Amber	EPR programme leadership
Conversion of capability into measurable benefits	Benefits identified and monitored through programme governance, with relevant financial and productivity benefits tracked through WRAP. Residual risk: benefits may be insufficiently evidenced against baselines and trajectories.	Amber	Benefit owners / Finance

5. Governance route and assurance

Governance forum / route	Assurance or exception	Date considered / frequency
Programme Management Group	Routine oversight of delivery, risks, issues, programme plan and escalation.	Regular programme reporting
Clinical and Operational Design Authority	Oversight and approval of clinical and operational design decisions.	Established programme route
Trust Resilience Group	Operational oversight and preparedness for implementation.	Established programme route
Executive Steering Group / Executive Committee	Executive oversight of delivery, business change, alignment and escalation. Overall evidence supports Green delivery and reasonable assurance at Q2; further assurance is required on adoption and realised benefits.	Established executive route

6. Board attention or decision required

Type	Request to Board
Assurance / Note	Take reasonable assurance that the EPR programme is delivering against its 2026/27 AOP commitments; note successful delivery of Tranche 2 and continued progress towards Tranche 3; and expect future assurance to include evidence of adoption, operational outcomes and validated benefits.

Continuous Quality Improvement (CQI) - Better Together

SRO	Q2 RAG	Assurance
CCIO	Green	Reasonable on mobilisation and foundations

1. AOP commitment and Q2 delivery

AOP commitment	Q2 position / evidence	Assessment
Appoint and mobilise a strategic partner from summer 2026	Procurement has been completed and the strategic delivery partner has been appointed and mobilised to support the Quality Management System and CQI roadmap.	**Delivered**
Commence workforce engagement to refresh values and behaviours in Q2	Significant workforce engagement has taken place through the Values and Behaviours programme, informing the refreshed organisational framework.	**Delivered**
Establish a consistent Trust-wide improvement approach	Better Together has been agreed as the Trust improvement methodology, providing a common framework and language.	**Foundation delivered**
Develop a systematic, organisation-wide Quality Management System	The strategic partner has been mobilised and development of the Quality Management System, governance and roadmap is progressing.	**In progress**
Embed a structured productivity and improvement programme across Care Groups	The CQI roadmap is being aligned with organisational priorities and Care Group delivery, with a phased implementation approach being developed.	**In progress**
Expand CQI capability, training and support	Capability development and training form part of the roadmap, supported by the delivery partner and developing internal improvement infrastructure.	**In progress**
Strengthen governance and reporting of improvement activity and outcomes	Governance arrangements are being established to report milestones, risks, benefits, capability transfer and delivery progress through agreed executive and quality improvement routes.	**Governance established / progressing**

2. Overall programme update

The CQI programme has progressed from programme design into mobilisation and implementation during Q2. The strategic delivery partner has been appointed and mobilised, ‘Better Together’ has been established as the Trust improvement methodology, and development of the Quality Management System and associated roadmap is continuing.

The programme has therefore established important foundations for a more consistent, organisation-wide approach to improvement. The next phase is to embed the approach across services and develop internal capability so that improvement activity becomes part of routine management and delivery.

3. Benefits and impact

The programme is intended to support measurable improvement in quality, flow, access, productivity and financial performance. At Q2, the strongest evidence relates to mobilisation, infrastructure and the establishment of a common improvement method. These inputs and outputs do not, by themselves, demonstrate improved outcomes.

Future assurance should distinguish between inputs, outputs, adoption, operational outcomes and validated benefits. Relevant financial and productivity benefits are tracked through WRAP, alongside the AOP requirement to report against the agreed benefits trajectory, including minimum savings of £1.6 million over two years.

4. Key risks and mitigating actions

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Organisational capacity and competing operational pressures	Phased implementation, Executive sponsorship and prioritisation of programme activity. Residual risk: pace and consistency of deployment may be affected.	Amber	Executive SRO / programme leadership
Inconsistent adoption across services	'Better Together' common method, capability development, training, partner support and Care Group alignment. Residual risk: mobilisation may not translate into routine practice.	Amber	Programme Board / Care Groups
Dependency on external support and capability transfer	Internal capability development and explicit tracking of capability transfer through programme governance. Residual risk: sustainability may be weakened if knowledge transfer is incomplete.	Amber	Programme leadership / strategic partner
Insufficient translation into measurable outcomes and benefits	Benefits trajectory, outcome tracking and financial/productivity validation through WRAP. Residual risk: activity may be evidenced before attributable benefits mature.	Amber	Benefit owners / Finance

5. Governance route and assurance

Governance forum / route	Assurance or exception	Date considered / frequency
CQI Programme Board / formal programme management	Oversight of milestones, risks, benefits, capability transfer and corrective action.	Routine programme reporting
Integrated Quality Improvement Group	Progress update against milestones, RAG, risks, mitigations, decisions and next-period plan.	Monthly
Executive Committee	Executive oversight of delivery and escalation. Mobilisation and foundation commitments support Green delivery and reasonable assurance at Q2; outcome and benefit assurance remains developing.	Monthly

6. Board attention or decision required

Type	Request to Board
Assurance / Note	Take reasonable assurance that the CQI programme is delivering against its 2026/27 AOP commitments; note progress in mobilising the strategic partner, Better Together and the Quality Management System; and expect continuing evidence of adoption, capability, operational outcomes and validated benefits.

Living Within Our Means

SRO	Q2 RAG	Assurance
Director of Finance	**Red**	**Partial assurance**

Important context: the approved financial plan has changed since the AOP was written. The AOP referenced a £22.646m deficit and £61.6m WRAP requirement. The final plan agreed with NHSE is an £18.5m deficit before Deficit Support Funding (DSF) with a £65.7m WRAP requirement. The Q2 evidence below therefore preserves the original AOP commitments but assesses performance against the latest approved financial plan.

1. AOP commitment and Q2 delivery

AOP 2026/27 commitment	Q2 position / evidence	Assessment
Delivery of financial plan: £22.646m deficit	Latest approved NHSE plan: £18.5m deficit before DSF. Month 6 plan was £9.2m YTD deficit excluding DSF; actual adjusted deficit was £18.4m, £9.2m adverse. Variance worsened from £6.3m at Month 5 to £9.2m at Month 6. Best case remains £18.5m; mid-range forecast is £30.5m and worst case £45.5m.	**Off track / Red**
Delivery of efficiency programme: £61.6m	Latest approved WRAP requirement: £65.7m. Month 6 cumulative target £31.8m; YTD delivery £24.7m, £7.0m below trajectory. Full-year savings delivered £34.5m. Mid-range forecast assumes a £3.6m shortfall against the full-year requirement.	**Off track / Red**
Deliver targets for bank and agency spend: 25% reduction on 2025/26 forecast outturn	Subsequent 2026/27 limits are £25.2m bank and £6.3m agency. At Month 6, agency was £2.8m against £3.3m plan (£0.5m favourable); bank was £18.7m against £12.9m plan (£5.8m adverse). Combined spend was £21.5m, £5.3m adverse to the Q2 trajectory.	**Mixed; behind trajectory / Red overall**

2. Overall programme update

The financial recovery programme is materially off trajectory at the end of Q2. The adjusted year-to-date deficit excluding DSF is £18.4m against a planned £9.2m, an adverse variance of £9.2m; the variance deteriorated further in September. Achieving the approved £18.5m full-year deficit is now the best-case scenario and depends on full WRAP delivery, delivery of recovery actions and recovery of income for activity above plan. The current mid-range forecast is a £30.5m deficit, £12.0m worse than plan.

WRAP remains the principal delivery risk. Month 6 delivery is £24.7m against a £31.8m cumulative target, a £7.0m shortfall. Full-year savings delivered are £34.5m against the £65.7m requirement. The shortfall has partly been managed through deferred investment and other non-recurrent measures, which do not reduce the underlying cost base. Outside the Q2 cut-off, Finance reports that the WRAP programme is now fully planned, which is a significant milestone, but the assurance test remains conversion of plans into recurrent delivery.

Workforce expenditure is also behind trajectory overall. Agency spend is favourable to plan, but bank spend is £5.8m adverse at Month 6, with medical and dental staffing the principal operational pay pressure. Vacancy control, rota management, substantive recruitment and temporary staffing controls remain in place.

3. Benefits and impact

The intended benefit of Living Within Our Means is a sustained reduction in the Trust underlying cost base and delivery of the agreed financial trajectory. Q2 evidence does not yet demonstrate that this has been achieved: the deficit variance has worsened, WRAP is behind trajectory and temporary or non-recurrent mitigations have partly managed the savings gap. The programme focus for the second half of the year is therefore recurrent WRAP delivery, validated recovery actions and lower workforce costs, while protecting patient care.

The Executive Committee recovery actions identify £10.0m of potential impact. £4.4m has been incorporated into WRAP, leaving a further £5.6m of potential expenditure recovery to validate and deliver. Full receipt of the £18.5m DSF is conditional on delivery of the agreed plan and associated recovery, productivity and control requirements.

4. Key risks and mitigating actions

Key risk or issue	Mitigating action and delivery impact	RAG	Owner
Year-end deficit materially exceeds the approved £18.5m plan	Deliver WRAP and recovery actions with clear accountability; validate and deliver the remaining potential expenditure recovery; agree activity income with commissioners; evidence compliance with DSF conditions. Mid-range forecast remains £30.5m.	Red	Director of Finance / Executive Committee
WRAP is not delivered in full and/or not delivered recurrently	Weekly and monthly tracking, variance analysis, scheme-lead challenge and formal accountability through Financial Improvement Boards. Focus on replacing deferred investment and other temporary mitigations with recurrent savings.	Red	Finance / Care Groups / scheme leads
Bank and temporary staffing costs remain above plan	Vacancy controls, rota management, substantive recruitment, bank fill-rate monitoring and Medical Bank and Agency Panels. Agency is favourable, but bank is £5.8m adverse at Month 6.	Red	Workforce / Care Groups / Finance
Income for activity above plan is not fully recovered	Contract Management Board engagement and reconciliation with commissioners; forecast scenarios explicitly reflect non-recovery risk.	Amber	Finance / operational teams
Cash pressure increases if recovery and DSF conditions are not met	Weekly cash monitoring, cash-support application and prioritisation of critical supplier payments.	Red	Director of Finance

5. Governance route and assurance

Governance forum / route	Assurance or exception	Date considered / frequency
Financial Improvement Boards	Weekly tracking and challenge of WRAP delivery, scheme ownership, slippage and higher-risk schemes.	Weekly / routine
Executive Committee	Recovery actions and financial recovery plan oversight. Current actions identify £10.0m potential impact, with £4.4m incorporated into WRAP and £5.6m further potential expenditure recovery to validate and deliver.	Ongoing
Resource Committee	Finance TPR provides detailed scrutiny of I&E performance, forecast outturn, WRAP, workforce costs, cash and key financial risks.	September Q2 reporting
Board	Receives finance and AOP assurance, including the Q2 position, forecast risk and matters requiring continued oversight.	Quarterly AOP / routine finance reporting

6. Board attention or decision required

Type	Request to Board
Assurance / Escalation	Take partial assurance from the clarity of the Q2 financial position, governance and recovery actions; note that delivery against all three AOP financial measures is currently off trajectory overall; note that the AOP baseline has been superseded by the final NHSE-approved £18.5m deficit and £65.7m WRAP requirement; maintain oversight of recurrent WRAP delivery, recovery actions, workforce costs, activity-income recovery and DSF conditions; and require evidence during Q3 that the adverse run rate is reducing and recovery actions are converting into recurrent financial benefit.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	Q2 Well-Led Action Plan Progress Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

Reports of progress against the External Development Well-Led Action Plan are to be provided quarterly to Board. Updates at the end of Q2 are as follows:

- 62% of Q1/Q2 actions completed.
- 66% of all actions completed.

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

The attached report provides an update of those actions with closure dates during Q1 or Q2.

In addition, for completeness the following supporting information is provided:

- Appendix 1 – Actions with closure dates during Q3 and Q4.
- Appendix 2 – Actions already closed reported previously to the Board.

Recommendation:

The Board of Directors is asked to note the Well-Led Progress Update Report.

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

Meeting/Engagement	Date	Outcome/Recommendation
Well-Led Action Owners	September/October 2026	Updated

Q2 Update Report

York and Scarborough Teaching Hospitals NHS Foundation Trust

Well-Led Developmental Review

York and Scarborough Teaching Hospitals NHS Foundation Trust

December 2025

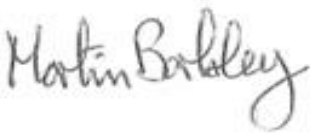
Version: Final Report

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

Executive Summary

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

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





Chair

Chief Executive

Introduction

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

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

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

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

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

Overview – summary of findings

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

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

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

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

Quality statement 1: Shared direction and culture

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By (2026/27 unless specified)	Progress Update Q2 2026
1.	**The Trust should consider strengthening senior leadership capacity and ownership of strategy and planning to help raise socialisation of the Trust strategy and drive through formal front-line to Board objective delivery connectivity.**	1.1 Appointment of Executive Director of Strategy by Q2 of 26/27.	Chief Executive	End Q2	Closed. A new Clinical Strategy Implementation Lead in post following interim Director of Strategy input. Full recruitment will take part in 27/28.
		1.2 Executive development workshop to ensure clear Executive sponsorship of supporting strategies.	Chief Executive	End Q2	This work is being delivered through the Strategy deployment work and development sessions as part of our CQI work 'Better Together'. Capacity has been strengthened in 26/27 by the Clinical Strategy Implementation Lead.
		1.3 As part of the Trust's review of organisational engagement approach develop and implement plan to socialise the Trust strategy through leadership forums, communications, Board discussion and visible executive leadership.	Director of Communications	End Q1	Closed.
		1.4 Develop and implement a Trust-wide Performance Management and Accountability Framework, aligned to a defined organisational development plan to support high quality objective setting, appraisal,	Chief Executive	End Q1	This development work will be completed by the end of October 26 moving through into implementation in Q3.

		and consistent and escalation and delivery monitoring.			
3.	**The Trust should consider ways in which it can further socialise the Trust's strategic objectives and values alongside reinforcement of the values and behaviour framework.**	As part of the Trust's review of organisational engagement strategy, it will develop and implement plan to socialise the Trust strategy through leadership forums, communications, Board discussion and visible executive leadership.	Director of Communications	End Q1	Closed.
4.	**The Trust should consider ways in which it can ensure that appropriate focus is given over to strategy, oversight of delivery and ensuring that an appropriate culture is in place.**	4.1 (also 1.1) Appointment of Executive Director of Strategy by Q2 of 26/27.	Chief Executive	End Q2	Closed.
		4.2 (also 1.2) Executive development session in Strategy development to ensure clear executive sponsorship of supporting strategies.	Chief Executive	End Q2	Closed. As per 1.4. There will be further work will be undertaken during 26/27.
5.	**The Trust should consider development of a renewed cultural and organisational development (OD) plan that targets considerations contained within this report, and in particular strengthens cultural oversight and focus along with staff feedback and**	5.1 Develop and implement a Chief Executive lead deep and meaningful approach to staff engagement across the Trust.	Chief Executive	End Q1	Analysis of Big Conversation completed with plans to respond to what we heard. In addition to Values & Standards of Behaviour conversation, 11 other themes emerged from conversation which will be responded to in Q3 clarifying: what we heard, what's already in place, what more is being doing in response, what can't be

	engagement processes including improvements in connectivity of senior leaders with the Trust.				done (and why) and what colleagues can do to help.
		5.2 Full review and revision of the Trust's approach to Organisational Development including leadership and management.	Director of Workforce & OD	End Q2	Staff Standards launched nationally in July - mapped to existing work with proposal to prioritise Line Management standard (for review by CCPO). Leadership and Management offer mapped to national L&M Framework (also launched in July), work commenced on proposals for training offer pending further review following launch of Values & Standards of Behaviour Framework and Integrated Accountability Framework.
6.	The Trust should look to develop a medium term financial plan once the suite of enabling strategies are sufficiently developed and respond accordingly to its outcomes in terms of ensuring the necessary capacity and capability is in place to deliver its	6.1 Develop through co-production a comprehensive clinical strategy in order support the development of a financial sustainability plan.	Chief Executive Medical Director	End Q1 for framework End Q3 for detail	Clinical Strategy Implementation Lead in post. Draft Clinical Strategy under review and undergoing further engagement
		6.2 Commission and then embed a continuous improvement approach across the Trust to support transformation of services with clear expected outcomes and KPIs.	Chief Executive	End Q1 for commission	Closed. 'Better Together' training has commenced in the organisation.
		6.3 Develop Trust Performance Management and Accountability Framework.	Chief Executive	End Q1	This work will be concluded at the end of October in partnership

	requirements (including transformation).				with KPMG and Catalysis as part of Better Together.

Quality statement 2: Capable, compassionate, and inclusive leaders

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q2 2026
9.	**The Trust should consider how it might increase the voice of stakeholders (staff, patients and external partners) into Board and committee to provide improved triangulation of assurances.**	9.2 Patient survey results to be reported to Board.	Chief Nurse	Start Q1	There are 6 national patient experience surveys per year that focus on specific areas such as cancer, inpatient care and end of life care as well as other areas. The next main national inpatient survey is due to be released in August 2026 and will be reported to Patient Experience Subcommittee in September 2026 and onward to Quality Committee then Trust Board as required.
		9.3 Patient complaints and PALS reports to Board every three months.	Chief Nurse	End Q1	The first report that will be formally presented to Trust Board is scheduled for October 2026.
		9.5 Develop and implement a structured stakeholder management plan for 26/27, including objectives, engagement cadence, escalation routes and feedback loops.	Director of Communications	Start Q1	Complete subject to approval. See 29.1 and 30.1.
10.	**The Trust should consider introducing a more formalised NED induction process addressing the points raised within this report.**	Develop and implement new and strengthened Non-Executive Director induction plan. All NEDs who have commenced in the last 18 months to undertake in addition to new starting colleagues.	Associate Director Corp Governance	End Q2	Closed. A revised induction plan has been drafted for Non-Executive Directors, scheduled to commence from November 2026.

12.	**The Trust should consider the relevance of the existing Leadership Framework and how it might re-energise it and monitor take up and impact.**	12.1 Undertake a full review of the leadership and development programme across the organisation (see 4.3)	Director of Workforce & OD	End Q2	See 5.2

Quality statement 3: Freedom to speak up

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q2 2026
14.	**The Trust should consider frequency and triangulation of reporting into Board across a number of assurance areas to help identify areas of cultural concern and/or themes.**	14.1 Dedicated session at Board on the staff survey outputs and what it is telling us about the culture of the organisation.	Director of Workforce & OD	End Q1	Closed. Staff Survey results discussed at Board March 26. Action plan discussed in May 26.
		14.2 Clear and Board owned engagement plan led focused on improving how people experience work and care in YSFT	Chief Executive	End Q1	Closed. The Big Conversation has now concluded and the outputs have been incorporated into the IAF and the wider outputs will be incorporated into a behavioural framework and compact.
		14.4 To further embed the Managing Violence and Aggression policy launched in 2025 to manage patients who are racist or discriminatory to colleagues	Chief Nurse	End Q1	Due date amended to Q4 and understanding the impact of violence and aggression added to the action following Board of Directors approval.

Quality statement 4: Workforce equality, diversity and inclusion

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q2 2026
18.	**The Trust should ensure that EDI issues form part of the overall Trust approach to improving culture including Board oversight and scrutiny of EDI matters.**	Progress against plan to be reported back to the Board every six months on progress to date via the Executive Sponsors.	Director of Workforce & OD with Exec Sponsors	End Q2	WRES and WDES plans to be reviewed by Board in October.

Quality statement 5: Governance, management and sustainability

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q2 2026
23.	**The Trust should seek to clarify the role and purpose of the unitary Board and its committees and ensure an appropriate focus is maintained at each level supported by strengthened governance processes as identified within our report.**	23.3 Board development session to be scheduled on the role and optimal function of a unitary Board and highly functioning committees.	Associate Director Corp Governance	End Q2	Closed. A Board Development and Strategy Timetable has been drafted for the remainder of 2026/27 and into 2027/28.
		23.7 Strengthen Programme Management and reporting arrangements	Chief Executive	End Q1	This work is linked to the implementation of the CQI approach and will be finalised by the end of Q3.
26.	**The Trust should consider introducing a Performance Management and Accountability Framework supported by appropriate roll out training and support.**	26.1 (Also 6.3) The Trust will develop an Integrated Accountability Framework from ward to Board that has clearly defined roles and responsibilities.	Chief Executive	End Q1	This will be concluded by the end of October 26 as part of 'Better Together' and the development of the IAF and overall CQI approach.
		26.2 Each lead executive responsible for a pillar of delivery (Quality, finance, workforce, service delivery) will work to streamline and strengthen assurance processes from ward to Board through good governance.	Chief Executive	End Q1	As above.
		26.3 Launch of the IAF will be supported by organisational development so roles and responsibilities at all levels are understood.	Director of Workforce & OD	Start Q2	Big Conversation completed and feedback analysed. IAF in draft and due for launch in Q3.
27.	**The Trust should consider strengthening its approach to risk management in line with our report observations**	27.3 Develop and deliver a comprehensive risk management training package	Associate Director Corp Governance	End Q2	Closed. Risk Management training provided to all Care Group teams where

	including the operationalisation of risk appetite to support risk escalation / de-escalation within the Trust				need for upskilling identified.
28.	**The Trust should consider implementing a more consistent and Trust-wide approach to PRIM and care group management level meetings which includes clear 'do minimum' expectations regarding inputs (agenda, coverage, paper format, and attendance) and outcomes (minutes, action logs, escalations) in line with our report observations.**	28.1 (Also 26) Review of PRIM and approach to accountability framework to be undertaken, including roles and responsibilities.	Chief Executive	End Q1	This will be concluded by the end of October 26 as part of 'Better Together' and the development of the IAF and overall CQI approach.
		28.2 Develop 'standard work' for agendas and minutes etc of PRIMs and Care Group Management Boards.	Chief Operating Officer	Start Q2	Closed. All Care Group governance reviewed and an improvement plan drafted.

Quality statement 6: Partnerships and Communities

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q2 2026
29.	**The Trust should consider how it might raise the profile and voice of stakeholder feedback as part of triangulation of assurances. This should include the voice of staff, patients and system partners.**	29.1 See recommendation 9.	Director of Communications	Start Q1	See 9.5. and 30.
30.	**To support the above, the Trust should consider the development of a more proactive and structured approach to stakeholder management.**	See 9.5	Director of Communications	Start Q1	See 9.5. and 29.1.
31.	**The Trust should ensure that its Communications Strategy refresh exercise takes into consideration the findings within this report, the work of the Trust change makers as well as wider engagement with internal and external stakeholders.**	31.1 Refresh the Communications Strategy to strengthen two-way communication and visible feedback loops.	Director of Communications	Start Q1	Complete subject to approval.
		31.2 (See 1, 3 and 5) detailed and deep staff engagement exercise to be completed with the aim embedding a strong and supportive culture across the organisation.	Chief Executive	End Q1	This has been delivered via 'The Big Conversation'. The embedding of the culture will be the ongoing effort arising from that work.
32.	**As part of the shift to proactive and more strategic partnership relations, the Trust should consider its anchor institution role and what this means for the Trust alongside how it can best**	32.2 Clinical Strategy to contain focused work on helping to address health inequalities across the Trust's geography.	Medical Director	End Q2	Clinical Strategy development ongoing.

	support improvements in health inequalities.				

Quality statement 7: Learning, improvement and innovation

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q2 2026
34.	**The Trust Board should ensure appropriate oversight and assurance of the rollout of QI methodology and building of QI capacity given that it is one of the Trust's breakthrough objectives for 2025/26.**	34.1 Initial rollout plan to be monitored Resources Committee and reported to Board.	Chief Executive	After commissioning and commencement	On track.
		34.2 Strengthened PMO oversight, clear benefit realisation and assurance framework to be developed as part of the programme and reported to Board via Resources and Quality committees.	Chief Executive	After commissioning and commencement	Is being undertaken as part of alignment of transformational leadership.
35.	**The Trust should consider ways in which it can strengthen the dissemination of learning within and across care groups. This should also include consideration of the formal mechanisms and processes for triangulating learning across multiple data points.**	35.1 Approach to shared learning across care groups will be agreed via Senior Leaders Forum and mapping conducted in how sharing is already conducted.	Director of Quality, Improvement and Patient Safety	End Q1	Mapping our learning opportunities and current learning approaches underway within Care Groups and we will triangulate this with corporate approaches. Currently we have the weekly Patient Safety Bulletin that is disseminated via email to all users. This is also presented to Patient Safety and Clinical Effectiveness Subcommittee on a monthly basis. We also have the Staff Matters Magazine in which there is a dedicated section on patient safety. In addition, we also have the Health and Safety Bulletin that goes out via email on a monthly basis.

		35.2 Executive Committee and Senior Leaders Forum will be used for triangulation purposes and a schedule of areas of focus will be devised (supported by data) in order to direct and focus on continuous quality improvement.	Director of Quality, Improvement and Patient Safety	End Q1	The update from July is still relevant. In addition, we have started the work of mapping key safety indicators across 6 specialties linked to national Quality Accounts and through engaging senior clinical staff in identifying key safety indicators to them. This will then support further work to develop key quality indicators for triangulation of multiple data points within specialties.
36.	**The Trust should consider its approach to assuring itself that it has sufficient transformational change capacity and capability to support its forward agenda. This should include clarity of leadership of transformation and Board/committee reporting for assurance purposes.**	36.1 Chief Executive to review programme management, project management and continuous improvement capacity and capability, including approvals, reporting and accountabilities arrangements as well as benefit realisation	Chief Executive	Start Q2	This work is being undertaken as part of the 'Better Together' work and will link through to the roll out during Q3.

Quality statement 8: Environmental sustainability

TABLE: STRENGTHS AND DEVELOPMENT AREAS

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

Recommendations

TABLE: RECOMMENDATIONS

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

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update Q2 2026
38.	**The Trust should review its Green Plan against the latest NHSE guidance to ensure compliance with requirements.**	Review the Green Plan against the latest NHSE guidance.	Managing Director YTHFM	End Q2	The Green Plan refresh has been completed. Leadership of the Sustainable Models of Care workstream has transferred to a joint clinical model across nursing, medical and allied health professional teams, strengthening clinical ownership and accountability for sustainable healthcare initiatives. The updated Green Plan has been finalised and is ready for Trust Board approval.
40.	**The Trust should consider the merits of appointing a clinical lead for sustainability to support wider engagement with services.**	Appoint a clinical lead for sustainability.	Medical Director	End Q1	Plan has been created for clinical models associated with sustainability. Potential sustainability champions and clinical leads across professions being engaged with.

Quality statement 1: Shared direction and culture

Ref	Recommendation	Action	Responsible Officer	Completion By (2026/27 unless specified)	Last Update
2.	**The Trust should ensure that it has a full suite of in-date and aligned enabling strategies which support delivery of the Trust strategy and provide sufficient detail to enable clarity of understanding how they are to be delivered and are capable of measurement, monitoring and oversight over delivery.**	Develop and align strategies which in turn have measurable plans with scorecards, defined ownership and assurance mechanisms. Supporting strategies will be: • Clinical Strategy – Medical Director • Quality Strategy – Chief Nurse • Estates Strategy – YTHFM Managing Director • Financial Sustainability Strategy – Finance Director • Organisational Development – YTHFM Managing Director • Sustainability – YTHFM Managing Director	Chief Executive	End Q3	
4.	**The Trust should consider ways in which it can ensure that appropriate focus is given over to strategy, oversight of delivery and ensuring that an appropriate culture is in place.**	4.6 Strengthen organisation development and a programme of strategic leadership development for all sub Board leaders.	Director of Workforce & OD	End Q3	New CCPO appointed - commences on 12 October 2026. Completion of Senior Leaders appraisals including 360 feedback. Big Conversation held in August to refresh Values and Standards of Behaviour to provide an updated framework to support organisational

					leadership development and people processes. Analysis completed in September ahead of launch of framework in Q3. Work underway to support actions in Q3 include scheduling of CQI Training for Deputy Directors and mapping of Leadership Development offer against national L&M Framework.

Quality statement 2: Capable, compassionate, and inclusive leaders

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
8.	**The Trust should consider how it can strengthen Board connectivity into the Trust, paying particular attention to executive visibility across sites and all services.**	8.3 Schedule a Board meeting in 2026 at Malton and Selby followed by Board visits to clinical areas.	Associate Director Corp Governance	End Q3	Closed. Board Meetings schedule paper provided to 28th October Board of Directors meeting.
12.	**The Trust should consider the relevance of the existing Leadership Framework and how it might re-energise it and monitor take up and impact.**	12.2 Provide digital literacy and AI training for managers and leaders where this is identified on their PDP	Chief Digital Officer	End Q4	Closed. Over the past year the Trust has delivered a comprehensive Microsoft skills and adoption programme covering Outlook, Teams, OneDrive, SharePoint, Microsoft 365 collaboration tools, Power BI

					and Microsoft Copilot. This has included formal Microsoft-led training, self-service learning through the NHSmail Academy and Viva Learning, SharePoint and Teams adoption support, dedicated Copilot training pathways, prompt engineering workshops, a Copilot Champions network, and access to national NHS AI learning programmes. Together these initiatives have helped staff develop digital confidence, adopt modern ways of working and realise productivity benefits from the Trust's investment in Microsoft technologies.

Quality statement 3: Freedom to speak up

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
No Q3 or Q4 actions					

Quality statement 4: Workforce equality, diversity and inclusion

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
No Q3 of Q4 actions					

Quality statement 5: Governance, management and sustainability

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
25.	**The Trust should consider how it can assure itself over the adequacy of data capability and capacity both within the digital function and wider Trust to deliver the forward requirements of the digital transformation agenda.**	Undertake a comprehensive review of the current data and analytics capability across the Digital function and the wider Trust, including skills, capacity, operating model, and data quality maturity. Using the findings, develop and implement a Trust-wide Data Capability and Capacity Framework that sets out required competencies, resource levels, training pathways, role clarity (including information asset ownership), and an approach to improving data literacy across all levels of the organisation. This framework will also define the model for business intelligence service delivery and ensure alignment with the Trust's digital and clinical strategies.	Chief Digital & Information Officer	End Q3	Each Care Group has 1 WTE Analyst to support their care group. Wider comprehensive review not yet commenced.

Quality statement 6: Partnerships and Communities

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
29.	**The Trust should consider how it might raise the profile and voice of stakeholder feedback as part of triangulation of assurances. This should include the voice of**	29.2 Seek specific partner stakeholder feedback annually prior to appraisal.	Director of Communications	Start Q4	

	staff, patients and system partners.				
32.	**As part of the shift to proactive and more strategic partnership relations, the Trust should consider its anchor institution role and what this means for the Trust alongside how it can best support improvements in health inequalities.**	32.1 Director of Strategy to take Executive responsibility in advancing the role of the Trust as an Anchor Institute with an annual report to Board on progress and plans.	Director of Strategy	End Q3	

Quality statement 7: Learning, improvement and innovation

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
36.	**The Trust should consider its approach to assuring itself that it has sufficient transformational change capacity and capability to support its forward agenda. This should include clarity of leadership of transformation and Board/committee reporting for assurance purposes.**	36.2 Commission a follow-up internal audit of the Quality Assurance Framework	Associate Director Corp Governance	End Q3	To be concluded. Discussion required at the Audit Committee for a change to the Internal Audit annual plan to incorporate a review of the Quality Assurance Framework.

Quality statement 8: Environmental sustainability

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
No Q3 or Q4 actions					

Quality statement 1: Shared direction and culture

Ref	Recommendation	Action	Responsible Officer	Completion By (2026/27 unless specified)	Last Update
4.	**The Trust should consider ways in which it can ensure that appropriate focus is given over to strategy, oversight of delivery and ensuring that an appropriate culture is in place.**	4.3 The timetable of Board development sessions will be reviewed and sufficient time given to the review, development and discussion of strategies will be scheduled.	Associate Director Corp Governance	End Q1	Completed. The annual Board Development and Strategy Programme has been reviewed and redesigned to ensure dedicated time is scheduled throughout the year for the review, development and discussion of the Trust Strategy and associated enabling strategies.
		4.4 Executive development sessions will be held four times a year focused on strategic development.	Chief Executive	End Q1	Completed and reported – May 2026.
		4.5 Review and rebalance Board agendas and assurance processes to ensure appropriate focus on strategic delivery, outcomes, culture and performance against agreed scorecards.	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
5.	**The Trust should consider development of a renewed cultural and organisational development (OD) plan that targets considerations contained within this report, and in**	5.3 Development and implementation of a revised senior leadership visibility programme to strengthen connectivity with staff across sites and services.	Director of Communications	End Q4 25/26	Completed and reported – May 2026.
		5.4 Full review of all corporate meetings with the aim of releasing 30% back to focus on engagement and transformation.	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.

	particular strengthens cultural oversight and focus along with staff feedback and engagement processes including improvements in connectivity of senior leaders with the Trust.				

Quality statement 2: Capable, compassionate, and inclusive leaders

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
7.	**The Board should consider formalisation of its capability assessment via a structured Board Development Programme that includes team building, development of a formal Board Skills Matrix to demonstrate suitability of skills/experience and identify gaps, and an associated Succession Plan which sets out the forward look regarding Board requirements and known churn.**	7.1 Commission a Board Development Programme agree requirements, scope and timescales.	Associate Director Corp Governance	End Q1	Completed. A revised Board Development Programme proposal has been received and is being considered.
		7.2 Strengthen Board assurance arrangements and Fit and Proper Persons Test annual report to be on CoG agenda	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
		7.3 Maintain and refresh Board and Executive succession plans, taking into informed by skills gaps, anticipated churn and diversity considerations.	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
8.	**The Trust should consider how it can strengthen Board connectivity into the Trust, paying particular attention to executive visibility across sites and all services.**	8.1 See actions 5.3 and extend executive and senior leader visibility arrangements consistently across Care Groups and services.	Director of Communications	End Q4 25/26	Completed and reported – May 2026.
		8.2 Executive Directors meeting to be held at each Hospital site with purposeful 'back to the floor' time prior to each meeting.	Chief Executive	Complete	Completed and reported – May 2026.
9.	**The Trust should consider how it might increase the voice of stakeholders (staff, patients and external partners) into Board and committee to provide improved triangulation of assurances.**	9.1 Patient story at start of each Board meeting.	Chief Nurse	Complete	Completed and reported – May 2026.
		9.4 Increase Freedom to Speak Up reporting to the Board every three months supported by triangulated themes with other workforce and quality intelligence	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.

11.	**The Trust should consider how it might further strengthen collegiate working within the executive team and ensure that briefings/reports into Board and committee meetings have been socialised, discussed and owned across the executive team.**	Corporate Directors meeting to be restructured with scheduled areas of focus each week along with a clearly communicated requirement for papers to be socialised and agreed prior to submission to Board.	Chief Executive	Complete	Completed and reported – May 2026.
12.	**The Trust should consider the relevance of the existing Leadership Framework and how it might re-energise it and monitor take up and impact.**	12.3 (see 5.1 and 5.2) Undertake detailed scrutiny of staff wellbeing, absence trends and workforce processes, identifying root causes and targeted interventions.	Director of Workforce & OD	End Q1	Completed
		12.4 KPIs for completion of HR processes with points of escalation for additional support	Director of Workforce & OD	End Q1	Completed

Quality statement 3: Freedom to speak up

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
13.	**The Trust should consider the overall FTSU resource and ensure adequacy of cover across sites/services to meet the needs of staff and the Trust.**	13.1 Benchmark with a view to increase if required FTSU capacity across the Trust	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		13.2 Review administrative support to FTSU Guardian	Associate Director Corp Governance	End Q1	Completed. Specific administrative support requirements have been identified by the FTSU Guardian and are being implemented.
		13.3 (see 12.1 and 12.4) Training for managers to be expanded beyond the current offer to include listening compassionately and responding constructively to concerns, avoiding defensiveness, and providing full responses in a timely way.	Director of Workforce & OD	End Q2	Completed. The LMF training has been updated to include this e.g. in relation to Stay Conversations 'Listen actively and avoid defensiveness', in relation to Appraisals 'Actively LISTEN to the answers – show interest, patience, understanding'. Further work on the broader training offer is ongoing.
14.	**The Trust should consider frequency and triangulation of reporting into Board across a number of assurance areas to help identify**	14.3 Reportable issues log to include themes of grievances along with triangulation of FTSU data.	Director of Workforce & OD	End Q4 25/26	Completed.
		14.5 Support staff networks to fulfil their potential through clarifying their role, support they can expect and executive sponsorship.	Director of Workforce & OD	End Q1	Completed.

	areas of cultural concern and/or themes.				
15.	**The Trust should consider the appropriateness of hosting the FTSU process within the DWOD's portfolio and the effect on perceived independence.**	Host FTSU process via the CHIEF EXECUTIVE	Chief Executive	Complete	Completed and reported – May 2026.
16.	**The Trust should consider ways in which it can strengthen feedback from the FTSU process to demonstrate impact of speaking up to encourage take up of the service.**	16.1 FTSU report to Board every three months (as per 9.4).	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		16.2 Quarterly article in *Staff Matters* on positive changes resulting from FTSU.	Director of Communications	End Q1	Completed. First article featured June 2026. Quarterly meetings in place with communications team and FTSU Guardian to plan content.
		16.3 At quarterly Board meetings where FTSU report will be received substitute a patient story for a colleague story in an anonymised way to evidence how learning from FTSU has been taken.	Director of Workforce & OD	End Q1	Completed and reported – May 2026.

Quality statement 4: Workforce equality, diversity and inclusion

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
17.	**The Trust should consider strengthening alignment of EDI actions with feedback concerns and ensure systematic evaluation of the effectiveness of interventions.**	Full review of key themes arising from the staff survey for colleagues with protected characteristics leading to a targeted plan that is co-produced with the staff networks	Director of Workforce & OD	End Q1	Completed. Full analysis of results have been undertaken and shared with the Anti Racism Steering Group. Actions added to WRES and WDES action plans, EDI workstream actions and played into planning for the next Staff Survey.
19.	**The Board should consider how it can further improve the diversity of inputs at Board and senior leadership levels of the Trust.**	Increase the diversity of Board members to be more reflective of the organisation.	Associate Director Corp Governance	Q1	Completed. Explicit considerations of diversity will be included in future Board role advertisements. The Trust is also works with underrepresented groups on Board experience as part of the Insights Programme.
20.	**The Trust should ensure that executive sponsorship of staff networks leads to meaningful inputs, dialogue and effective outcomes.**	20.1 CHIEF EXECUTIVE to set clear expectations of role of Executive Sponsors of the staff network groups (also see 18).	Chief Executive	End Q4 25/26	Completed and reported – May 2026.
		20.2 Each executive Director to have a meaningful and measurable EDI objective set at annual appraisal	Chief Executive	End Q1	Completed.
21.	**The Trust should undertake deep dive scrutiny over staff absences and ensure that the Trust wellbeing offer helps**	Undertake ongoing scrutiny of staff wellbeing, absence trends and workforce processes, identifying root causes and targeted interventions	Director of Workforce & OD	End Q1	Completed.

	address and mitigate the root causes.	feeding through to the Resources committee.			
22.	**The Trust should seek ways in which it can improve medical staffing appraisal rates.**	N/a	Medical Director	Complete	Completed and reported – May 2026.

Quality statement 5: Governance, management and sustainability

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
23.	**The Trust should seek to clarify the role and purpose of the unitary Board and its committees and ensure an appropriate focus is maintained at each level supported by strengthened governance processes as identified within our report.**	23.1 Review Terms of Reference and work plan of the Trust Board meeting and Committees including frequency, scope and attendees.	Associate Director Corp Governance	End Q2	Completed and reported – May 2026.
		23.2 Clarify inclusion or exclusion of the BAF at committees via review of the terms of reference.	Associate Director Corp Governance	End Q1	Completed. Oversight of the respective Board Assurance Framework (BAF) risks are included on Committee's Terms of Reference, to be reviewed quarterly and reported to the Board of Directors.
		23.4 Improve action plan/log hygiene through standard work e.g. specific dates not 'asap' and only complete when it can be evaluated (i.e. not an intention)	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		23.5 Board Committee escalation reports to include a heading "Assurance Gained".	Associate Director Corp Governance	End Q4 25/26	Completed and reported – May 2026.
		23.6 Capital expenditure report in the monthly financial report to include forecasts	Director of Finance	Complete	Completed and reported – May 2026.
		23.8 Consider annual joint working programme with Council of Governors	Associate Director Corp Governance	End Q1	Completed. A joint Board of Directors/Council of Governors meeting is scheduled for 9 September to discuss the Clinical Strategy where further joint working will be discussed.

		23.9 Governor questions to be on the public agenda of CoG and categorised by: governance, public, staff, stakeholder	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
24.	**The Trust should consider the appropriateness of oversight of the digital agenda including the existing arrangements for EPR implementation given the level of risk such a transaction presents to the Trust.**	24.1 EPR as standing item on Risk Committee Meeting.	Chief Executive	Complete	Completed and reported – May 2026.
		24.2 Increase Board visibility and assurance over EPR delivery via Monthly Board report, including risks, readiness, dependencies and post-implementation requirements.	Chief Digital & Information Officer	Start Q1	Completed and reported – May 2026.
27.	**The Trust should consider strengthening its approach to risk management in line with our report observations including the operationalisation of risk appetite to support risk escalation / de-escalation within the Trust**	27.1 Risk Committee terms of reference to be reviewed to become a subcommittee of the Board	Associate Director Corp Governance	Start Q1	Completed and reported – May 2026.
		27.2 Ensure consistent format of reports from Care Groups and Directorates	Associate Director Corp Governance	End Q1	Completed and reported – May 2026.
		27.4 Resolve, explain difference between SHMI and HSMR	Medical Director	End Q1	Completed and reported – May 2026.

Quality statement 6: Partnerships and Communities

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
33.	**The Trust should ensure that deputies are well briefed and able to represent the Trust when deputising for Trust officers at system meetings beyond any immediate operational needs.**	Individual Executives are to ensure that deputies who attend understand meetings on their behalf are able to attend meetings in an informed way with a clear understanding and pre agreed level delegated authority.	Executives	End Q4 25/26	Completed and reported – May 2026.

Quality statement 7: Learning, improvement and innovation

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
37.	**The Trust should consider whether the existing profile and membership of the Research & Innovation Committee is commensurate with the Trust's teaching status and stated desire to increase research activities as part of delivering the Trust's strategy.**	37.1 Review the profile, membership and reporting of the Research and Innovation Committee to align with strategic ambition and teaching status.	Associate Director Corp Governance	End Q1	Completed. A proposal has been drafted for review for revised Research and Innovation Committee arrangements.
		37.2 Agreed and including role as MEDICAL DIRECTOR as Chair or Deputy Chair of R&I Committee	Associate Director Corp Governance	End Q1	Completed. A proposal has been drafted for review for revised Research and Innovation Committee arrangements.

Quality statement 8: Environmental sustainability

Ref	Recommendation	Action	Responsible Officer	Completion By	Last Update
39.	**The Trust should consider how it might demonstrate increased whole Board interest and ownership of sustainability including the appointment of a Board level sustainability champion.**	Agree a Board level sustainability champion.	Associate Director Corp Governance	End Q1	Completed. YTHFM Managing Director is the Board level sustainability champion.

OTHER CONSIDERATIONS - MISCELLANEOUS

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 15

TRUST PRIORITIES REPORT

October 2026

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NHS Foundation Trust

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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.

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 – RTT – Waits over 52 weeks for Incomplete Pathways – Provisional Position.
Operational Activity & Performance – Outpatients – Follow-up Partial Booking (FUPB) overdue (over 6 weeks).
Maternity – Homebirth service suspended – York.
Workforce – Monthly sickness absence.
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	2026-09			13.9%	8.2%	5%
ED - Conversion rate (Proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero)	2026-09			22.5%	28.8%	28%
Cancer - Faster Diagnosis Standard - Declared Position	2026-08			74%	80%	84.3%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-09			61.8%	63.6%	67.1%
2-hour Urgent Community Response (UCR) Compliancy %	2026-09			83%	70%	70%
Total Number of Trust Onset MSSA Bacteraemias	2026-09			5	7	7
Response rate overall for complaints and concerns	2026-09			66.2%	90%	90%
Monthly sickness absence	2026-08			5.8%	5%	4.7%
Variance year-to-date to financial plan	2026-09			-2%	0%	0%

National Oversight Framework performance overview

Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

The latest published NHS Oversight Framework position is Q1 2026/27. York and Scarborough is ranked 102nd of 134 providers, with an average delivery score of 2.68. The Trust is in segment 3, with its segment capped because it is reporting a financial deficit and has an Amber/Red capability rating. Nationally, the Trust is in the lowest quartile for access to services and finance, productivity and innovation, while effectiveness of care and population health is in the highest quartile. Patient safety, people and experience of care are all in quartile 3.

The latest internal position (next page) indicates that the overall assessment is unlikely to improve materially at Q2 without a significant shift in access, flow and financial performance. The following pages contain 42 NOF metrics, with current Trust information available for 37. Of the metrics assigned a local RAG position, 12 are rated red and eight green. The published national and internal reporting periods differ between metrics, so the position should be regarded as an emerging Q2 assessment rather than a formally calculated segment.

Access to services remains the principal area of concern. In elective care, 58.4% of pathways were within 18 weeks in August, compared with the latest published national value of 59.0%, while 2.2% were waiting over 52 weeks compared with 1.9% nationally. Diagnostics also remained below the national position, with 22.0% waiting over six weeks in September compared with 20.6% in the published June data. Community waiting times show a similarly mixed picture: 54.9% were within 18 weeks, below the published 60.1%, although the percentage waiting over 52 weeks was lower at 21.1% compared with 22.5%. Please note: August is used as that is a confirmed position, September is, at the time of this report, provisional.

Urgent and emergency care is a further material pressure. September four-hour performance was 65.2%, with the Q2 position at 66.2%, compared with the published Q1 value of 72.0%. The proportion of patients spending more than 12 hours in an emergency department was 14.4% in September and 14.2% across Q2, compared with 10.2% in Q1. The pages illustrate 2,187 corridor-care patients in September and 5,808 across Q2, although this metric does not yet have a published national comparator. Internal reporting identifies urgent care and flow as the Trust's most significant operational and patient-safety concern, with performance affected by demand, medical staffing, discharge delays and constrained community and social-care capacity.

There are, however, important areas of positive assurance. Cancer 62-day performance was 71.8% in August and 73.2% across Q2, above the Q1 published value of 71.2%. The Faster Diagnosis Standard was 74.0% in August and 73.5% for Q2, broadly in line with the published Q1 position of 73.6%. Clinical-trial setup performance increased from 60% in Q1 to 100% in Q2. The Trust also recorded four MRSA bacteraemia cases compared with five nationally at Q1, and the rolling E. coli rate was slightly below the latest published rate.

Finance and organisational sustainability remain a major constraint. The emerging Q2 combined finance score remains at 4. Although the planned deficit of 2.0% is less adverse than the Q1 published value of 2.6%, the year-to-date variance against financial plan has deteriorated to minus 2.0%, compared with minus 1.3% nationally. Relative costs are also higher at 0.94 compared with 0.86, the Data Quality Maturity Index has reduced from 92.2 to 91.1, and sickness absence is line with the with 5.79% recorded in Q1.

Overall assessment: performance is mixed, with credible strengths in cancer treatment, research delivery, aspects of infection control and effectiveness of care. These are outweighed by sustained challenges in elective and community access, emergency flow, long waits, diagnostics and financial delivery.

National Operational Framework
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Description	Latest National Reporting Date	Latest National Value	Latest Trust Reporting Date	Latest Trust Reporting Value	Latest Trust Reporting Quarter	Latest Trust Quarterly Value	RAG
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun-26	59.01%	Aug-26	58.38%	Aug-26	58.38%	
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Jun-26	1.93%	Aug-26	2.22%	Aug-26	2.22%	
Percentage of diagnostic waits over 6 weeks	Jun-26	20.64%	Sep-26	21.98%	Sep-26	21.98%	
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q1 2026/27	72%	Sep-26	65%	Q2 2026/27	66%	
Percentage of emergency department attendances spending over 12 hours in the department	Q1 2026/27	10.22%	Sep-26	14.43%	Q2 2026/27	14.18%	
Percentage of patients treated for cancer within 62 days of referral	Q1 2026/27	71.15%	Aug-26	71.75%	Q2 2026/27	73.23%	
Percentage of patients waiting less than 18 weeks for community care	Jun-26	60.12%	Sep-26	54.92%	Q2 2026/27	54.92%	
Percentage of patients waiting over 52 weeks for community services	Jun-26	22.47%	Sep-26	21.14%	Q2 2026/27	21.14%	
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q1 2026/27	73.56%	Aug-26	73.99%	Q2 2026/27	73.45%	
Number of patients cared for in corridors (ED only)	-	-	Sep-26	2187	Q2 2026/27	5808	
Percentage of intermediate care beds occupied by patients without criteria to reside	Q1 2026/27	15.61%	Sep-26	21.83%	Q2 2026/27	19.48%	
Average number of days between clinically ready for discharge date and actual discharge (including zero delays)	-	-	Aug-26	0.80	Aug-26	0.80	
Percentage of patients readmitted within 30 days of discharge – comparative band	-	-	2024/25	B5	2024/25	B5	
Level of growth in total community care contacts	-	-	Jul-26	-0.53%	Q1 2026/27	-1.84%	
Breadth and depth of clinical audit outliers score	-	-	-	-	-	-	
Number of MRSA bacteraemia cases (rolling 12 months)	Q1 2026/27	5	Sep-26	4	Q2 2026/27	4	
Rate of E. coli (rolling 12 months)	Q4 2025/26	1.10	Aug-26	1.08	Aug-26	1.08	
Rate of C. difficile (rolling 12 months)	Q4 2025/26	0.90	Aug-26	0.97	Aug-26	0.97	
Number of neonatal deaths and stillbirths per 1,000 births	-	-	2024	3.95	2024	3.95	
Delayed inductions rate	Q1 2026/27	17.8	Q1 2026/27	17.8	Q1 2026/27	17.8	
Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Q4 2025/26	52%	Jul-26	45.6%	Q1 2026/27	56%	
Rate of inpatient falls causing harm	-	-	2025	4.1%	2025	4.1%	
Percentage of patients acquiring a new Grade 3 or 4 pressure ulcer	-	-	-	-	-	-	
Percentage of safety incidents resulting in harm	-	-	Q1 2026/27	42.2%	Q1 2026/27	42.2%	
Summary Hospital-level Mortality Indicator	-	-	Jun 25 - May 26	89.8	Apr 25 - Mar 26	88.4	

NB: 'Latest Trust Quarterly Value' will contain all available months in the quarter where the metric is an aggregate or average figure. Please refer to 'Latest Trust Reporting Date' column for the latest position included

National Operational Framework
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Description	Latest National Reporting Date	Latest National Value	Latest Trust Reporting Date	Latest Trust Reporting Value	Latest Trust Reporting Quarter	Latest Trust Quarterly Value	RAG
Percentage of complaints open over 6 months	-	-	-	-	-	-	
Percentage of clinical trials set up within 90 days	Q1 2026/27	60%	Q2 2026/27	100%	Q2 2026/27	100%	
Healthcare Worker Flu Vaccination Rate	Q1 2026/27	51.70%	Q2 2026/27	51.70%	Q2 2026/27	51.70%	
NHS Staff survey – raising concerns sub-score	2025	6	2025	6	2025	6	
NHS staff standards score	2025	7.43	2025	7.43	2025	7.43	
NHS staff survey engagement theme sub-score	2025	6.51	2025	6.51	2025	6.51	
National Education and Training Survey satisfaction rate	2025	75.25%	2025	75.25%	2025	75.25%	
Sickness absence rate	Q1 2026/27	5.79%	Aug-26	5.83%	Q2 2026/27	5.87%	
CQC inpatient survey satisfaction rate	2025	8.1	2025	8.1	2025	8.1	
NHS staff survey advocacy rate score	2025	5.99	2025	5.99	2025	5.99	
Temporary staffing cost relative band score	Q1 2026/27	1	-	-	-	-	
Combined finance score	Q1 2026/27	4	Q2 2026/27	4	Q2 2026/27	4	
Data Quality Maturity Index score	Apr-26	92.20	Sep-26	91.1	Q2 2026/27	91.1	
Planned surplus/deficit	Q1 2026/27	-2.56%	Sep-26	-2.03%	Q2 2026/27	-2.03%	
Relative difference in costs	Q1 2026/27	86.27%	Sep-26	94%	Q2 2026/27	94%	
Variance year-to-date to financial plan	Jun-26	-1.33%	Sep-26	-1.99%	Sep-26	-1.99%	
Implied productivity growth	-	-	-	-	-	-	

NB: 'Latest Trust Quarterly Value' will contain all available months in the quarter where the metric is an aggregate or average figure. Please refer to 'Latest Trust Reporting Date' column for the latest position included

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

October 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

• Cancer 62-day performance was 71.8% in August, above the 70.7% trajectory, with Breast and Upper GI above the 75% standard.
• Urgent Community Response performance has improved and Hospital at Home pathways continue to develop.
• Outpatient productivity remains a relative strength: September DNA rate was 4.4%; Advice and Guidance utilisation remains above the provider median and consultant-to-consultant referrals are 12% lower year to date.
• Operational oversight has strengthened through external tiering, weekly specialty oversight, tumour-site reviews and implementation of the Q3 Focus on First RTT programme.

Areas giving confidence

• The Contract Management Framework with Humber and North Yorkshire ICB provides a mechanism to review referral growth, demand management opportunities, complex discharge and commissioning dependencies.
• Cancer, RTT and diagnostics recovery actions are supported through specialty level ownership and monitoring arrangements, with established escalation routes.

Key risks and concerns

• UEC and flow remain the most significant operational and patient-safety concern. September ECS was 65.2% against 75.8% trajectory; length of stay, discharge timeliness and 12-hour waits remain off plan.
• RTT deteriorated further: provisional waiting list 58,696 against 52,865 trajectory, 57.8% within 18 weeks, 1,303 over 52 weeks and five over 65 weeks.
• Diagnostics reduced to 78.0% against 78.3% trajectory, with the overall waitying list and long breaches increasing; NOUS, echocardiography, urodynamics and equipment resilience remain material risks.
• Faster Diagnosis Standard (FDS), Patient Initiated Follow Up (PIFU), Rapid Access Chest Pain (RACP), Children and Young Person (CYP) long waits and community Speech and Language Therapy (SLT) remain below plan, with delivery constrained by workforce, diagnostic capacity, affordability and system dependencies.

Executive Owner: Claire Hansen

Priority Area	Assurance Position	Q3 Outlook
UEC & Flow	September ECS was 65.2% against 75.8% trajectory. Handover averaged 21m 48s, 13.9% of Type 1 patients waited over 12 hours, LoS was 8.6 days and 85.2% were discharged on their DRD.	High Risk. Internal actions should improve grip, but sustained recovery depends on medical staffing, discharge capacity and wider system flow.
Cancer	August 62-day performance was 71.8%, above trajectory. FDS was 74.0% against 80%; pathology, colonoscopy and fast-track imaging remain limiting factors.	Moderate to High Risk. Sustain 62-day delivery while recovering FDS through tumour-site action, diagnostics and pathway redesign.
RTT & Long Waits	Provisional TWL was 58,696, with 57.8% under 18 weeks, 1,303 over 52 weeks and five over 65 weeks. GP referrals are 4.8% higher year to date.	High Risk. Q3 “Focus on First”, two-week RTT only clinics, validation and specialty controls are intended to improve pathway flow, however delivery of planned trajectories remain challenged.
Diagnostics	DM01 was 78.0% against 78.3% trajectory. The waiting list rose to 12,397, with 2,722 six-week and 341 thirteen-week waiters.	Moderate to High Risk. Additional endoscopy and imaging capacity provide mitigation, although material workforce, equipment and capacity risks remain. (NOUS, Echo, Urodynamics)
Outpatients & Productivity	DNA remained strong at 4.4%, and C2C referrals are down 12% YTD. PIFU was 4.9% against 5.9%, while RACP fell to 43.6% against 99%.	Moderate Risk. Improvement opportunities have been identified through utilisation, templates, PIFU, digital letters and SPoA, but RACP recovery requires clinical capacity.
Children & Young People	Nineteen CYP pathways were over 40 weeks provisionally at September, including five over 52 weeks. Paediatric ECS was 83.9% and remained below the 95% objective.	High Risk. Weekly oversight and the paediatric action plan are in place; recovery remains constrained by Head and Neck and Oral Surgery capacity.
Community Services	UCR performance has improved and Phase 1 of the community model is progressing. SLT ended September at 391 against a trajectory of 321.	Moderate to High Risk. Further progress s dependent upon recruitment, commissioning decisions,I mplementation of the SLT mitigation plan and sustainable medical workforce arrangements.
Service Transformation & Demand Management	Contract management, SPoA, pathway redesign, Hospital at Home and Focus on First provide a clearer transformation programme.	Positive direction, benefits not yet secured. Delivery requires measurable implementation, affordability and timely ICB and local-authority decisions.

Executive Owner: Claire Hansen

Overall assurance remains mixed and recovery is not yet secure. September data confirms further pressure in UEC, RTT and diagnostics, while FDS, PIFU, RACP, CYP and SLT remain below plan. Positive assurance is concentrated in cancer 62-day delivery, low DNA rates, reduced consultant to consultant referrals and an improving Urgent Community Response performance.

The Q3 outlook is better defined through established recovery programmes and governance arrangements, but remains high risk. UEC recovery is constrained by medical staffing, delayed discharge and community and social-care capacity. RTT requires a material improvement in first appointments, validation, activity mix and scheduling discipline. Diagnostics is close to trajectory overall but now carries greater risk following growth in the waiting list and increased 13 week waiters.

Operational leadership and transformation priorities for October and Q3:

- Focus on First RTT recovery: a seven-week programme using time-boxed sprints, daily stand-ups, two-week RTT clinics, long-wait validation, clinical re-triage, patient opt-in and active use of available outpatient capacity.

- UEC and Coming Off Corridors: align rotas to peak demand, improve time to doctor, maximise EEMAC/EAU and Type 3 performance, strengthen board rounds and criteria-led discharge, and continue breach validation.

- Cancer and diagnostics: sustain 62-day delivery, recover FDS, implement tumour-site actions, progress the endoscopy programme and maintain recruitment, insourcing and equipment mitigations.

- Demand and pathway management: implement single points of access, reduce internal referrals, progress Pain thresholds, strengthen Contract Management Framework actions and develop community alternatives.

Executive Owner: Claire Hansen

Focus on the Trust strategic priorities

Strategic priorities for Q3:

- Stabilise UEC and flow: recover ECS from 65.2%, reduce 12-hour waits, align medical rotas to peak demand, maximise EEMAC/EAU and Type 3 performance, strengthen ambulance handovers and deliver Coming Off Corridors actions.
- Improve discharge and community pathways: strengthen board rounds, criteria-led discharge and complex-discharge escalation; progress Phase 1 of the community model, Hospital at Home and UCR expansion.
- Deliver RTT recovery actions and improve elective pathway performance: deliver Focus on First, two-week RTT clinics, long-wait validation and clinical re-triage; maintain weekly oversight of 52- and 65-week waits and target capacity through ARIP.
- Sustain cancer and recover diagnostics: maintain 62-day performance above trajectory, improve FDS, strengthen pathology, imaging and endoscopy turnaround, and address NOUS, Echo and Urodynamics capacity.
- Improve outpatient productivity and strengthen demand management: improve PIFU from 4.9%, recover RACP, maintain low DNA rates, improve clinic utilisation and RTT activity share, reduce C2C referrals and implement Single Point of Access (SPoA).
- Address CYP and community backlogs: deliver paediatric ECS and long-wait recovery plans, progress Oral Surgery and Head and Neck RTT actions, reduce the SLT backlog and secure sustainable workforce models.

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 September 2026 Emergency Care Standard (ECS) position was 65.2%, behind the monthly planned improvement trajectory of 75.8%. As per a national mandate for 2026/27 100% of Bridlington UTC and 50% of Whitby UTC activity is mapped to the Trust for performance purposes.
- In August 2026 (latest available national data) the Trust ranked 103rd out of 118 providers and 10th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group (July performance saw the Trust at 108th and 11th respectively).
- Average ambulance handover time in September 2026 was behind trajectory at 21 minutes 48 seconds against trajectory of 18 minutes 39 seconds.
- 13.9% of Type 1 patients spent over 12 hours in our Emergency Departments during September 2026, behind trajectory of 8.2%.
- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 8.6 days in September 2026, behind the trajectory of 6.9 days. To note: NEL admissions no longer include admissions classed as Type 5.
- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) during September 2026 was 85.2%, against the trajectory of 88.3% submitted as part of the 2026/27 annual planning process. The average delay (number of days after the DRD that a patient was subsequently discharged) was 6.3 days, behind the submitted trajectory (2.8 days).

Factors impacting performance:

- Staffing issues continue, with instances of high levels of absence - medics and nurses - and the need for internal aid.
- Days with very high attendances to our Emergency Departments
- 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 October 2026:

- Submit business case for investment in substantive frontline staff in both Emergency Departments/Emergency Assessment Units.
- Implement the revised medical rota pattern designed to better align workforce availability with periods of peak demand aligned to establishment.
- Move into new Discharge Command Centre at York, supporting closer working with system partners

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 - Ambulance average handover time (number of minutes)	* ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - 12 hour trolley waits - Declared Position * ED - Emergency Care Standard (Type 1 level) - Declared Position * ED - Proportion of Ambulance handovers waiting > 45 mins
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 - 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	2026-09			76.7%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-09	L		6.3%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-09	L	F	13.9%	8.2%	5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-09		F	1742	885	558
ED - 12 hour trolley waits - Declared Position	2026-09	L	F	315		0
ED - Emergency Care Attendances - Declared Position	2026-09			18329		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-09		F	65.2%	75.8%	82%
ED - Emergency Care Standard (Trust level) - Declared Position	2026-09			61.8%		
ED - A&E attendances - Type 1 - Declared Position	2026-09	H	?	12536	10737	11309
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-09	H	F	48.3%	58%	70.1%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-09	L	P	5793	7902	8324
ED - Median Time to Initial Assessment (Minutes)	2026-09	L		3		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-09	L		31.7%		

Summary MATRIX 2

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

MATRIX KEY

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

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

Acute Flow (2)
Scorecard

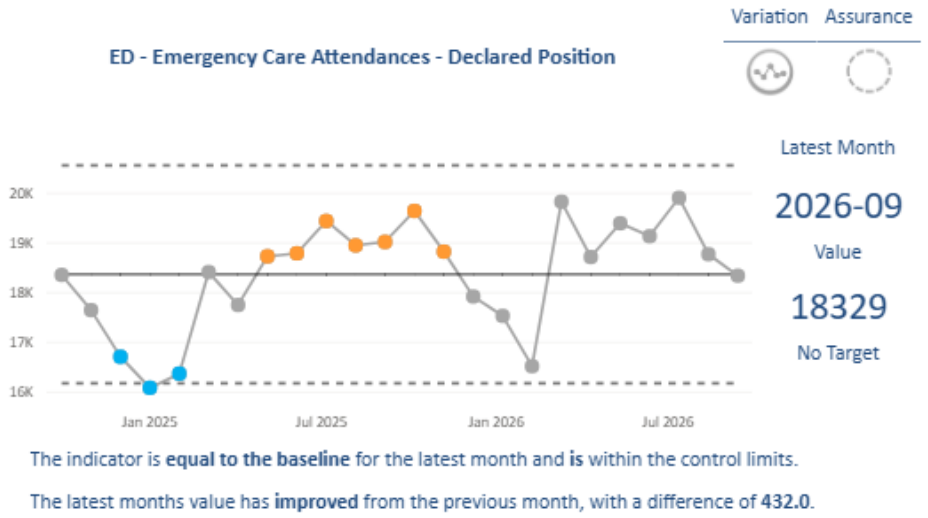
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of SDEC attendances	2026-09			6416		
Proportion of SDEC attendances transferred from ED	2026-09			48.6%		
Proportion of SDEC attendances transferred from GP	2026-09			15.7%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-09			83.4%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-09			26.3%		
Number of RAFA attendances (York Only)	2026-07			0		
Number of attendances at SAU (York & Scarborough)	2026-07			0		
ED - Proportion of Ambulance handovers within 15 mins	2026-09			33.2%		
ED - Proportion of Ambulance handovers over 15 mins	2026-09			66.8%	54.9%	49.6%
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-09			20.7%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-09			3.8%	1%	0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-09			0%		0%
ED - Number of ambulance arrivals	2026-09			4594		
ED - Ambulance average handover time (number of minutes)	2026-09			22	18	19

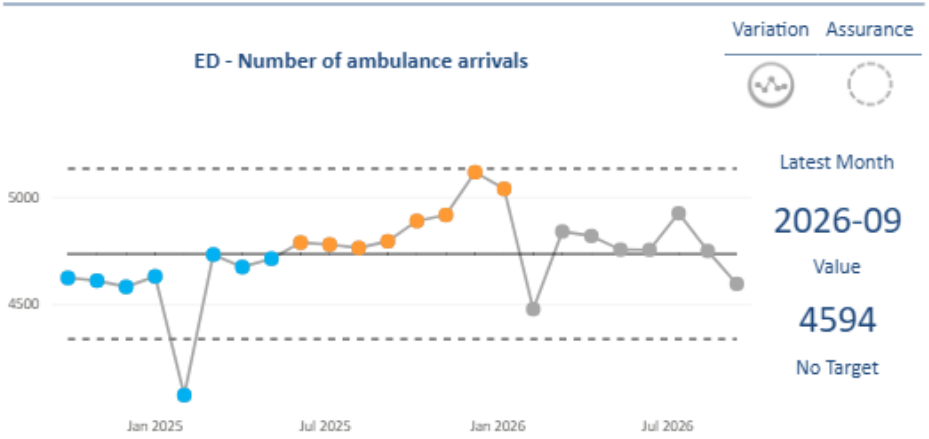
Executive Owner: Claire Hansen

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 **432.0**.



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 **154.0**.

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 current and future alternative pathways. The Community Improvement Group has been refreshed to focus on Alternatives to ED. Data is being reviewed about use of pathways including 'Direct SDEC' and community frailty pathways, to understand rejected referrals and further improvement opportunities.

What is the expected impact?

Maximising use of alternative pathways and developing more options will support a reduction in conveyances and attendances at Emergency Departments.

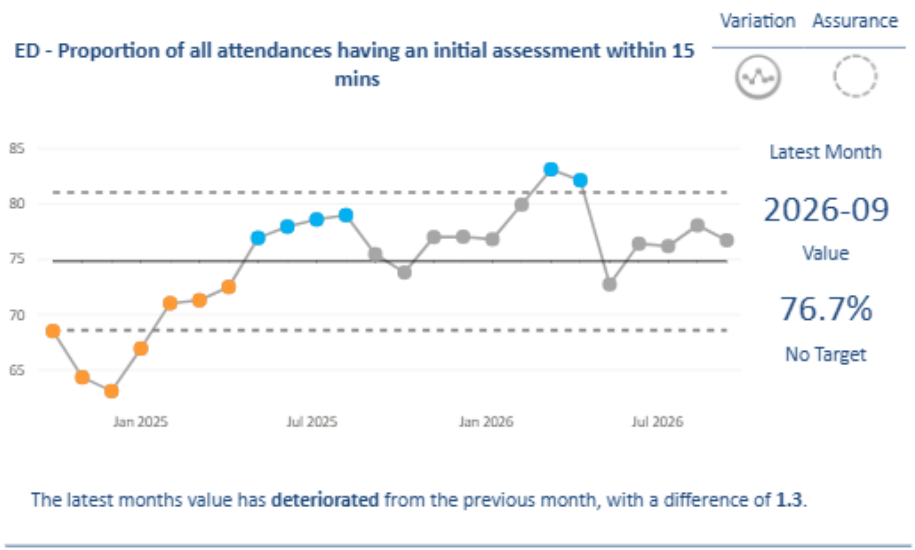
Potential risks to improvement?

Development of strategic plans is complex.

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



The latest months value has **deteriorated** from the previous month, with a difference of **1.3**.

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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 is in-line with levels achieved last year.

There have been days with extremely high attendances a both sites, with instances of over 20 patients per hour arriving to York Hospital for over 6 hours. This makes initial streaming and triage within 15 minutes very challenging.

The First Assessment Bay (FAB) trial at Scarborough Emergency Department continues when staffing levels allow. Rotas are being reconsidered to enable this more often. This model brings triage, early clinical assessment and patient flow coordination into a single front-door process. The aim is to reduce clinical risk through earlier assessment, prioritisation and management planning.

What is the expected impact?

A delay to initial assessment contributes to time in the department and delays that can impact four-hour performance. Increasing medical cover at Scarborough during peak times will support continuation and consistency of the FAB model.

Potential risks to improvement?

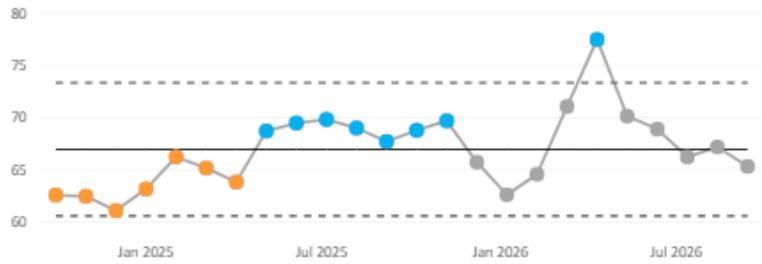
- Business case for substantive additional medics at Scarborough ED is still pending finalisation and approval.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)

Variation Assurance



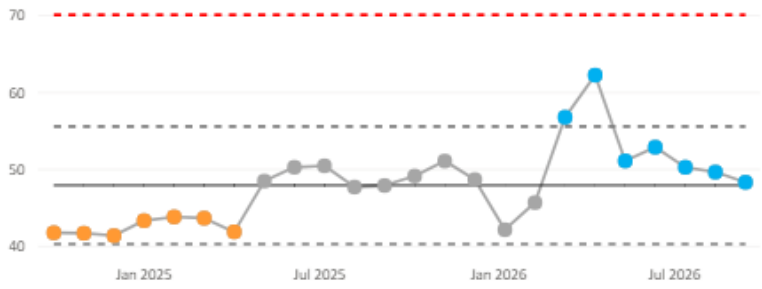
Latest Month
2026-09
Value
65.2%
Target
82%

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 **1.9**.

ED - Emergency Care Standard (Type 1 level) - Declared Position

Variation Assurance



Latest Month
2026-09
Value
48.3%
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 **1.3**.

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?

ECS performance is in-line with the same time last year and an action plan is in place to support recovery. One area of focus is 'time to doctor' and rosters are being redrawn to support times of peak activity.

Paediatric performance remains below 90% and the Paediatric action plan is being progressed. Through this additional scrutiny, some false breaches have been found due to inaccurate recording of the time the patient has left. Additional communication has taken place to remind teams of the importance of real time coding.

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?

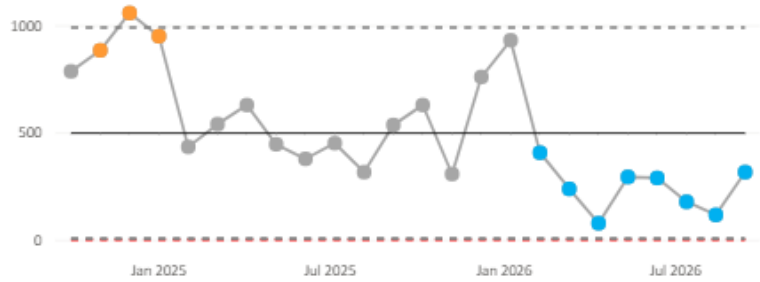
- Limited operational and clinical capacity to complete actions, due to multiple conflicting priorities.
- Varying levels of clinical buy-in and utilisation of the new pathways.
- Delay to business case finalisation

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

ED - 12 hour trolley waits - Declared Position



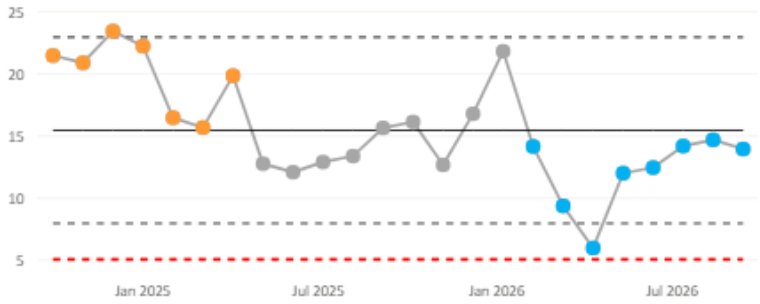
Latest Month
2026-09
Value
315
Target
0

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 **199.0**.

Variation Assurance

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



Latest Month
2026-09
Value
13.9%
Target
5%

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 **0.7**.

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 higher in Scarborough (21%) than York (9%). One remaining issue is the challenge in senior medical cover at Scarborough which drives long waits. Short term funding has been agreed to support, though uptake of additional shifts is limited.

The increase in 12-hour trolley waits against the decrease in overall 12-hour waits highlights the ongoing challenges with flow and bed availability. The Coming off Corridors programme completed observation work in September and are planning actions to support flow in October, including increasing effectiveness of board rounds and endorsing criteria led discharge.

What is the expected impact?

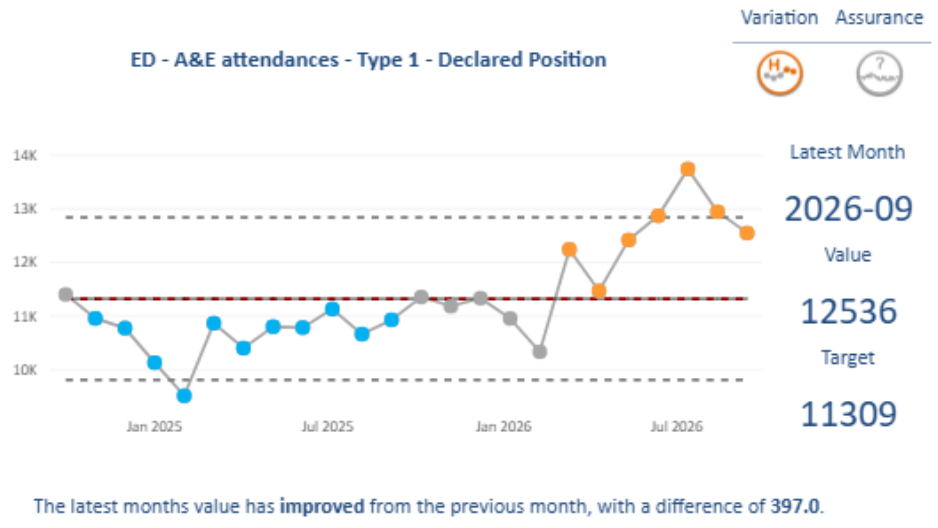
- A continuation of inconsistent performance at Scarborough due to variation in medical cover level.
- Coming off Corridors work to support increased flow.
- Ongoing challenges with social capacity, particularly at York City where there is a significant financial risk to the current spot-purchasing model

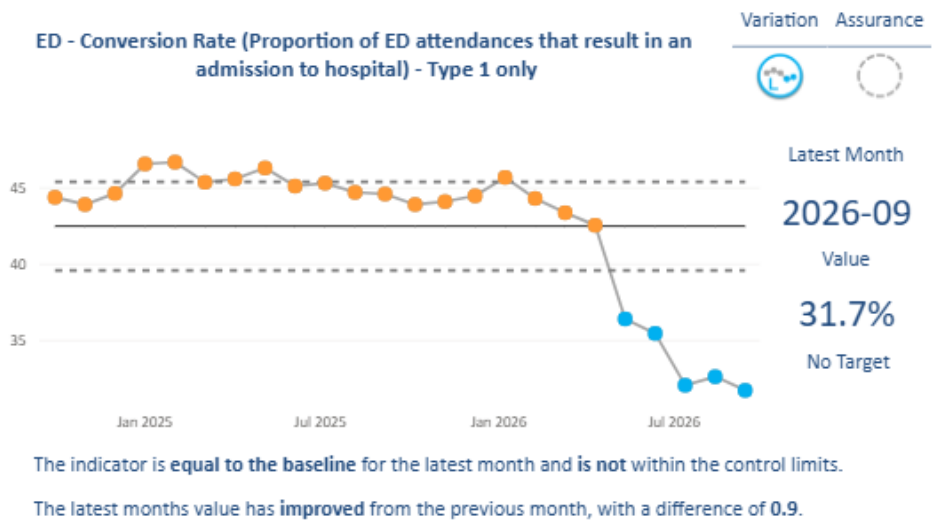
Potential risks to improvement?

- Continued gaps in medical rosters.
- Insufficient community health and social care capacity.
- Limited capacity in ED and acute teams to complete actions.

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 (including EEMAC and EAU). This explains 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. In September there was a challenge maintaining this model, which is likely to have contributed to the increased admission rate.

The business case for additional medical cover is still progressing, with a further round of executive level comments being taken into account.

What is the expected impact?

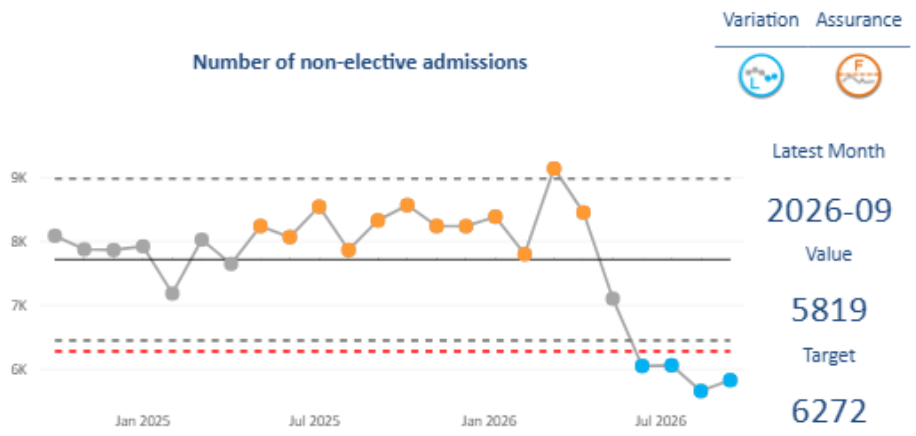
Increased admissions, if unnecessary, could lead to poor patient experiences and outcomes. It will also lead to increased flow challenges and reduced performance across all key metrics.

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.

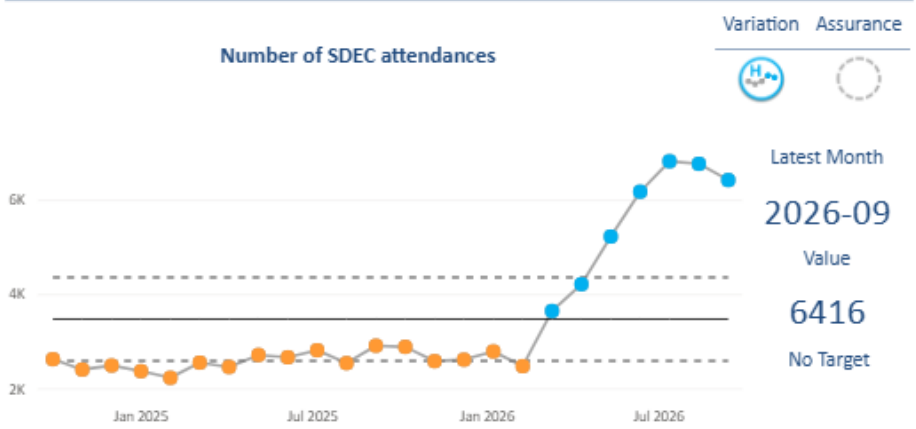
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The indicator is **better 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 **170.0**.



The latest months value has **deteriorated** from the previous month, with a difference of **344.0**.

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 (which includes EEMAC and EAU).

What actions are planned?

The number of patients being treated in an SDEC environment, including EEMAC and EAU, has fallen slightly in September – in part due to the staffing challenges highlighted on the previous slides. Additional efforts will be made in October to maximise the use of EEMAC in particular.

York EEMAC saw an average of 11 patients per day in September, with 25% of those staying in EEMAC over 8 hours. The ambition is to reduce time in EEMAC to enable more patients to be seen through this pathway.

Scarborough EEMAC saw an average of 14 patients per day in September, with 44% staying over 8 hours. These delays are linked to the previously highlighted challenges with medical cover.

What is the expected impact?

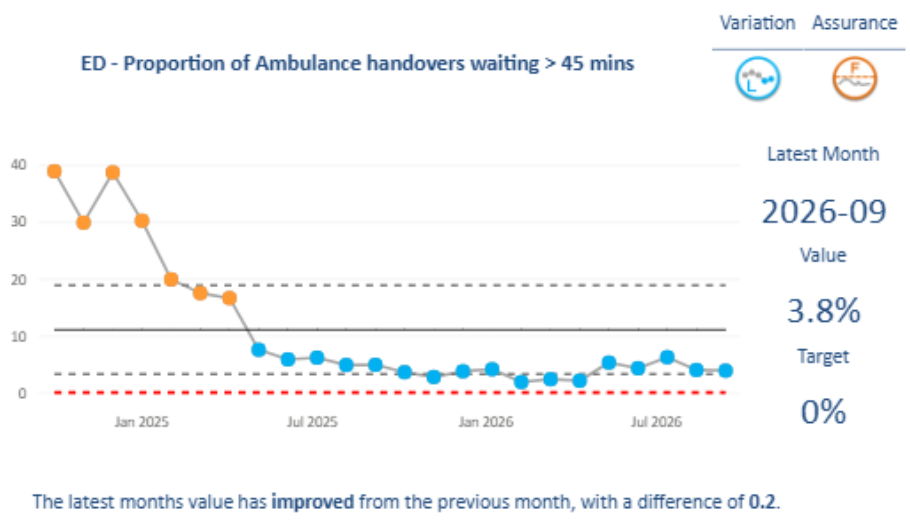
The impact of making quicker decision to send patients to EEMAC and increasing overall use of SDEC – including EEMAC - activity would be improved ECS performance.

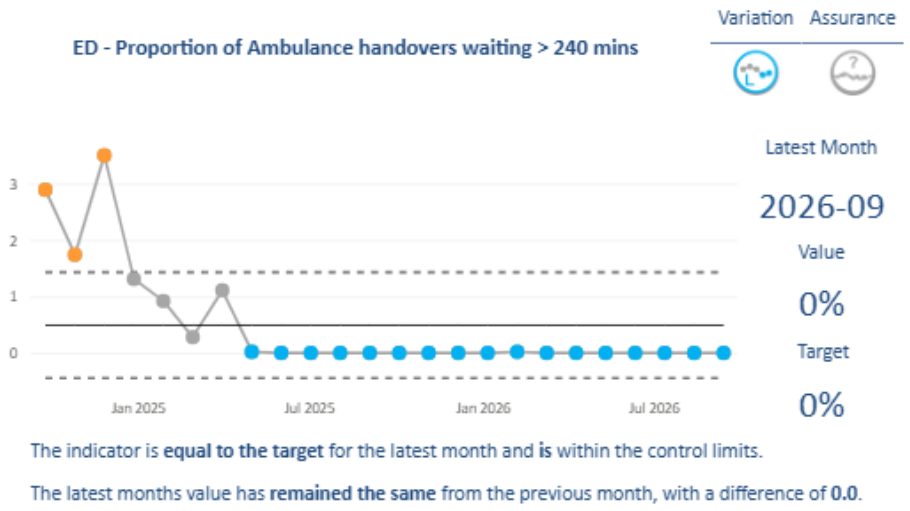
Potential risks to improvement?

- Varied support levels for the EEMAC pathway leading to inconsistent use
- Medical staffing levels

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

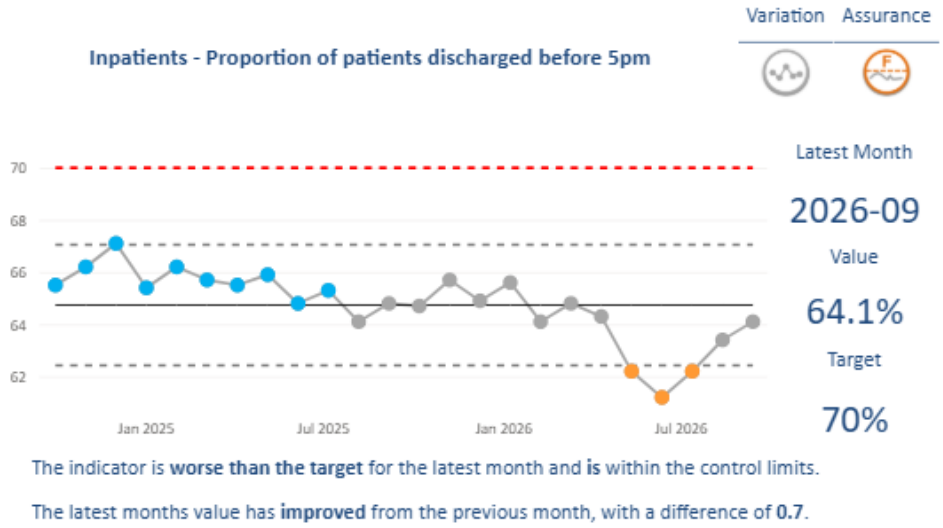
York and Scarborough Teaching Hospitals NHS Foundation Trust

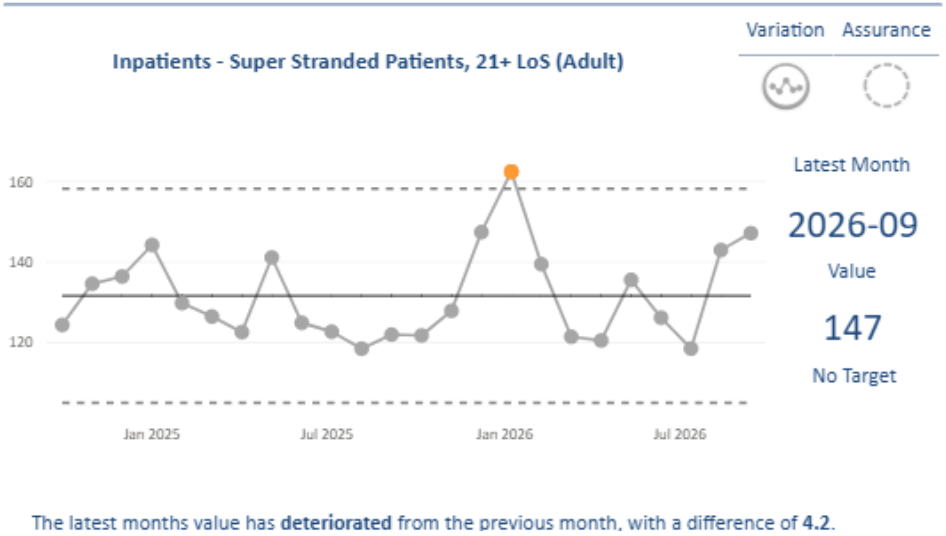
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

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	2026-09		F	64.1%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-09	H		1987		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-09			16.2%		
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-09	H	?	6.3	2.8	3.7
Number of non-elective admissions	2026-09	L	F	5819	7538	6272
Number of zero day length of stay non-elective admitted patients	2026-09	L		905		
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-09			147		
Overnight general and acute beds open	2026-09	L	P	875	843	843
Of those overnight general and acute beds open, proportion occupied	2026-09		?	92.6%	91.9%	93.2%
Community bed occupancy/availability	2026-09		?	93%		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 gave senior clinicians protected time in September to support earlier discharges. Observation work took place and five areas of focus have been identified, with a lead for each, to work on from October. These include:
  - Improving EAU, SDEC and other ambulatory pathways
  - Ward and board round improvements, and use of criteria led discharge
  - Clear escalation and site model with operational engagement
  - Use of internal professional standards

What is the expected impact?

- More efficient processes will result in earlier discharges and improved flow, with a possible further impact of reduced 12 hour delays in ED.
- Greater use of criteria led discharge and improved discharge processes are intended to reduce length of stay and support flow.

Potential risks to improvement?

- Ongoing limitations in community health and social care capacity.
- Cultural change at ward level will take time to achieve

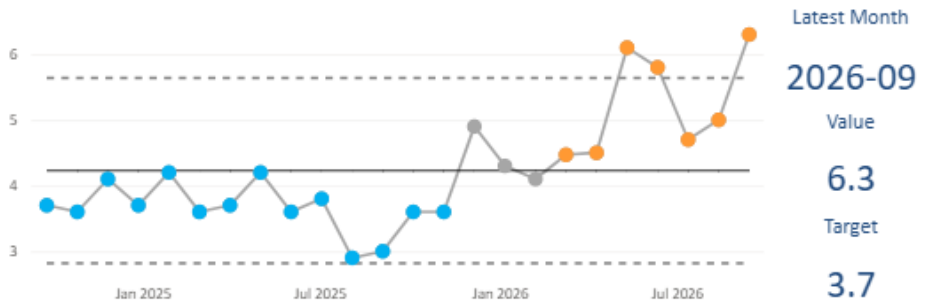
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

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.

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

Variation: H | Assurance: ?



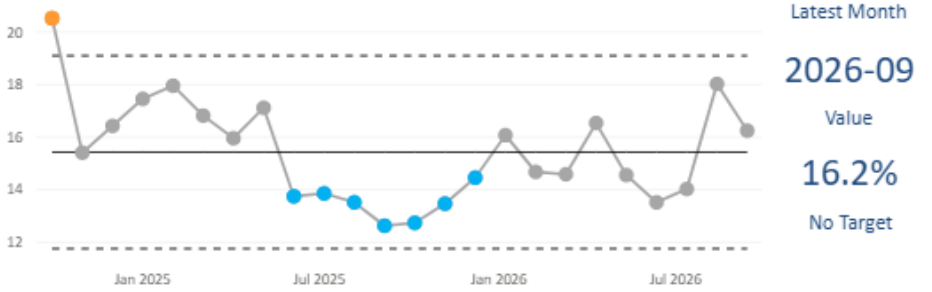
Latest Month: 2026-09
Value: 6.3
Target: 3.7

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

The latest months value has **deteriorated** from the previous month, with a difference of **1.3**.

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

Variation | Assurance



Latest Month: 2026-09
Value: 16.2%
No Target

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

The latest months value has **improved** from the previous month, with a difference of **1.8**.

What factors are impacting performance?

It remains an issue that social care partners 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.

What actions are planned?

- The new Discharge Command Centre space at York is due to be completed in mid-October with the move planned this month.

What will the impact be?

Co-location and closer working with system partners has proven to be successful at Scarborough and during MaDE events – it is hoped that that new office in York will support similar improvements.

Potential risks to improvement?

- Ongoing limited community health and social care capacity to release patients no longer meeting the criteria to reside.
- In City of York Council the discharge to assess model 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			* Cancer - Faster Diagnosis Standard - Declared Position
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait - treatment within 31 days of a decision to treat for all cancer patients- 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	2026-08			74%	80%	84.3%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-08			71.8%	73.8%	80%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-09			170		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-09			7.1%		
Cancer 31 day wait - treatment within 31 days of a decision to treat for all cancer patients- Declared position	2026-08			97.4%	96.2%	96.3%
Total Cancer PTL size	2026-09			2264		

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

- The Cancer performance figures for August 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 74.0% behind the monthly improvement trajectory of 80%. In the latest available national data (July 2026) the Trust ranked 104th out of 119 NHS providers nationally and 9th out of 11 against our Model Hospital peer group (June: 98th and 8th respectively). **This is a True North Metric.**

- 62 Day waits for first treatment service standard in August 2026 was 71.8% , with the monthly trajectory of 70.7% achieved. In the latest available national data (July 2026) the Trust ranked 48th out of 119 providers nationally and 3rd out of 11 against our Model Hospital peer group (unchanged from June: 48th and 3rd respectively).

Factors impacting performance:

- The following cancer sites achieved or exceeded 80% FDS in August 2026: Breast, Lung and None Site Specific. Haematology, and Urology achieved above their internal trajectory.

- The following cancer sites achieved or exceeded 75% 62-day service standard in August 2026: Breast, and Upper GI. Head and Neck 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 Breast surgical capacity.

- At the end of August, 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 and was 2.0% in July. 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 62% of this patient cohort.

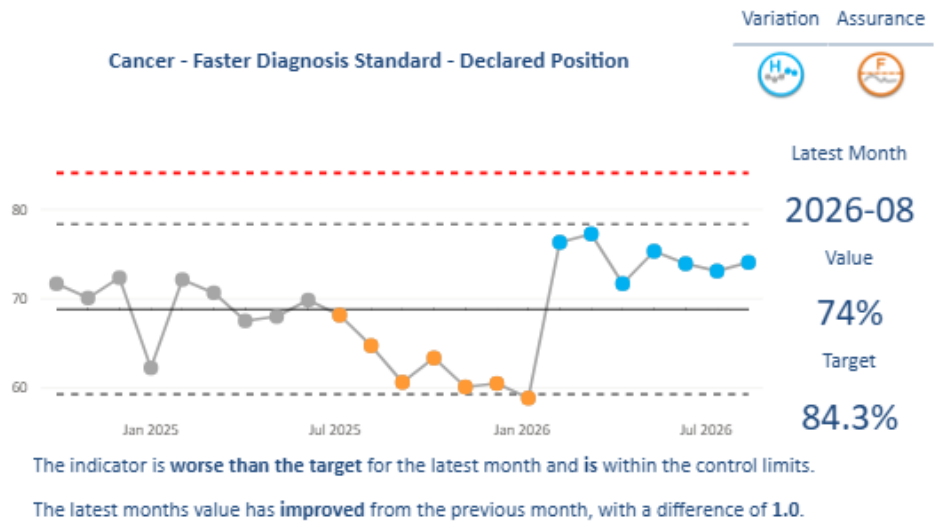
- Diagnostic performance, in particular pathology turnaround time, colonoscopy and fast track imaging acquisition is impacting faster diagnosis performance due to delays in diagnostic pathways.

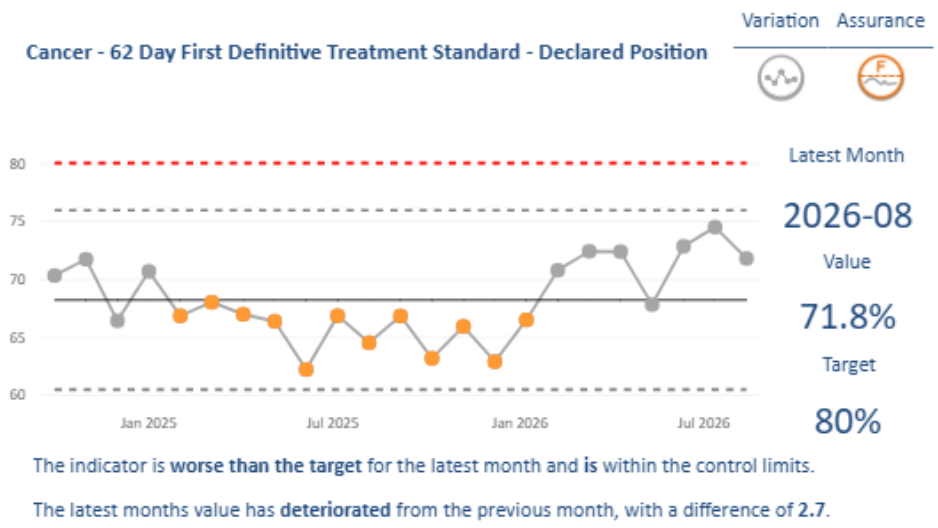
Actions:

- Please see following pages for details.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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

What actions are planned?

•2nd weekly Trust wide meeting implemented to review specific FDS cohort and newly diagnosed patients, alongside new PTL breach process
•Targeted investment and transformation schemes from alliance funding
•Head of Cancer review of care group PTL meetings, external review of cancer information team and tactical focus on 1st seen dates
•MDT streamlining summit- meeting of all clinical leads September 26 and engagement with NHSE and cancer alliance

Colorectal Plan : Provisional position of 58.4% against internal trajectory of 77.0% for FDS. Review of Prof Rutter report and recommendations for maximising endoscopy capacity. Implementation of return of referrals to primary care. Review of surgical theatre capacity and demand

Gynaecology Plan: Provisional position of 64.1% against internal trajectory of 75% for FDS., Working group initiated for IOTA ADNEX one stop model and SOP progressing, with alliance funded national training course booked. Senior perational gaps mitigated with cancer alliance support for tumour site PTL meetings with ops appointments now complete.

Skin : Provisional position of 52.8% against internal trajectory of 82.5%. For FDS LES resolved but 20-30% refs stil being received without image. Review of booking rules with outpatient services and consultant trial of see and treat model.

Lung : Provisional position of 76.7% against internal trajectory of 80% for FDS. Operational and service manager change and flux escalated to ACOO for additional support. 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?

Breach avoidance strategic plan presented to chief executive August 26 with ACOO & COO endorsement
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 for FDS in September account for 31% as primary reason (compared to 16.5% August, 9.6% in July and 7.3% 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 September 2026, the Trust had five **Referral To Treatment (RTT) patients waiting over sixty-five weeks**. All these patients had a plan in place and had been closely managed by the relevant teams; however one was a cancellation by the prison, and the other four were patient choice within the Pain specialty.

- The Trust's **RTT Total Waiting list position** provisionally ended September 2026 behind the trajectory submitted to NHSE as part of the 2026/27 planning submission: 58,696 against the trajectory of 52,865 (+5,831).

- 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 September: 57.8% against 62.4%. In the latest available national data (July 2026) the Trust ranked 108th worst out of 118 NHS providers and 9th worst out of 11 in our Model Hospital peer group (June: 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; 1,303 waiters and 2.2% of the total RTT Total Waiting list against the trajectories of 529 and 1%, respectively (+774 and 1.2%). Validation before submission is expected to improve but not deliver performance against the trajectories. In the latest available national data (July 2026) the Trust was ranked 90th worst out of 118 NHS providers and 7th worst out of 11 in our Model Hospital peer group for the proportion of the TWL waiting over 52 weeks (June: 91st and 8th respectively). Nationally at the end of July 2026 there were 6,687,433 patients on the national TWL, of which 104,286 (1.6%) were waiting over 52 weeks.

- The Trust was behind 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 61.8% against the end of August 2026 ambition to be above 63.6%. There is no nationally available comparative data for this metric. **This is a True North Metric.**

Factors impacting performance:

- 4.8% 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, +7.4% August from August 2025 and +5.5% September from September 2025 (4.8% 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, 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 - 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 * RTT - Waits over 52 weeks for Incomplete Pathways - 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	2026-09	H	F	58696	52865	49360
RTT - Waits over 78 weeks for incomplete pathways - Provisional Position	2026-09	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Provisional Position	2026-09	L	F	5		0
RTT - Waits over 52 weeks for Incomplete Pathways - Provisional Position	2026-09	H	F	1303	529	0
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-09	H	F	57.8%	62.4%	67.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-09	L		17.5		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-09	L	F	2.2%	1%	0%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-09	H	F	61.8%	63.6%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-09	H		2.1%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-09	H		12.5%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-09	H		68.7%		

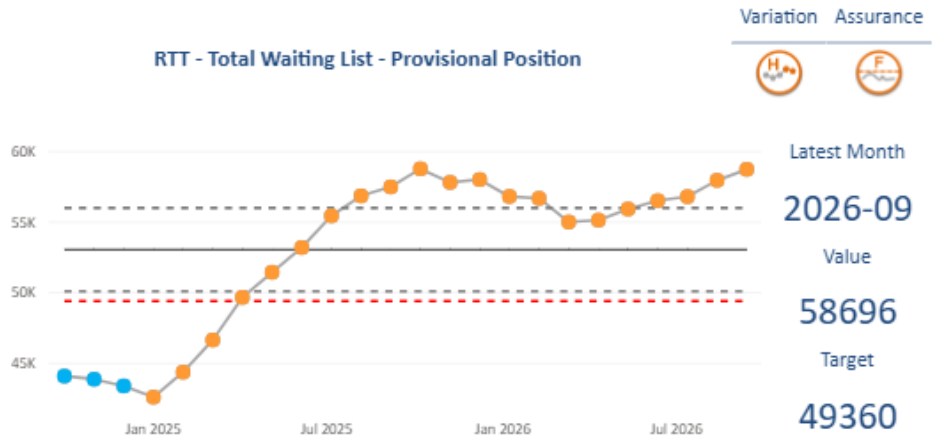
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

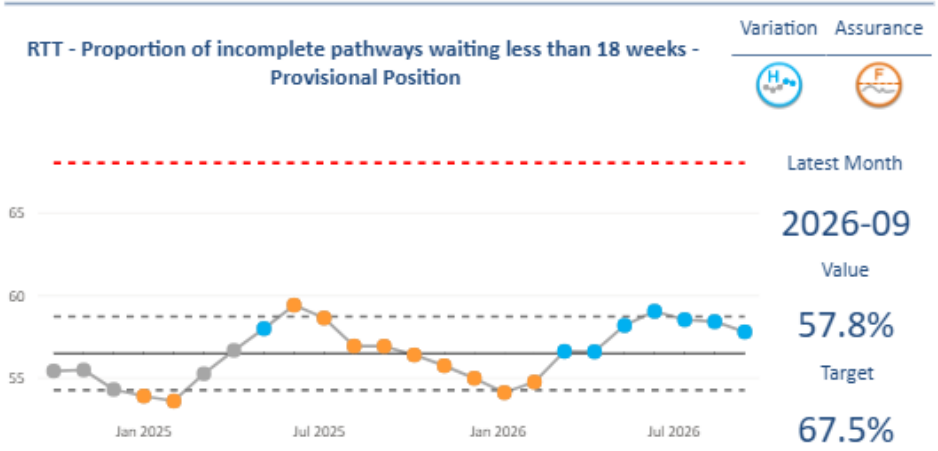
Executive Owner: Claire Hansen

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 **783.0**.



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 **0.6**.

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.
- 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.
- Implementation of 7-week intensive improvement project to support NHSE focus on first initiative, which includes all specialties undertaking 2-weeks of RTT clinics. This will be supported by 5 sprints and daily stand ups with care group general managers.
- ICB contract discussions to approve pain referral threshold in Octobe.

What is the expected impact?

- Reduction in the TWL and 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?

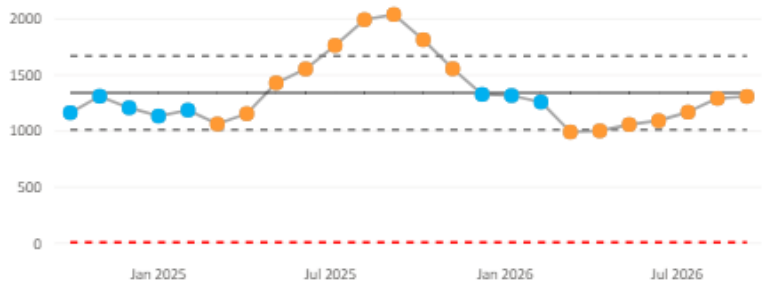
- Increase in GP referrals in YTD 2026/27 compared to 2025/26 (up 4.6%).
- Impact of delayed capital builds (Hybrid theatre, MRI, VIU, SGH Roof and RAAC), resulting in reduction in capacity and increasing waiting times.
- Proportion of first attendances of all attendances remains below model hospital average.
- Availability of activity related investment for high-risk specialties as identified in plan

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

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

Variation: H | Assurance: F



Latest Month: 2026-09

Value: 1303

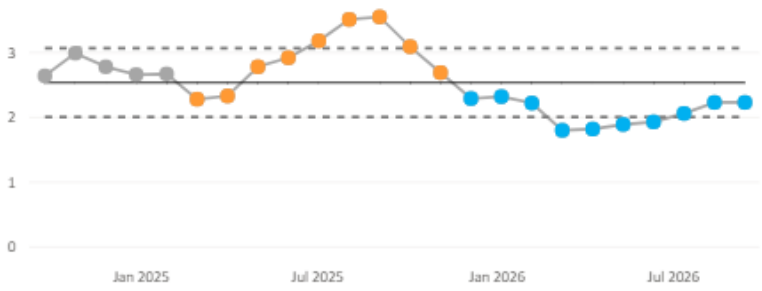
Target: 0

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 **17.0**.

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

Variation: L | Assurance: F



Latest Month: 2026-09

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 **remained the same** from the previous month, with a difference of **0.0**.

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.
- Focus on scheduling long waiters in 2-weeks of RTT outpatient clinics to be held in each speciality during Q3.
- Activity Related Investment Panel (ARIP) to focus on requests for funding for targeted at specialties most in need.

What is the expected impact?

- Reduced RTT long waiters and a reduction in tip overs.

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 September 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 5.9% with performance of 4.9%. 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 43.6% below the target of 99% (August: 52.9%). The performance drop was caused by unexpected consultant absence in August. The service had expected to recover to pre-August levels in September but were impacted by further clinician absence. The issue has particularly impacted Scarborough, additional consultant clinics are scheduled for this month as well as utilising the using the RACP capacity at York to support.

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 was 4.4% in September 2026. The Trust has one of the lowest DNA rates in the country, the national average is 5.6% (NHSE).

- Digital Clinical Letters - Since the expansion of the pilot to Rheumatology, Neurology and Pain Management numbers are continuing to rise to over 600 files per day and from 8 October the whole of the Ophthalmology team are printing digitally. The Training team are working on a training video in readiness for the trust wide roll out. The roll out date will be agreed by the end of October. .

- 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 (S017a) * Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)
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)	* Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)
SPECIAL CAUSE CONCERN			* Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)

Outpatients & Elective Care
Scorecard

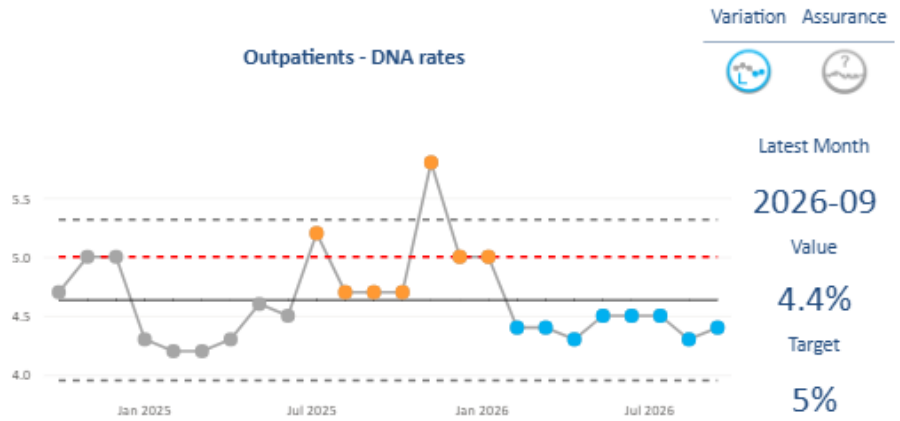
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2026-09	H	F	23%		25%
Outpatients - DNA rates	2026-09	L	?	4.4%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-09		?	19825	21618	23266
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-09		P	41629	53919	55935
Outpatient procedures	2026-09			13171		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-09	H	F	32428		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-09	H	F	4.9%	5.9%	6.6%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-09		F	43.6%		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*	2026-09		?	19		0
Day Cases (based on Activity v Plan)	2026-09		?	6823	7295	7781
Electives (based on Activity v Plan)	2026-09		?	586	751	660
Proportion of elective admissions which are day case	2026-09		P	92.1%		85%
Outpatients: All Referral Types	2026-09			24861		
Outpatients: Consultant to Consultant Referrals	2026-09			2539		
Outpatients: GP Referrals	2026-09	H		11379		

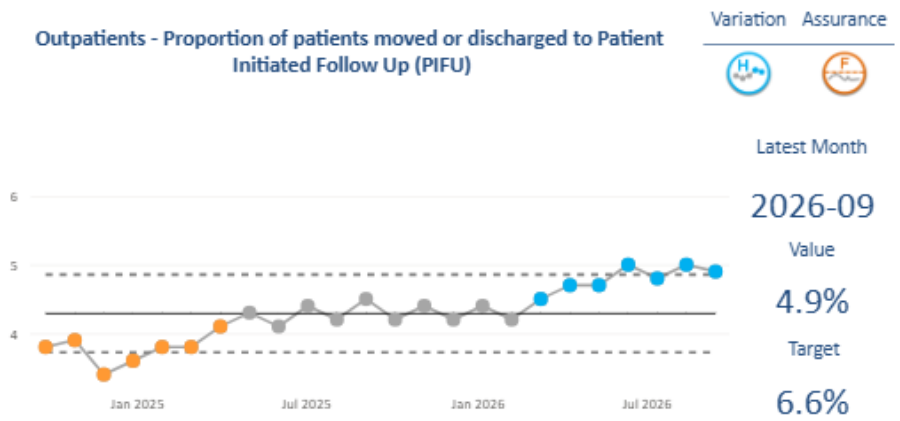
Executive Owner: Claire Hansen

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 **deteriorated** from the previous month, with a difference of **0.1**.



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

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

Rationale: 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. PMO support is provided, focus for Q3 is delivery of all specialty and ensuring recording in audiology as a high-volume specialty.
- 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. Systematic review with operational and GIRFT clinical lead commenced 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?

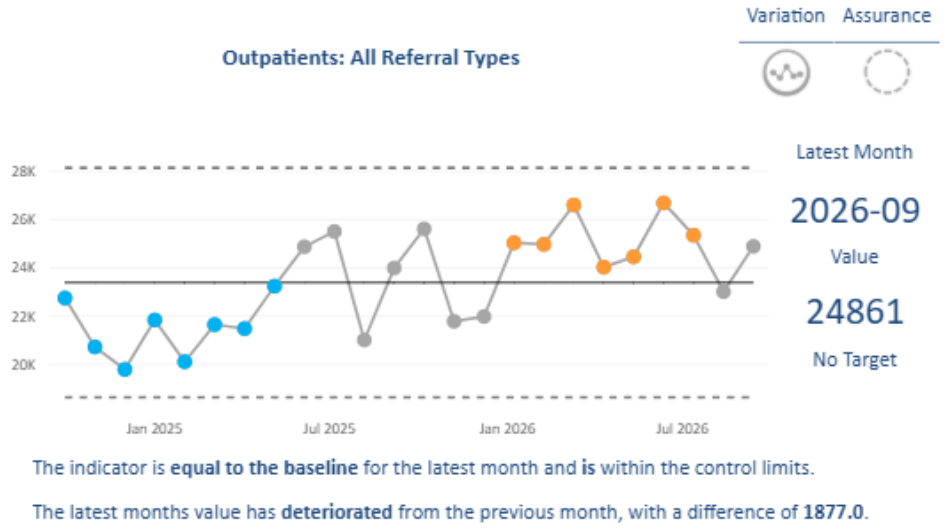
- PIFU improvement to 6.6% (March 2027).
- Delivery of 1st Outpatient plan and reduction in new to follow up ratios.
- Reduced demand for high-cost additional capacity.

Potential risks to improvement?

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

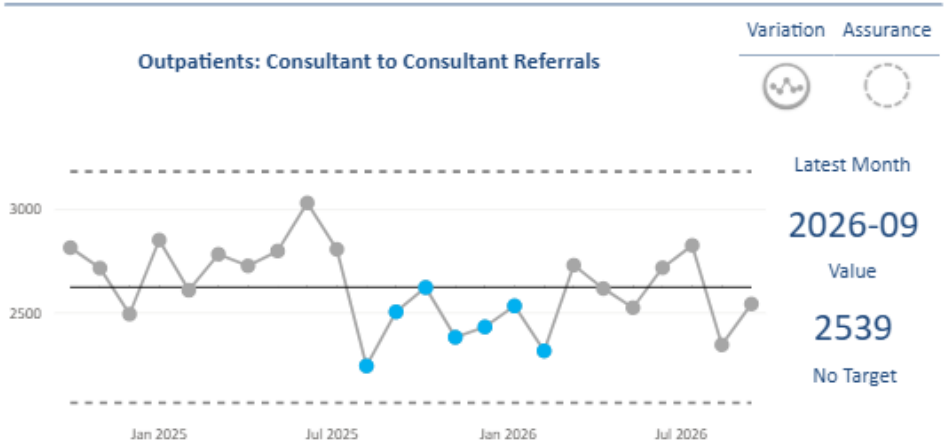
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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 **1877.0**.



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 **198.0**.

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

What actions are planned?

- Commenced with scoping project to reduce consultant to consultant referrals (C2C) by 10% from April 2026 (compared to 2025/26). 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?

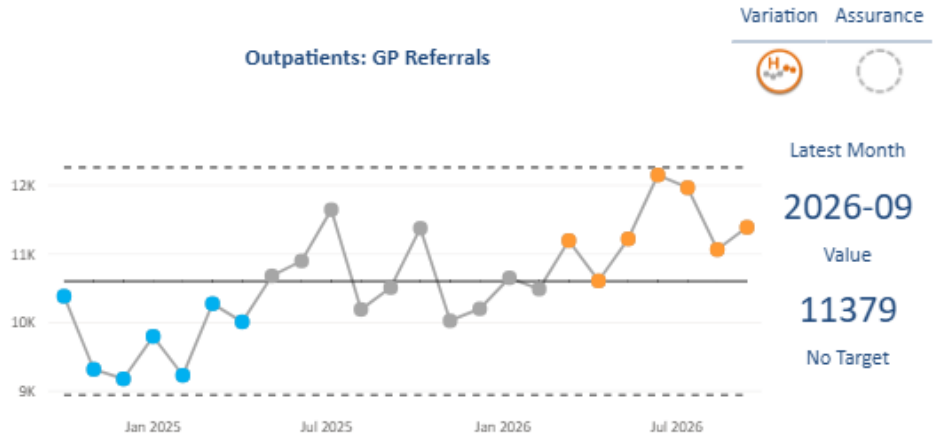
- Reduction in internal demand and reduction in open referrals**.**
- Reduction in GP demand.
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

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 **deteriorated** from the previous month, with a difference of **324.0**.

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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 September 2026 was 78.0% behind the trajectory of 78.3%.

- Total waiting list increased from 11,581 in August to 12,382 in September, along with an increase in the number of 13-week breaches from 305 to 341. 6-week breaches increased from 2,486 to 2,722.

- In the latest available national data (July 2026) the Trust ranked 74th worst out of 118 NHS providers and 6th worst out of 11 in our Model Hospital peer group (June: 71st and 7th respectively).

Factors impacting performance:

- There continue to be 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.

- Having recovered to trajectory level in June and July CT saw some deterioration in August and September, falling back below trajectory with performance in September of 86% against plan of 90.6%. Despite some successful recruitment we are not yet fully recruited with 2.2 WTE vacancy remaining in Scarborough and 3.4 WTE vacancy remaining in York. Mitigations in place using staffed mobiles and WLIs. Tests are being prioritised by clinical urgency so routine tests are being delayed which is impacting DM01.

- Non-Obstetric Ultrasound (NOUS) 6-week performance has remained essentially static for the last 4 months, currently standing at 67.9% at end September against trajectory of 76.2%. 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 staffing continues to be a challenge for Echocardiography due to vacancies and sickness, and clinical space is also an issue. A full evaluation of the service has been completed and multiple actions are underway with an aim to recover performance although this is likely to take some months.

- Staffing shortages continue to impact Urodynamics activity resulting in a build-up of backlog. Two posts recruited to in mid July, one has commenced in post and the second is still going through recruitment checks. The staff members will require UDS training once in post which can take up to two years, so performance recovery is likely to be longer term.

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

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 - 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 - CT * 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

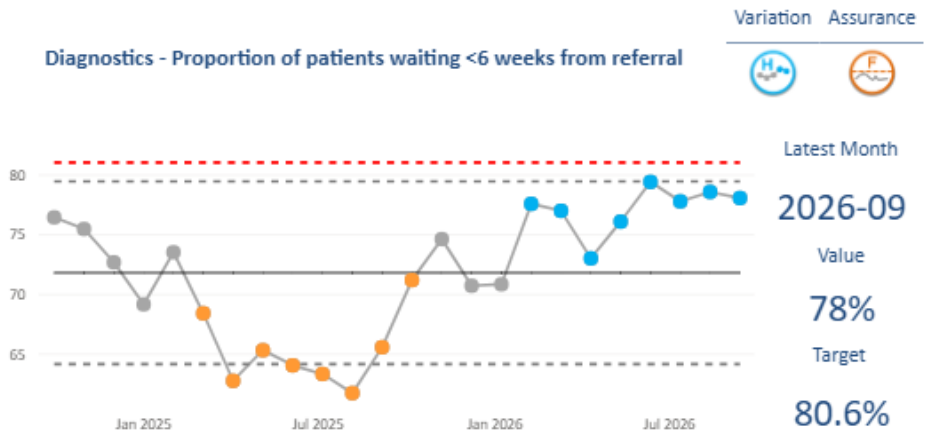
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2026-09	H	F	78%	78.3%	80.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-09	H	F	92.4%	86.5%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-09		F	86%	90.6%	91.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-09		?	67.9%	76.2%	77.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-09	H	F	98.8%	87.7%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-09	H	?	100%	83.2%	86.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-09	H	?	95.1%	77%	80%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-09	L	?	30.1%	78.3%	79.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-09		?	94.4%	95%	95.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-09		?	74.5%	94.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-09		F	48.1%	76%	84.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-09	H	F	85.9%	82.4%	86%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-09	H	?	76.6%	84.2%	85.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-09		?	77.4%	66.8%	69.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-09	H	?	85.8%	84.4%	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, summative assessment provisionally scheduled. If successful then able to commence independent lists with remote supervision from late October. 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 sufficient capacity only to sustain rather than recover performance. We have three current NOUS consultant vacancies which impacts the MSK Ultrasound service. One candidate has recently been identified; the service is awaiting sign off from the Trust's vacancy control before proceeding to interview. Recruitment is ongoing but there is a lack of candidates nationally. Ramsay and Nuffield have offered capacity to support clearing the backlog for injections, this is being worked through with an aim to implement as quickly as possible.
5 new starters are currently in training for CT and impact of additional capacity from these staff should be seen in Q4 2026/27. CT3 replacement anticipated to be fully operational in November. Cardiac CT mobile to be brought in October/November to bridge the gap while CT3 is in setup.

Physiological: Two posts recruited to in mid July for Urodynamics, though the staff members will require a significant period of training once commenced in post so performance recovery likely to be long term. Insourcing through Yorkshire Medical Solutions (YMS) is taking place to mitigate capacity over the coming months until we can return to establishment.
Bank staff onboarded for Echocardiography, induction complete and clinics being booked. Review of CDC funding has demonstrated there is underspent staffing budget which should allow recruitment of 1.4 WTE band 7 echocardiographers to more effectively utilise CDC capacity. Trust has applied to NHSE for additional funding for equipment/facilities to deliver more echocardiography capacity at CDC.

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	2026-09		?	7		0
Children & Young Persons: ED - Emergency Care Standard - All Types (Aged under 16)	2026-09		F	83.9%	95%	95%
Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Aged under 16)	2026-09			81.3%	95%	
Children & Young Persons: ED Attendances - Type 1 only (Aged under 16)	2026-09			2168		
Children & Young Persons: RTT - Total Waiting List	2026-09			4422		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-09	H	F	66.1%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-09	L	F	16	0	0

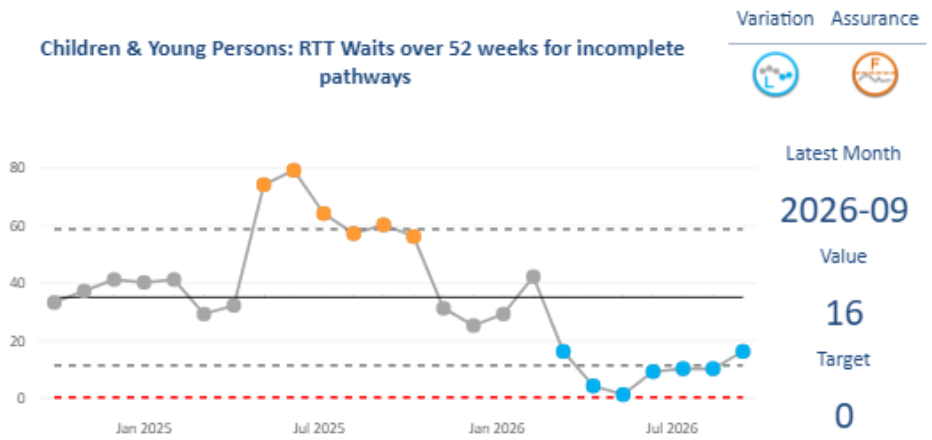
KPIs – Operational Activity and Performance

Children & Young Persons

York and Scarborough Teaching Hospitals NHS Foundation Trust

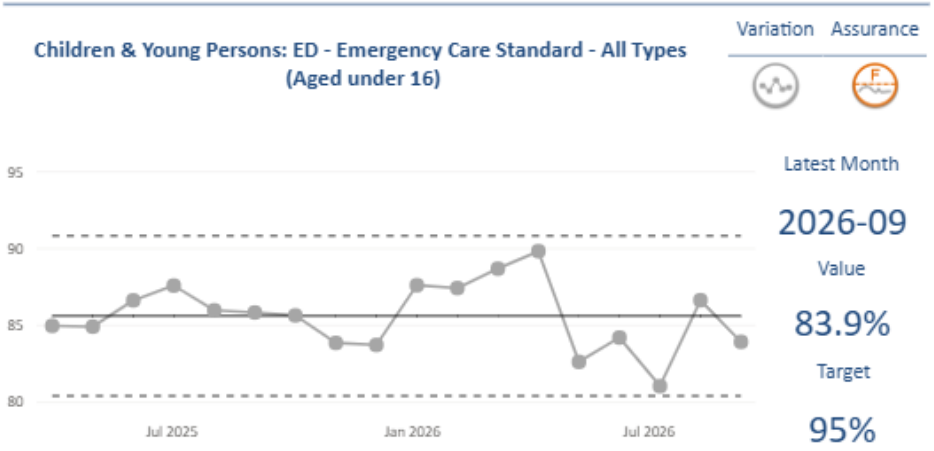
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi



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

The latest months value has **deteriorated** from the previous month, with a difference of **6.0**.



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 **2.7**.

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 nineteen at the end of September, of which five were over 52 weeks).

- Head and Neck were planning to deliver zero RTT52 week waiters by the end of July 2026; this was not achieved with thirteen patients waiting at month end. Due to clinician staffing levels Oral Surgery are not forecasting recovery and delivery of zero until end of 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 will be progressed throughout Q3.

What is the expected impact?

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

Potential risks to improvement?

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

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Total Urgent Community Response (UCR) referrals * 2-hour Urgent Community Response (UCR) Compliancy %	* 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 * 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	* 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
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	2026-09			21.8%	23%	20%
Number of open Virtual Ward beds	2026-09			33	33	33
Proportion of Virtual Ward beds occupied	2026-09			39.4%	82%	82%
Community Response Team (CRT) Referrals	2026-09			613		
Total Urgent Community Response (UCR) referrals	2026-09			615	521	514
2-hour Urgent Community Response (UCR) care Referrals	2026-09			232		
2-hour Urgent Community Response (UCR) Compliancy %	2026-09			83%	70%	70%
Attended Community Care Contacts	2026-09			38278	36938	41283
Number of District Nursing Contacts	2026-09			20318		
Number of Selby CRT Contacts	2026-09			2509		
Number of York CRT Contacts	2026-09			4589		
Referrals to District Nursing Team	2026-09			2051		

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	2026-09			479		
Number of CYP (0-17 years) on community waiting lists per system	2026-09			1371		
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	2026-09			54.9%	65.5%	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	2026-09			100%	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	2026-09			39.2%	48.3%	63.7%
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-09			391	321	0

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Number of open Virtual Ward beds

Variation Assurance



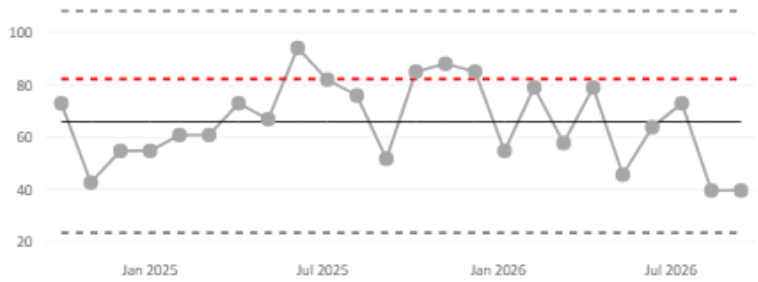
Latest Month
2026-09
Value
33
Target
33

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
2026-09
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 **remained the same** from the previous month, with a difference of **0.0**.

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: Frailty (12 beds) Heart Failure (10 beds) and Vascular and Cystic Fibrosis with 11 beds between them.
Data is a snapshot and not representative of monthly performance.

What actions are planned?

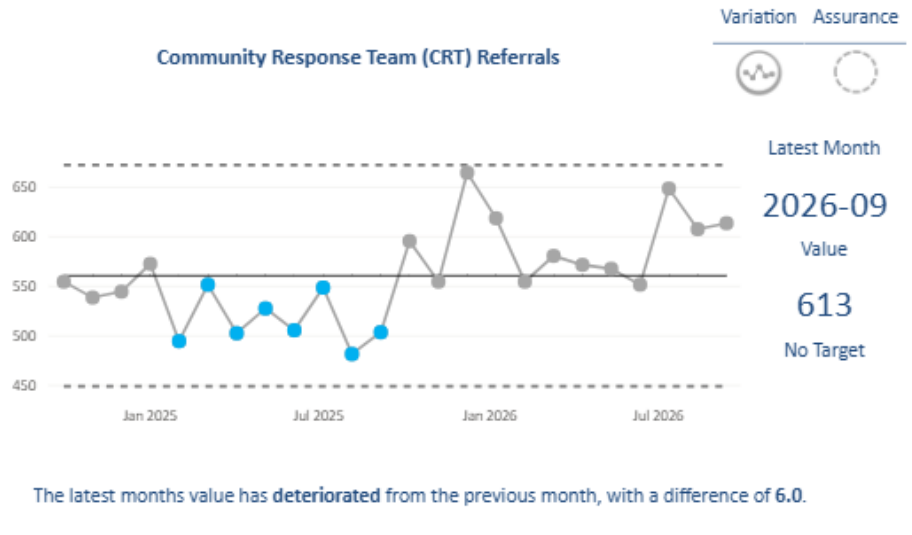
- Frailty Hospital at Home has high utilisation and an increase in referrals from York EAU.
- ICB will be visiting York Hospital at Home team in October as part of the Trailblazers programme.
- The Frailty Virtual Ward / Hospital at Home model remains keen to expand to Selby following a successful test. To meet GIRFT requirements and expand further requires investment.
- Plans are underway for Phase 1 of a new community model which will shift resource to home based teams including hospital at home expansion.
- The Heart Failure team runs an admission avoidance pathway at York, and now operates an early support discharge pathway. Charitable funds are being used for 0.8WTE Band 7 nurse for 6 months from November.
- A business case is being completed for the substantive nurse role and senior medical cover in line with GIRFT requirements.

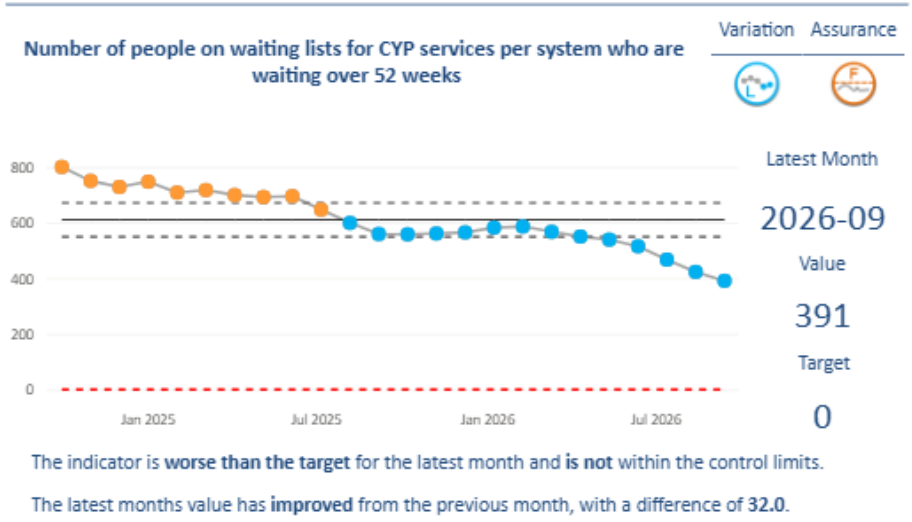
Potential risks to improvement?

- Challenges regarding medical cover cause instability in services.
- Business case for sustainable heart failure pathways may not be approved.

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.

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 implementing Phase 1 of the new community model which 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 September (391 against end of month ambition to be at or below 321). Commissioning discussions with the ICB continue. GIRFT bid has been submitted by ICB for non recurrent funding.

What is the expected impact?

SPC1: The community model will see expansion of the Intermediate care and UCR team resource, likely next financial year.

SPC2: 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

October 2026

Executive Owner: Karen Stone and Joe Hague

Highlights: IPC

- The IPC improvement plan is being refreshed and a further review meeting with the Chief Nurse is being held on 14th October.
- Ward 31 is going water lite following the ward refurbishment programme.
- September and October are the months of quality for IPC with a focus of back to basics and the management of both urinary catheters and peripheral venous cannulas
- There has not been a case of C.difficile on Ward 36 in September following the IPC improvement work undertaken in August 2026

Concerns / Risks :

- C.difficile **4 cases over** the year-to-date threshold
- MSSA bacteraemia **3 cases over** year-to-date threshold.
- MRSA bacteraemia **1 case** reported in August against a zero tolerance.
- E.coli bacteraemia - **5 cases over** the year-to-date threshold
- Pseudomonas bacteraemia – **8 cases over** the year-to-date threshold and we have breached the year end threshold.
- Klebsiella bacteraemia **11 cases under** the year-to-date threshold.
- An outbreak of C.difficile on G1 has been confirmed with ribotyping, actions taken to prevent further cases.

Next Steps:

- 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
- The Trust are involved in an ICB wide review of peripheral cannula and need free devices procurement due to procurement framework change in April 2027. This will support a review of our practice and ensure we have consistent and compliant medical devices for IV care

Highlights: Pressure ulcers

In September, 52 Category 2 pressure ulcers reported, against a monthly target of 60. Pressure ulcer rate (all categories) = 3.1 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, scheduled dates of Oct 27th and 28th planned for the completion of the work.

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 will be undertaking the Cat 2 validation check moving forward.
- Datix dashboard development ongoing for Matrons to validate Category 2 pressure ulcer incidents. Current validation being undertaken by TVN lead and Quality Matron.
- 91 patient chairs, funded via charitable funds, have now all been delivered (30 Scarborough and 61 York) to Elderly care areas at York and Scarborough sites.
- The TVN lead has completed a thematic review for Category 3 & 4 pressure ulcers reported during Jan 2026. Key themes identified related to end-of-life patients and those living with frailty. The TVN Lead also conducted a thematic review of Deep Tissue Injuries, with findings highlighting a significant proportion occurring on the heels and within the first 72 hours of care. The findings from both reviews conducted will inform the development of focused improvement actions and preventative measures.

Quality & Safety
Scorecard (1)

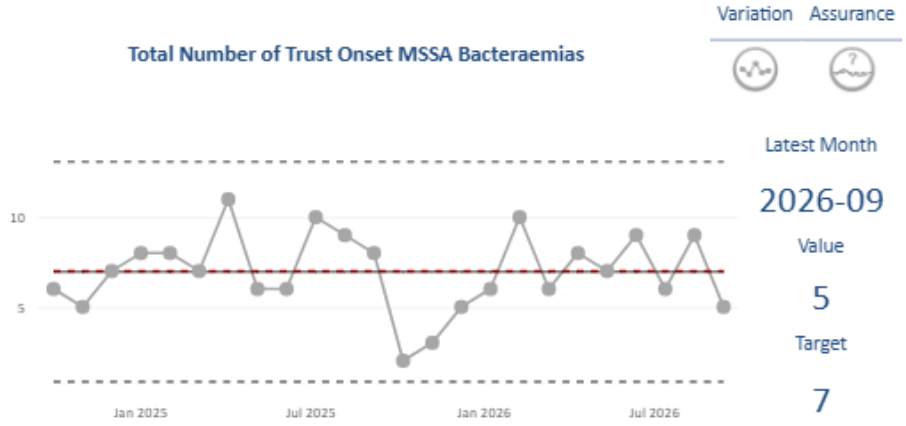
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2026-09			5	7	7
Total Number of Trust Onset MRSA Bacteraemias	2026-09			0		0
Total Number of Trust Onset C. difficile Infections	2026-09			8	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-09			11	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-09			10	6	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-09			4	1	2
Pressure Ulcers per thousand Bed Days	2026-09			3.1		4
Patient Falls per thousand Bed Days	2026-09			8.1		8.7
Medication incidents per thousand bed days	2026-09			5.4		6

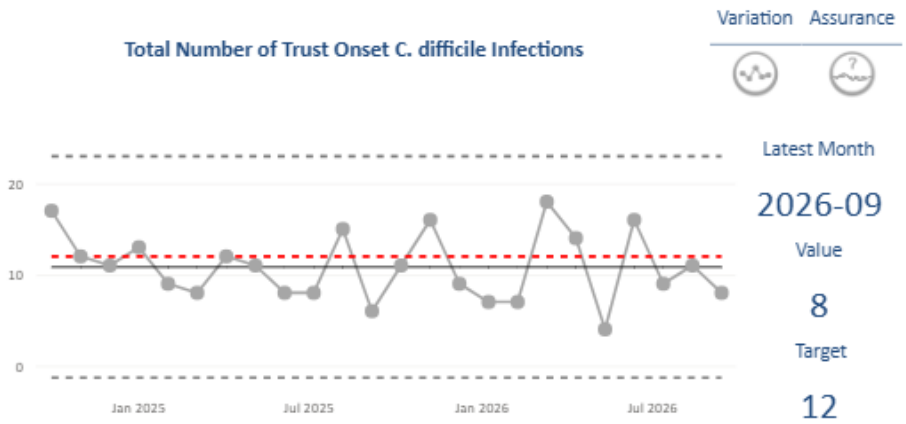
Executive Owner: Joe Hague

Operational Lead: Sue Peckitt



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 **4.0**.



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

The latest months value has **improved** from the previous month, with a difference of **3.0**.

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 **3 cases over** year-to-date threshold.
- MRSA bacteraemia **1 case** reported in August against a zero tolerance.
- E.coli bacteraemia - **5 cases over** the year-to-date threshold
- Pseudomonas bacteraemia – **8 cases over** the year-to-date threshold and we have breached the year end threshold.
- Klebsiella bacteraemia **11 cases under** the year-to-date threshold.
- An outbreak of C.difficile on G1 has been confirmed with ribotyping, actions taken to prevent further cases.

Key assurances/brilliances

- The Deputy Director of Infection Prevention & Control (DIPC) reports against the agreed strategic IPC improvement plan to the Infection Prevention Strategic Advisory Group, Patient Safety and Clinical Effectiveness Group and to Quality Committee.
- The IPC improvement plan is being refreshed and a further review meeting with the Chief Nurse is being held on 14th October.
- There has not been a case of C.difficile on Ward 36 in September following the IPC improvement work undertaken in August 2026
- Ward 31 is going water lite following the ward refurbishment programme.
- 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 being delivered with a focus of back to basics and the management of both urinary catheters and peripheral venous cannulas

Next Key Improvements:

- 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
- The Trust are involved in an ICB wide review of peripheral cannula and need free devices procurement due to procurement framework change in April 2027. This will support a review of our practice and ensure we have consistent and compliant medical devices for IV care

Quality & Safety
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patient Safety Incidents per thousand Bed Days	2026-09			54.3		57
Harmful Incidents per thousand bed days	2026-09			18.2		18
Total Number of Never Events Reported	2026-09			0		0
In-Hospital Deaths	2026-09			160		
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	2026-09	H		159		
Antepartum Stillbirths	2026-08			0		
Intrapartum Stillbirths	2026-08			0		
Early neonatal deaths (0-7 days)	2026-08			1		
PPH > 1.5L as % of all women - York	2026-08			5.1%		
PPH > 1.5L as % of all women - Scarborough	2026-08			0%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-08			53.7%		

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 remained stable and within expected control limits throughout the reporting period, consistent with normal variation.

Learning from Patient Safety Events (LFPSE) data

In response to the Patient Safety Incident Data Quarterly Publication for Q1 2026/27, 28,610 incidents were reported across seven quarters, averaging 4,087 per quarter. Reports increased from 3,723 to a peak of 4,424 in Q3 2025/26. The latest quarter recorded 3,930 incidents, 5.6% above the starting point. The reporting rate also rose from 48.6 to a peak of 58.2 per 1,000 bed days and now stands at 53.1, 9.3% above the first quarter.

Great-ix

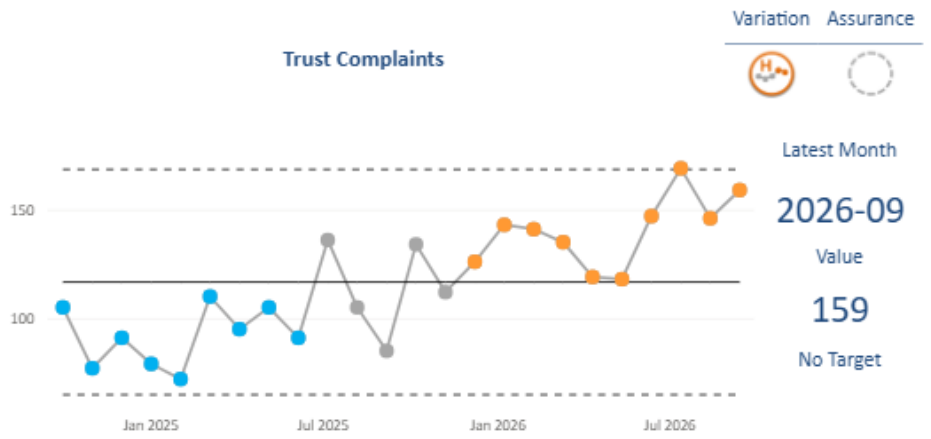
September received a record **110 Great-ix** submissions, surpassing the previous high of 66 in January 2026. Highlights from the month's submissions are provided below.

September Great-ix Highlights:

"You ensured a high level of care and patient safety while at the same time providing excellent staff support and continuing MDT communication."
"X showed bravery, immense patience and most importantly no judgement. She remained professional and caring. She embodied perfectly what a nurse is and should always be."
"She not only demonstrates how tasks should be completed but also instils the resilience, positivity and can-do attitude that are so important in today's challenging environment."
"X demonstrated excellent situational awareness, maturity and composure under pressure. She was a highly valuable and dependable member of the wider team, and her contribution made a real difference during a challenging clinical situation."
"She will always speak to all patients, as if they were part of her family which is lovely to hear and really brings joy to all the patients she comes into contact 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 **deteriorated** from the previous month, with a difference of **13.0**.

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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 an increase in complaints in the month of August 2026 with 159 new complaints across the Trust (in contrast to 146 in August 2026).

77% of complaints were closed in 30 days (compared to 71% in July 2026) and 66% of complex complaints were closed in 45 days (compared to 61% in July 2026). Performance continues to remain below the expected compliance rate of 90%.

Key risks and emerging risks

- 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 commenced 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 continue to work towards achieving the 90% target for complaints/complex complaints responses. Medicine Care Group have planned two rapid complaint resolution days to take place in October to focus on responding to complaints.
- 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.
- 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	2026-09			100%		100%
Percentage of commercial studies that are on target to recruit the set number of patients within our hospitals the study requires	2026-09			50%		100%
Percentage of non commercial studies that are on target to recruit the set number of patients within our hospitals the study requires	2026-09			59.7%		100%
Total number of participants recruited into research studies this year within our hospitals	2026-09			1160		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

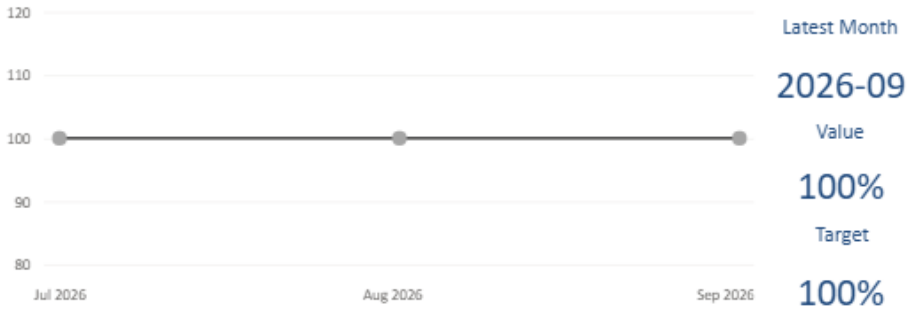


The indicator is **equal to the target** for the latest month and **is not** within the control limits.

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 remaining top in the region for the 60-day metric.

In September, six non-commercial studies were included in the 30-day metric, and all six recruited the first patient in the required timeframe, representing 100% performance. This reflects effective study planning and preparation, including early identification of eligible patient populations to support timely recruitment following study activation.

Additional information
Recruitment to NIHR Portfolio Studies

The Trust continues to support 79 active research studies, with no change from the previous month and no new studies entering the 60-day study set-up metric during the reporting period.

NHS Oversight Framework: 90-Day Metric

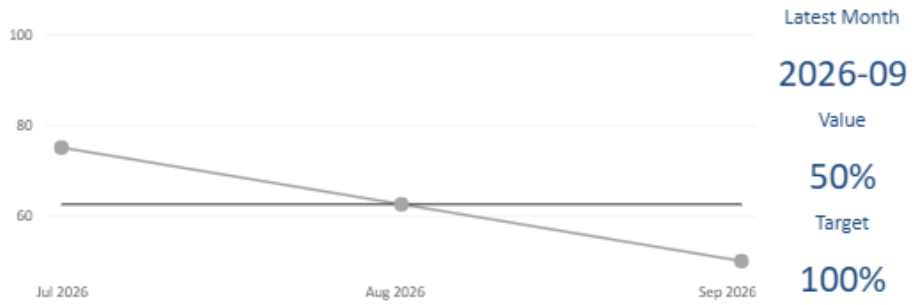
The 2026/27 NHS Oversight Framework (NOF) includes the percentage of clinical trials set up within 90 days as a scoring measure within the Finance, Productivity and Innovation domain. As a scoring metric, performance contributes to the Trust's overall NOF delivery assessment. The 90-day metric provides an end-to-end measure from the applicable start of study set-up to recruitment of the first participant and should not be interpreted simply as the existing 60-day and 30-day RDN measures added together. The methodology differs, as the 90-day metric measures the overall elapsed period and does not allow for the stop-clock periods applied within the RDN 60- and 30-day metrics. R&I will monitor this metric and report performance quarterly in this section. Performance improved from 66.7% in Q1 to 100% in Q2.

Executive Owner: Karen Stone

Operational Lead: Lydia Harris

Percentage of commercial studies that are on target to recruit the set number of patients within our hospitals the study requires

Variation Assurance

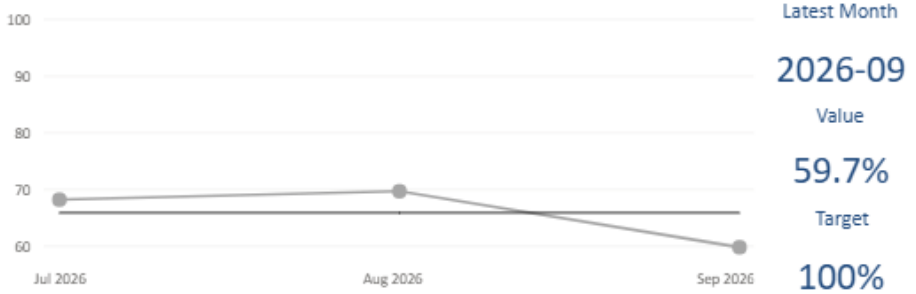


The indicator is **worse than the target** for the latest month and **is not** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **12.5**.

Percentage of non commercial studies that are on target to recruit the set number of patients within our hospitals the study requires

Variation Assurance



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 **9.9**.

Rationale: To monitor the National Research Delivery Network targets
Target: To meet the National Research Delivery Network targets

Commercial Research target

Recruitment to time and target performance for commercial studies decreased from 62.5% to 50%. This reflects a combination of reporting factors, including recruitment not yet reflected in central systems, and recruitment challenges in two studies due to restrictive eligibility criteria and small eligible patient populations. With a relatively small commercial portfolio of approximately 7 to 10 open studies, month on month performance is expected to fluctuate and can be disproportionately affected by individual studies. Longer term trends therefore provide a more meaningful indication of performance. Research teams continue to closely monitor studies at risk of not achieving agreed recruitment targets.

Non Commercial Research target

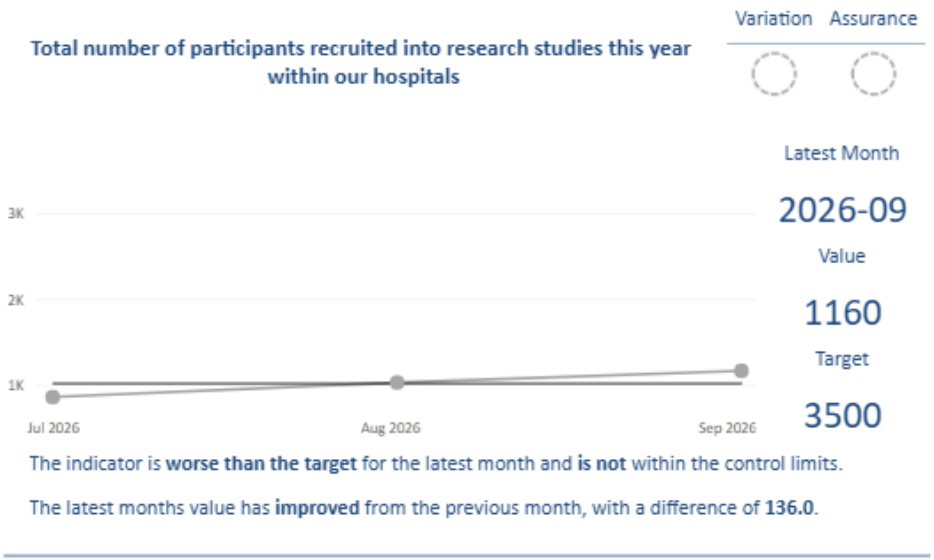
For non-commercial studies recruitment to time and target performance decreased slightly compared with the previous month. This reflects a combination of reporting factors, including recruitment not yet reflected in central systems, and recruitment challenges within a small number of studies, primarily due to restrictive eligibility criteria and small eligible patient populations. Specialty specific capacity constraints have also affected recruitment opportunities in some studies but are not considered the main driver of overall performance. Recruitment performance is monitored through monthly Portfolio Review Meetings, where RAG ratings and studies at risk of under recruitment are reviewed and actions agreed to support delivery against set 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 is Born and bread In (BaBi) run by our maternity teams. Cumulative recruitment increased from 1,024 participants in August to 1,160 in September, an increase of 136 participants. The Trust has now achieved 33.1% of its annual target of 3,500.

Additional information
NIHR Grants and Awards

Three grant applications were submitted this month, including proposals focused on severe mental illness and late cancer diagnosis (£75k), discharge excellence and learning (£1.49m), and developing good practice for adult social care trials (£349k). In addition, the Trust is a partner in the Leeds Biomedical Research Centre (BRC) funding application, with a total bid value of £49.82m.

Professor James Turvill's £4.12m NIHR Programme Grant application exploring the use of Colon Capsule Endoscopy to improve early bowel cancer diagnosis in rural and coastal communities has successfully progressed to Stage 2.

The previously reported Integrated Neighbourhood Frailty Services application was unsuccessful.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

October 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 * Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	* Homebirth service suspended - Scarborough
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2026-08		P	103		169	Target
No. of women delivered - Scarborough	2026-08		?	95		112	Target
Births - Scarborough	2026-08		?	95		113	Target
Induction of labour - Scarborough	2026-08		?	36.8%		42.9%	Baseline
Elective caesarean - Scarborough	2026-08		?	8.4%		17.3%	Baseline
Emergency caesarean - Scarborough	2026-08		?	28.4%		29.7%	Baseline
BBA - Scarborough	2026-08		?	1		2	Target
Total number of Stillbirths - Scarborough	2026-08			0			No Target
Neonatal Death - Scarborough	2026-08		?	0		0	Target
Number of maternity diverts/unit closures - Scarborough	2026-08			1			No Target
Homebirth service suspended - Scarborough	2026-08		F	31		3	Target
SCBU at capacity - Scarborough	2026-02			0		0	Baseline
% of 3rd and 4th degree tears - Scarborough	2026-08			0%			No Target
L/W Co-ordinator supernumerary % - Scarborough	2026-08	H	?	100%		100%	Target
Breastfeeding Initiation rate - Scarborough	2026-08		?	81.1%		75%	Target

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	2026-08			0		0	Target
% of women seen within 15 minutes in triage - Scarborough	2026-08			97.2%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - Scarborough	2026-08			2			No Target
Number of babies transferred out for cooling - Scarborough	2026-08			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - Scarborough	2026-08			8			No Target
Number of babies born with an Apgar of 7 at 5 mins - Scarborough	2026-08			4			No Target
Number of maternal deaths - Scarborough	2026-08			0			No Target
Number of midwifery red flags - Scarborough	2026-08			0			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - Scarborough	2026-08			2			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - Scarborough	2026-08			0			No Target
Number of planned caesarean sections > 24 hours - Scarborough	2026-08			0			No Target

Summary MATRIX
Maternity York

MATRIX KEY
- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* 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	2026-08			267		295	Target
No. of women delivered - York	2026-08			217		242	Target
Births - York	2026-08			219		245	Target
Induction of labour - York	2026-08			44.7%		42.4%	Baseline
Elective caesarean - York	2026-08			16.6%		16.6%	Baseline
Emergency caesarean - York	2026-08			22.1%		24.1%	Baseline
BBA - York	2026-08			1		2	Target
Total number of Stillbirths - York	2026-08			0			No Target
Neonatal Death - York	2026-08			1		0	Target
Number of maternity diverts/unit closures - York	2026-08			1			No Target
Homebirth service suspended - York	2026-08	H	F	31		3	Target
SCBU at capacity - York	2026-02			0		0	Baseline
% of 3rd and 4th degree tears - York	2026-08			3.1%			No Target
L/W Co-ordinator supernumerary % - York	2026-08		P	100%		100%	Target
Breastfeeding Initiation rate - York	2026-08			92.2%		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	2026-08			0		0	Target
% of women seen within 15 minutes in triage - York	2026-08			91.4%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - York	2026-08			0			No Target
Number of babies transferred out for cooling - York	2026-08			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - York	2026-08			5			No Target
Number of babies born with an Apgar of 7 at 5 mins - York	2026-08			3			No Target
Number of maternal deaths - York	2026-08			0			No Target
Number of midwifery red flags - York	2026-08			1			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - York	2026-08			1			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - York	2026-08			0			No Target
Number of planned caesarean sections > 24 hours - York	2026-08			0			No Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

October 2026

Executive Owner: Sarah Dexter-Smith

1. Highlights

- Sickness absence reduced slightly in August following sustained increases during spring and early summer. While remaining above plan, the Group's rate compares favourably with most NHS organisations across the North East and Yorkshire region.
- Workforce numbers reduced during August and remain close to planned levels, supported by continued vacancy controls and low colleague turnover.
- Recruitment activity remained strong, with new doctors, nurses and midwives joining or due to join the organisation, alongside continued reductions in bank and agency workforce use.

2. Concerns

- The annual sickness absence rate remains above the planned trajectory, with stress and anxiety continuing to be the most common reason for absence.
- Healthcare support worker vacancies increased during September, creating additional recruitment pressure in a key staff group.
- Mandatory training compliance remains below the Group target, partly due to national changes to Mental Capacity Act and deprivation of liberty training requirements.

3. Future

- The seasonal influenza vaccination campaign is underway, with strong early uptake and continued delivery through workplace vaccinators and drop-in clinics.
- Targeted actions to reduce temporary staffing usage will continue, including strengthened approval arrangements for medical bank and agency shifts and ongoing conversion to substantive employment.
- The NHS Staff Survey has launched, providing an opportunity to build on feedback from the Big Conversation and inform future improvements in colleague experience, culture and patient care.

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	* Medical and dental vacancy rate * 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		* Overall 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	* Monthly sickness absence * Annual absence rate

Workforce
Scorecard (1)

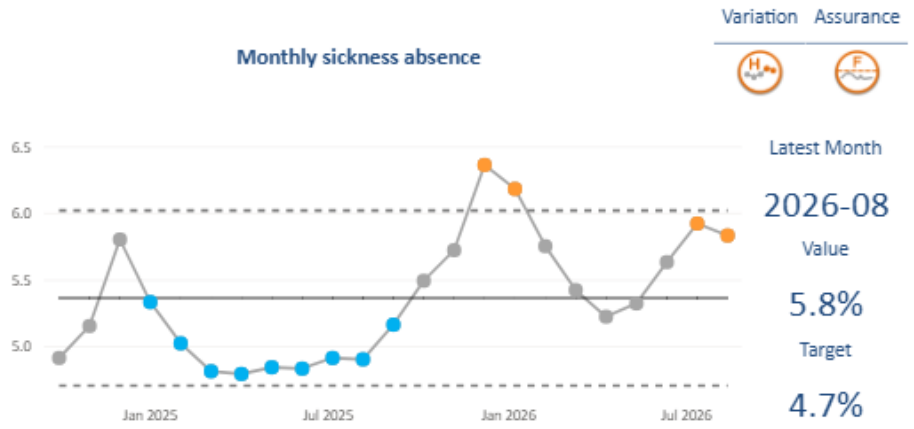
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Sarah Dexter-Smith **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-08	H	F	5.8%	5%	4.7%
Annual absence rate	2026-08	H	F	5.6%	5.2%	4.9%
Total Agency Whole Time Equivalent Filled	2026-08	L	F	46.5	47	52
Total Bank Whole Time Equivalent Filled	2026-08		?	522.9	554	536
12 month rolling turnover rate Trust (FTE)	2026-09	L	P	6.8%		8.5%
Overall vacancy rate	2026-09		?	8%		7.7%
HCSW vacancy rate	2026-09	H	?	15.1%		8%
Midwifery vacancy rate	2026-09	H	?	4.6%		0%
Medical and dental vacancy rate	2026-09	L	?	1.8%		6%
Registered Nursing vacancy rate	2026-09	L	?	3.8%		5%
AHP vacancy rate	2026-09		?	7.5%		7%

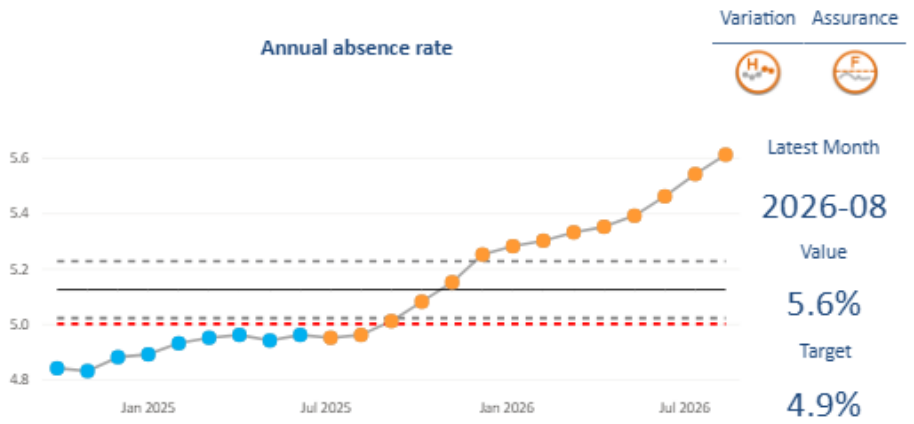
Executive Owner: Sarah Dexter-Smith

Operational Lead: Lydia Larcum



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 **0.1**.



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

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

Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.9% annual absence rate (March 2027)

Factors impacting performance and actions:

Colleague absences in August reduced nominally from July, by 8 WTE to 547 WTE. This follows a period of sustained increase in absence through spring and early summer. Stress and anxiety remains the top reason for sickness absence.

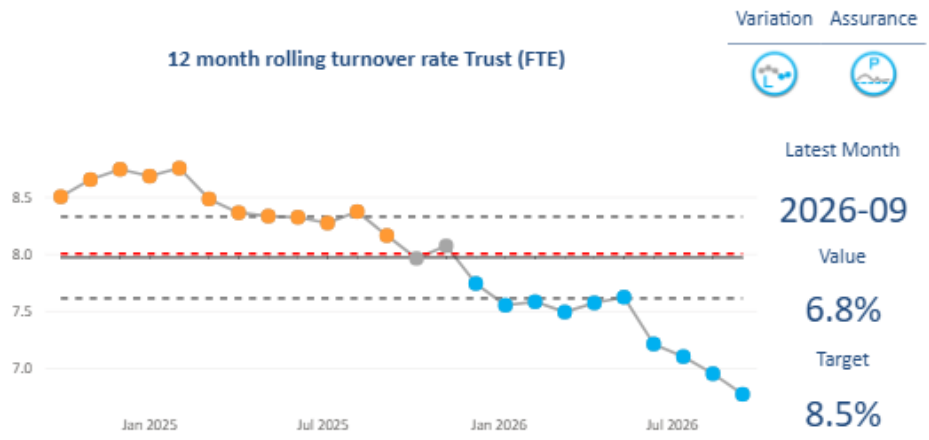
The August rate contributed to an annual absence rate of 5.6% across the Group. This is 0.4% higher than the trajectory in the workforce plan.

Other providers in the North East and Yorkshire region are experiencing challenges with absences. The most recent benchmark data from July put the annual absence rate for the region at 5.9% (also 0.4% higher than planned). Only 2/33 providers met their planned trajectories, with annual absence rates ranging from 4.6% to 7.9%. The regional benchmarking places the Group's annual absence rate 15th lowest out of 33 providers.

The 'flu vaccination campaign began on 1 October. As in previous years, drop-in clinics are being complimented by a team of trained peer vaccinators who provide vaccinations in colleagues' place of work. During the first week of the campaign, 1,402 colleagues received a vaccination from the organisation.

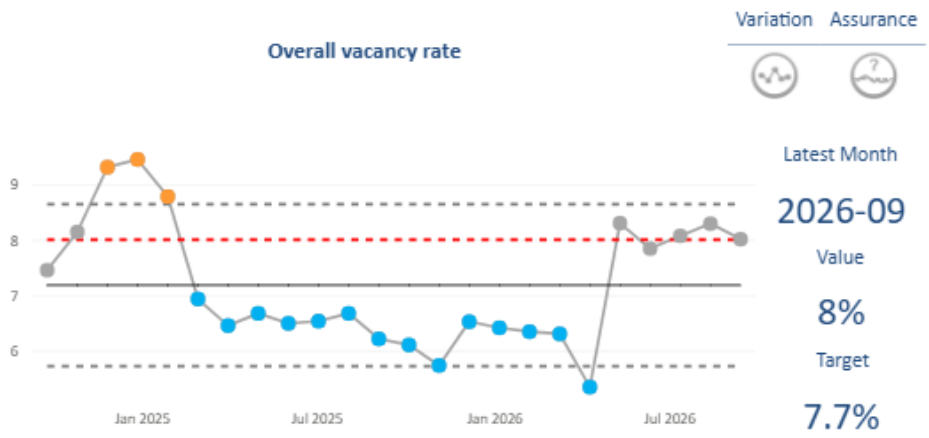
Executive Owner: Sarah Dexter-Smith

Operational Lead: Lydia Larcum



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 **improved** from the previous month, with a difference of **0.3**.

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 8.5% Vacancy Rate 7.7%

Factors impacting performance and actions:

In August 2026, the Group's total workforce WTE was 9,961, which was +32 above plan for August, but -19 WTE smaller than in July.

The table below shows the position in August broken down into substantive, bank and agency WTE and compared with the planned WTE outturn position for 2026-27:

Staff Group	Aug-26 WTE actual	Mar-27 WTE plan	Variance (Plan – Actual)
Substantive	9391	9314	-77
Bank	523	524	1
Agency	47	48	1
Total	**9961**	**9886**	**75**

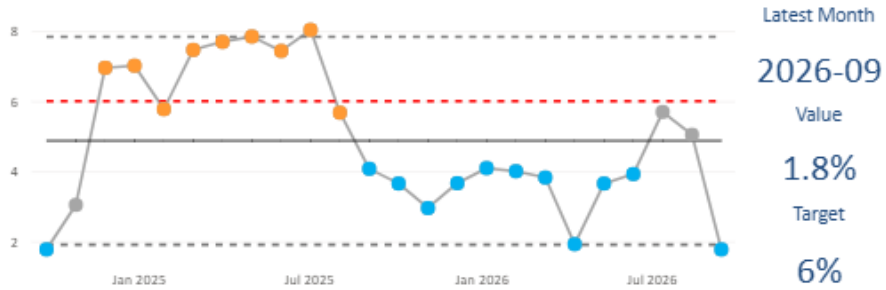
The Trust is continuing to operate a rigorous vacancy control process while ensuring recruitment proceeds for roles which are safety-critical. Administrative and clerical vacancies have been ring-fenced for internal recruitment by default. More generally, the rate of colleague turnover within the Group remains low, in common with other NHS providers.

Executive Owner: Sarah Dexter-Smith

Operational Lead: Lydia Larcum

Variation Assurance

Medical and dental vacancy rate



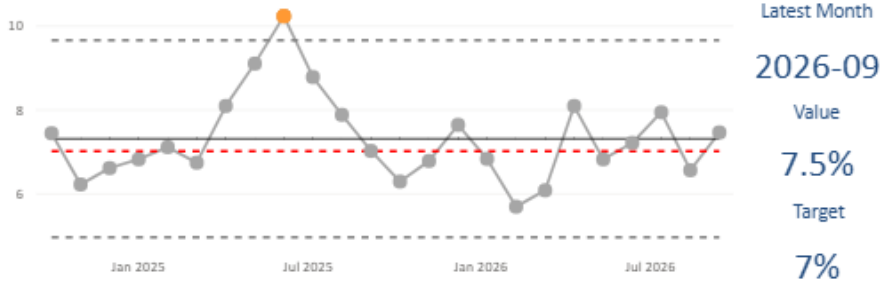
Latest Month
2026-09
Value
1.8%
Target
6%

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 **3.2**.

Variation Assurance

AHP vacancy rate



Latest Month
2026-09
Value
7.5%
Target
7%

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

The latest months value has **deteriorated** from the previous month, with a difference of **0.9**.

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 7%

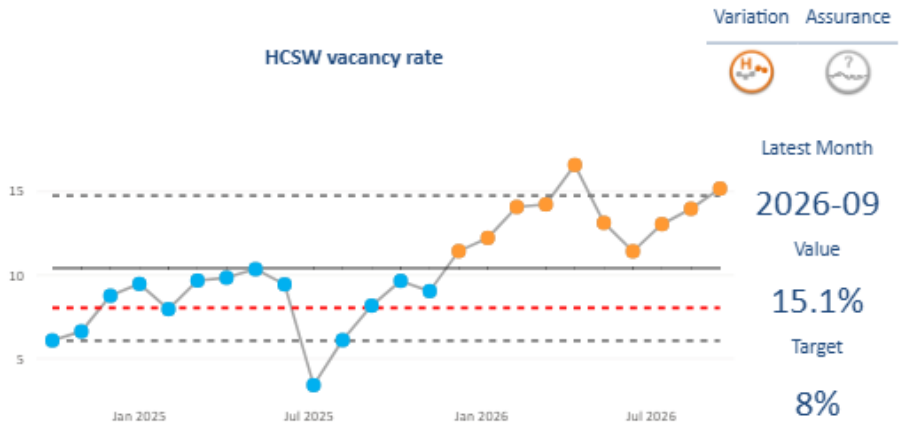
Factors impacting performance and actions:

In addition to the 39 Resident Doctors that joined the Trust in September, the organisation also welcomed 22 new medical colleagues, including nine permanent Consultants within Ophthalmology, Oncology, Respiratory, Paediatrics, Rheumatology and Radiology. The Trust also made 11 offers for medical posts, including four permanent Consultant posts in Stroke, Anaesthetics and Trauma and Orthopaedics.

22 Pre-registered nurses commenced with the Trust in September, with an additional six due to commence in October.

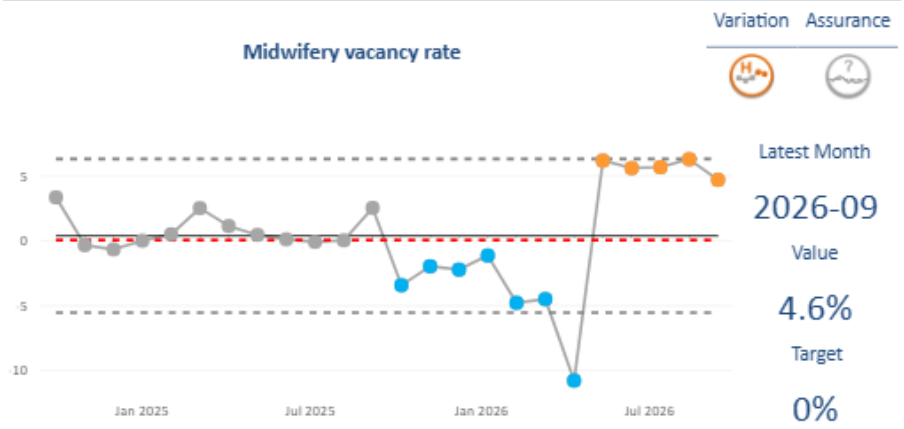
Executive Owner: Sarah Dexter-Smith

Operational Lead: Lydia Larcum



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

The latest months value has **deteriorated** from the previous month, with a difference of **1.2**.



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 **1.6**.

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 8%, Midwifery vacancy rate 0%

Factors impacting performance and actions:

In September, HCSW vacancies increased by 13 WTE.

The Trust has relaunched 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.

Participants at August's information sessions applied and were interviewed for posts in September, generating a pool of successful candidates from which 14 have been offered and accepted posts, with further offers pending vacancy approvals.

The number of qualified Nursing Associates within the Trust has remained consistent at 53.

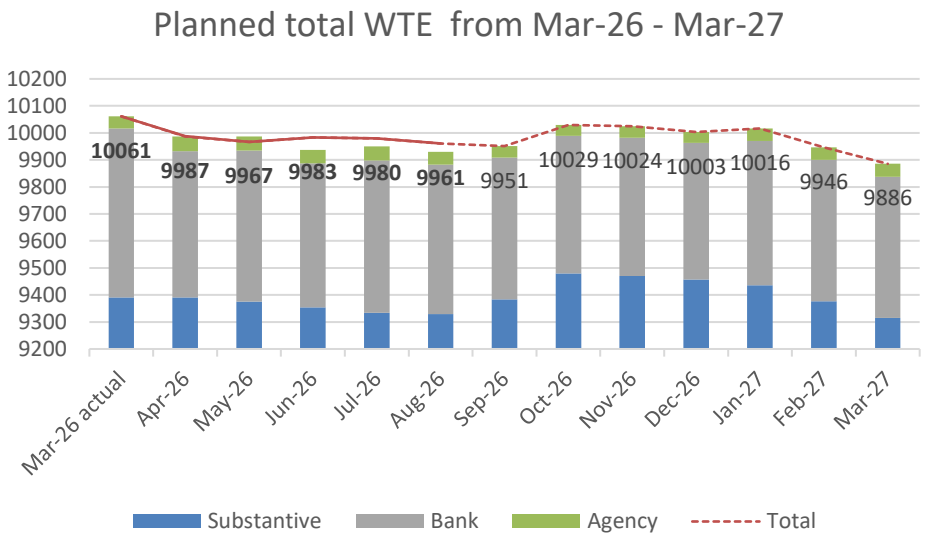
17 newly qualified midwives have been offered posts and are progressing through pre-employment checks with planned commencement dates in October and February.

Workforce Table

Workforce (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Sarah Dexter-Smith **Operational Lead:** Lydia Larcum



The table below shows actual WTE totals for Bank and Agency in August and September 2026.

	Bank		Agency	
Staff Group	Aug-26	Sep-26	Aug-26	Sep-26
Medical & Dental	85	67	21	17
Nursing & Midwifery	154	150	18	17
Support Workers	260	233	0	0
NHS Infrastructure	14	17	0	0
Scientific Therapeutic & Technical	11	12	7	6
Total	**523**	**479**	**47**	**40**

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. Early indications show a notable reduction in the number of medical bank shifts being requested.

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.

Despite a slight increase in activity from August where 578 administrative bank shifts were recorded, activity in September continues to show an improved position from previous months, with 593 shifts worked (previous activity between 897 and 744 shifts a month). The reduction is in conjunction with the adjustment of system permissions for managing bank shifts as part of stronger controls. The Trust continues to monitor this activity closely.

Workforce
Scorecard (2)

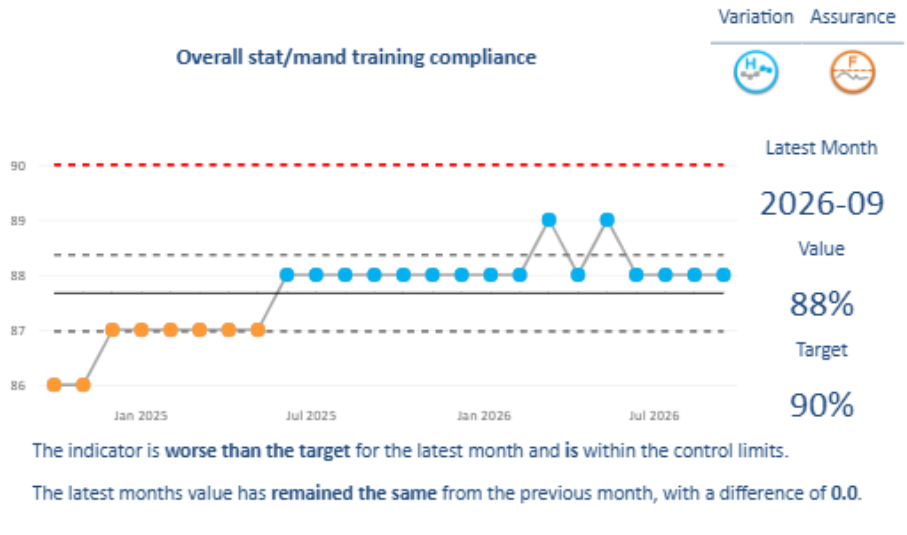
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

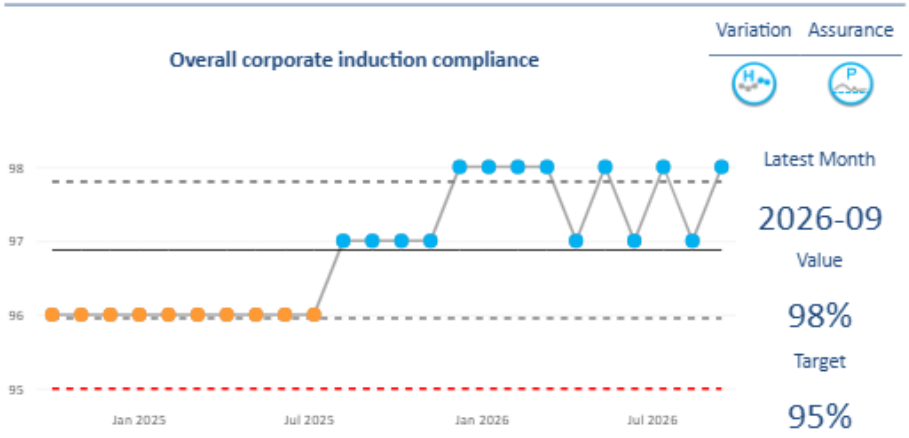
Executive Owner: Sarah Dexter-Smith **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2026-09	H	F	88%		90%
Overall corporate induction compliance	2026-09	H	P	98%		95%
A4C staff stat/mand training compliance	2026-09		?	89%		90%
A4C staff corporate induction compliance	2026-09	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2026-09		F	74%		90%
Medical & dental staff corporate induction compliance	2026-09	H	?	96%		95%
Appraisal Activity	2026-09		?	29.4%		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: Sarah Dexter-Smith

Operational Lead: Lydia Larcum





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 September, mandatory training compliance maintained at 88%.

Compliance improvement has been limited by the national suspension and subsequent revision of Mental Capacity Act and Deprivation of Liberty Safeguards eLearning following legal changes affecting deprivation of liberty guidance. MCA training has now been reinstated nationally; however, revised DoLS content is not expected until later in 2026, resulting in a need to develop local training arrangements. This has led to a reduction in training compliance in these subjects.

Building on the momentum created through the Big Conversation, the Group launched 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 are encouraged to participate throughout the survey period, which closes on 27 November, ensuring that the views of as many 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

October 2026

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

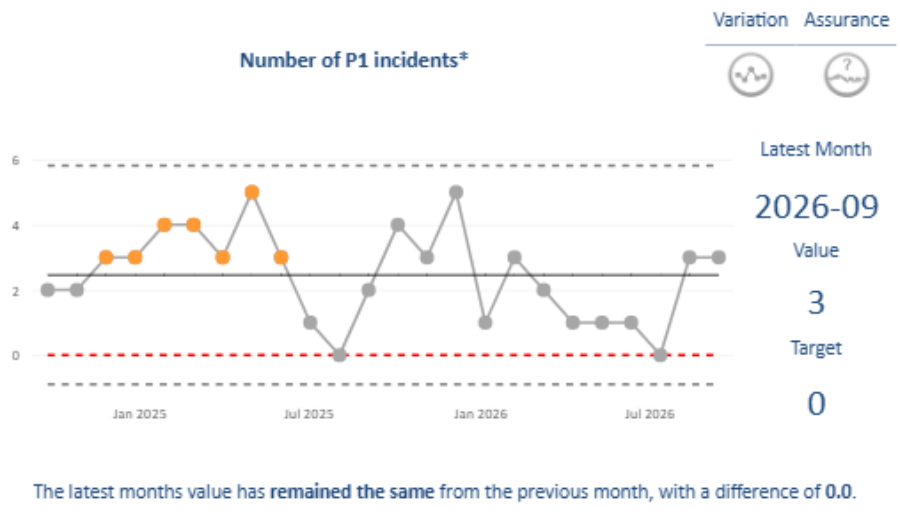
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* Percentage of FOIs and EIRs responded to within 20 working days (monthly)	* Number of P1 incidents*	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	

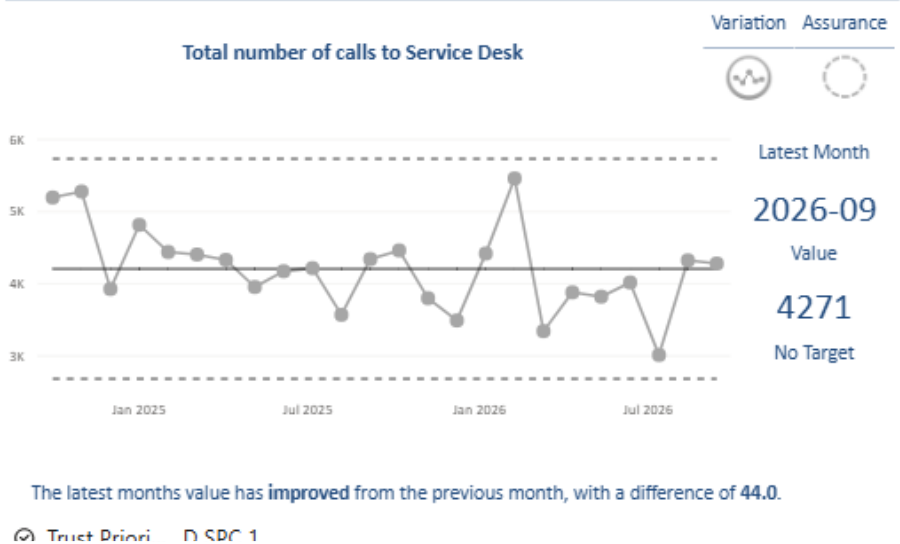
Executive Owner: James Hawkins

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-09			3		0
Total number of calls to Service Desk	2026-09			4271		
Total number of calls abandoned	2026-09			1265		
Number of information security incidents reported and investigated	2026-09			43		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-09			385		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-09			253		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-09			55%		80%
Number of FOIs and EIRs received (monthly)	2026-09			54		
Number of FOIs and EIRs completed (monthly)	2026-09			42		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-09			98%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy





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 September.

10/9 Unable to admit patients or print blood labels. This was a result of issues during a planned upgrade overnight by Nervecentre. Messaging was disrupted and caused updates from CPD to Nervecentre to fail and this prevented admissions which rely upon patient demographic data being sent from CPD. Print services were disrupted due to issues arising during the upgrade and operational process failures at Nervecentre.

21/9 Winpath (Laboratory system) was unavailable for a short period due to issues with resilient failover for this service during a planned infrastructure maintenance.

23/9 Order Comms services within Nervecentre were disrupted, following planned upgrade to Trust Firewall infrastructure. This introduced a minor change to a setting which triggered issues within Nervecentre handling of the messages relating to printing. Resolution was complicated due to other changes occurring within the same period.

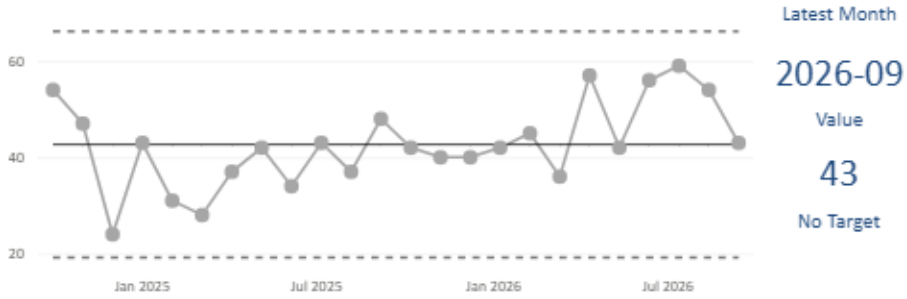
Action: Lessons Learnt discussions have been the focus of Service Reviews with Nervecentre to minimise risks of future incidents during planned upgrades and explore any actions we could implement.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2026-09
Value
43
No Target

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

Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

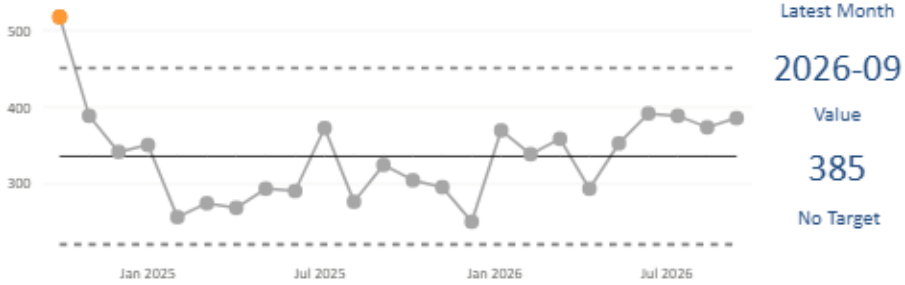
Factors impacting performance:

Information security incidents have decreased significantly since summer, this may be attributed to staff using Nervecentre more confidently.

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
2026-09
Value
385
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **12.0**.

Rationale: Monitoring of Subject Access Requests received to ensure the Trust is managing its statutory obligations under the UK GDPR.

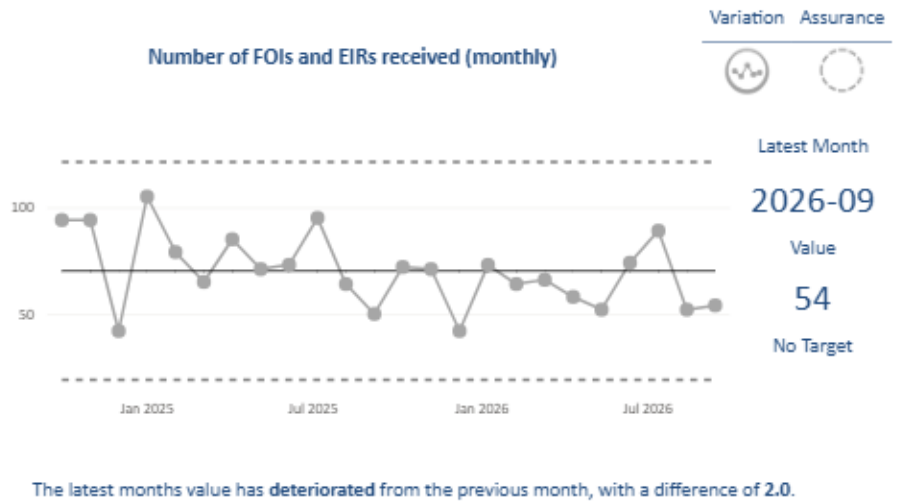
Number of Subject Access Requests (SAR) submitted by patients

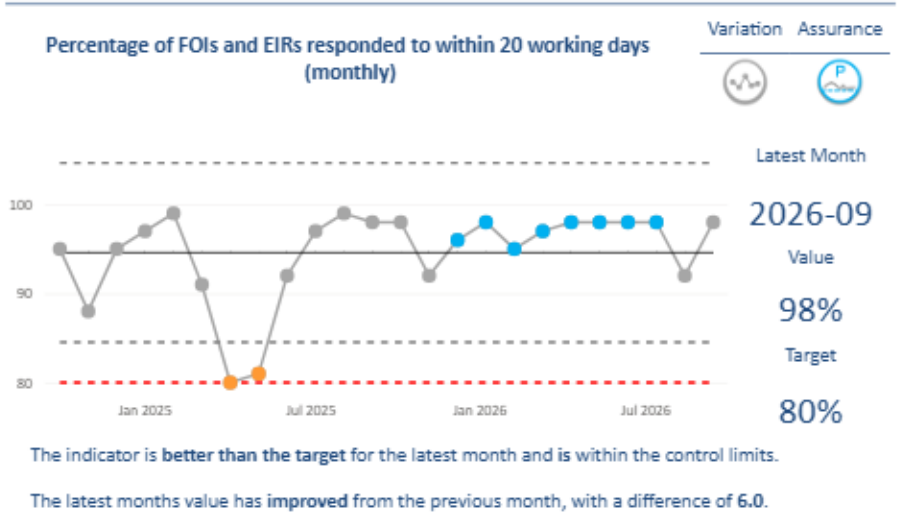
Factors impacting performance:
The reporting for SARs has changed to only include patient access requests. Previous reports have also included police requests, access to health records (deceased patients) and ad hoc external requests which are no longer included in this count.

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. The Information Commissioner is aware of the backlog and will be monitoring our progress.

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 increased slightly

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

October 2026

Executive Owner: Andrew Bertram

Highlights

At the end of September 2026, the adjusted year-to-date deficit excluding deficit support funding (DSF) is **£18.4m** against a planned **£9.2m**, an adverse variance of **£9.2m**. September was **£2.9m** adverse on the same basis. Including DSF, the adjusted year-to-date deficit is **£13.7m** against a planned **£0.1m** surplus, **£13.8m** adverse. September pay costs were consistent with recent months, while other expenditure was below the preceding 11-month average.

NHSE has agreed the **2026/27** plan at a year-end deficit of **£18.5m** before DSF. The associated **£18.5m** support is conditional and **must be earned** through delivery of the agreed plan and its recovery, productivity and control requirements. In September, NHSE confirmed **£4.6m** of DSF for the first quarter. Achieving the agreed deficit plan and receiving the full support allocation would enable the Trust to break even.

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 mid-range forecast is **£30.5m**, **£12.0m** worse than plan, and the worst case is **£45.5m**. NHSE's Provider Assurance Model gives a mid-case deficit of **£26.1m**, reflecting different assumptions on WRAP and income recovery. The Executive Committee's recovery plan was initially assessed as having a potential impact of up to £8.0m. The latest assessment puts this at £10.2m, of which £4.4m is now included in the WRAP programme, leaving a further potential £5.7m to support expenditure recovery. Delivery is supported by the Challenged Provider Programme.

Cash closed at **£3.9m** against a **£2.3m** plan, supported by holding **£9.0m** of supplier payments. The **£8.0m** cash-support application has been submitted, with an outcome expected by **6 November**. The latest available activity estimate remains **Month 6**: **£5.8m** above plan, including high-cost excluded drugs, subject to final coding, costing and commissioner agreement.

Capital is **£8.0m** behind plan at **Month 6**, mainly from RAAC slippage of **£11.0m**, partly offset by other schemes ahead of phasing. The forecast remains **£62.8m** against a **£63.4m** plan.

Concerns

WRAP remains the principal risk. **Month 6** year-to-date delivery is **£24.7m** against a target of **£31.8m**, a **£7.0m** shortfall. Full-year savings delivered are **£34.5m** against a **£65.8m** target. Deferred investment and other non-recurrent measures have helped manage the gap but do not reduce the underlying cost base. Delivery of the **£18.5m** deficit plan and receipt of full support funding remain at risk.

Workforce expenditure remains a material pressure. Agency spend is **£2.8m** against a **£3.3m** plan, **£0.5m** favourable, but bank spend is **£18.7m** against **£12.9m**, **£5.8m** adverse. Medical and dental staffing remains the main operational pay pressure, including **£0.6m** for industrial action cover. Vacancy controls, rota management, substantive recruitment and tighter temporary staffing approvals must reduce the underlying pay run rate.

We have assumed income above plan, subject to commissioner agreement, with the risk of non-recovery reflected in our mid-range and worst-case forecasts. The priority remains to replace temporary mitigations with evidenced recurrent delivery and maintain compliance with the conditions attached to the **£18.5m** support. The mid-range forecast puts our NOF rating and reputation at risk and would further increase cash pressure.

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	65,786	36,122	39,929
OPERATING SURPLUS / (DEFICIT)	**-14,169**	**-1,562**	**14,896**
Finance Costs	-12,677	-13,171	-13,564
SURPLUS / (DEFICIT) FOR THE YEAR	**-26,846**	**-14,733**	**1,332**
Technical Adjustments	8,346	-1,124	-1,079
ADJUSTED FINANCIAL SURPLUS / (DEFICIT)	**-18,500**	**-15,858**	**253**

The immediate priority remains recurrent WRAP delivery. At Month 6, the year-to-date shortfall is **£7.0m**, with **£24.7m** delivered against **£31.8m**. Full-year delivery is **£34.5m** against a **£65.7** target. Financial Improvement Boards must maintain scheme ownership and address slippage. The Executive Committee's priority is now to validate and deliver the remaining **£5.7m** of potential expenditure recovery identified in its recovery plan, with support from the recovery director, NHSE and the Challenged Provider Programme.

The Executive Committee continues to focus on implementing the financial recovery actions developed through Board discussions and the Challenged Provider Programme. The priority is to translate these actions into sustained reductions in monthly expenditure, supported by monthly progress reporting. Workforce and non-pay controls must support recovery while protecting patient care.

WRAP delivery requires continued development of opportunities into fully worked-up, deliverable schemes. Care groups must maintain clear ownership and realistic delivery plans, with weekly tracking and challenge through Financial Improvement Boards. Early escalation of delays and action on high-risk schemes will be essential to close the remaining gap and strengthen recurrent savings delivery.

Returning to financial sustainability requires a lasting reduction in the underlying cost base and improved productivity. Recurrent savings must progressively replace deferred investment and other temporary mitigations. Investment decisions should remain subject to affordability and appropriate business-case approval, so that improvements in this year's position also support a sustainable financial plan for future years.

Over the next quarter, Board reporting should evidence recurrent savings, recovery progress and lower workforce costs, alongside commissioner agreement of income and compliance with DSF conditions. The mid-range forecast deficit risks worsening the NOF rating and confidence in financial management. Further cash pressure or withheld DSF would increase the scale of recovery required.

Finance

High Level summary in numbers

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

ADJUSTED YTD DEFICIT	ADVERSE TO PLAN	IN-MONTH VARIANCE	APPROVED PLAN	CLOSING CASH	CAPITAL SLIPPAGE
£18.4m	£9.2m	£2.9m	£18.5m	£3.9m	£8.0m
Excl. DSF Plan: £9.2m deficit	Up from £6.3m at Month 5	Adverse in September	Deficit excluding DSF	Plan: £2.3m £9.0m payments held	Behind plan at M6 Forecast: £62.8m

What this tells us

The Trust is behind the year-to-date plan and the adverse movement continued in September. The formal annual plan is now approved, but delivery remains dependent on recurrent savings, recovery action and income assumptions.

Key subjective variances at Month 6

ICB income	£20.0m	Favourable	**NHSE income**	£14.5m	Adverse
Pay awards, delegated services, activity and Q1 DSF			Delegated commissioning movements		
WRAP	£7.0m	Adverse	**Employee expenses**	£5.3m	Adverse
Delivery below the amended financial plan			Includes funded pay effects and workforce pressure		
Drugs and devices	£4.3m	Adverse	**Other non-pay**	£4.0m	Adverse
Partly offset by income: net pressure £2.1m			Wider non-pay pressures		

Key Financial Risks

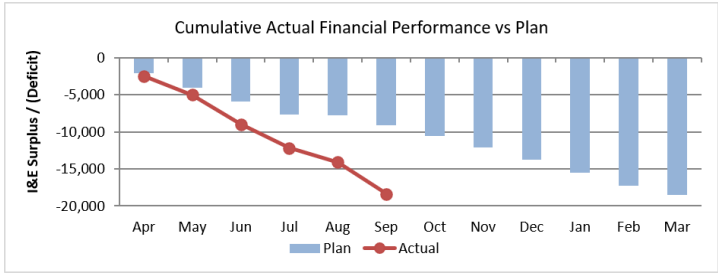
Key Risk Area	Board Level Risk Statement	Mitigations
Mid Range Forecast Deficit Position	Risk that the £30.5m deficit (£12.0m off plan) damages NOF rating and reputation, worsens cash and supplier delays, and puts £18.5m DSF at risk.	• Deliver WRAP and the £6.7m recovery plan with clear accountability, reporting progress and escalating slippage and funding risks to the Board and NHSE. • Agree activity income with commissioners and evidence compliance with DSF conditions. • Monitor cash weekly, pursue cash support and prioritise critical supplier payments.
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 • MAP Panels in place to validate all medical bank and agency shifts.
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, with supporting technical groups.
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

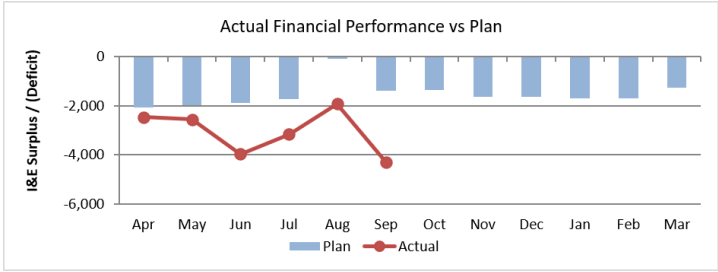
BAF

BAF Principal Risk	How this report provides assurance	Outlook
Financial sustainability	Month-end I&E, forecast outturn, key variance analysis and cash position.	WRAP and workforce pressures keep next quarter's plan at risk.
Delivery of recovery plans	WRAP delivery, high-risk schemes, slippage and recovery actions	Scheme slippage threatens recurrent savings and increases recovery needs.
External financial compliance	Agency and bank controls, capital and cash management, system reporting	No immediate issues identified, but spending and system risks remain.

	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	68,858	72,138	3,281	413,145	418,576	5,430
Other Income	84,561	7,052	7,257	206	42,311	44,789	2,478
Total Income	910,852	75,909	79,396	3,486	455,456	463,364	7,908
Pay Expenditure	-621,558	-50,793	-51,929	-1,136	-305,115	-310,401	-5,287
Drugs	-71,933	-5,959	-6,783	-824	-36,001	-40,266	-4,265
Supplies & Services	-97,954	-8,397	-7,690	707	-48,944	-48,546	398
Other Expenditure	-146,374	-9,705	-11,353	-1,648	-64,393	-68,746	-4,353
Outstanding WRAP	31,296	430	0	-430	7,046	0	-7,046
Total Expenditure	-906,521	-74,423	-77,754	-3,331	-447,407	-467,960	-20,552
Operating Surplus/(Deficit)	4,331	1,486	1,641	155	8,049	-4,595	-12,644
Other Finance Costs	-12,677	-1,056	-1,093	-36	-6,338	-6,337	1
Surplus/(Deficit)	-8,346	430	549	119	1,710	-10,933	-12,643
NHSE Normalisation Adj	8,346	-269	-208	61	-1,628	-2,809	-1,181
Adjusted Surplus/(Deficit)	0	161	341	180	82	-13,742	-13,824
Remove DSF	-18,500	-1,542	-4,625	-3,083	-9,248	-4,625	4,623
NHSE DSF Adjusted Position	-18,500	-1,381	-4,284	-2,903	-9,166	-18,367	-9,201

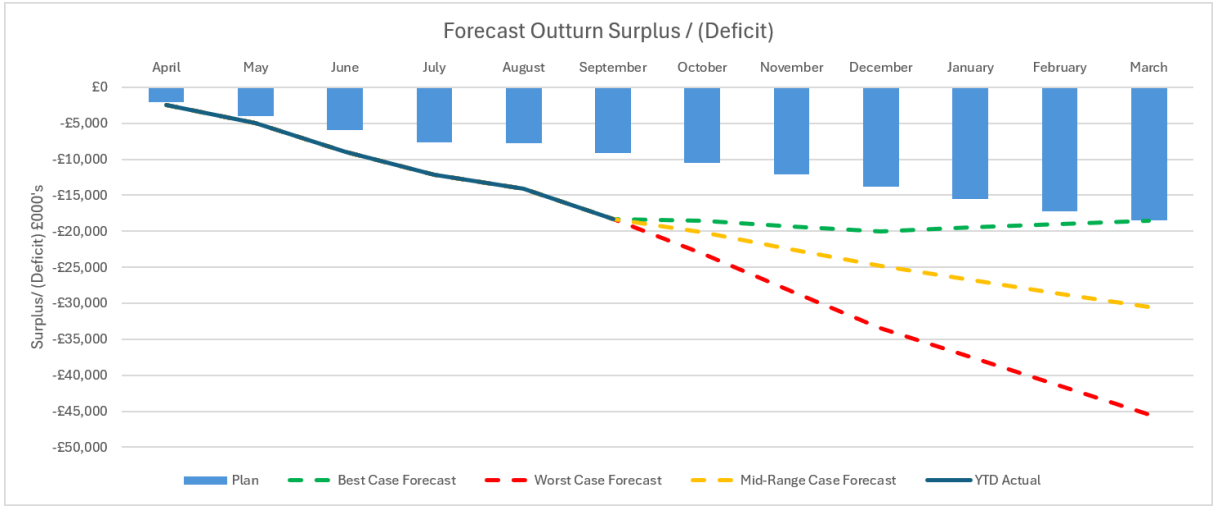
The I&E table confirms an actual adjusted year to date deficit of £13.7m against a planned surplus of £0.1m, leaving the Trust with an adverse variance to plan of £13.8m. The in-month position for September is a favourable variance of £0.2m. The year-to-date adjusted position excluding Deficit Support Funding (DSF) is a deficit of £18.4m compared to a planned deficit of £9.2m creating an adverse variance of £9.2m.





The charts above show the income and expenditure plan profile (excluding deficit support funding) both in cumulative and marginal terms. The graphs show 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 (excluding DSF) I&E performance at the end of September 2026 is an adverse variance to plan of £9.2m

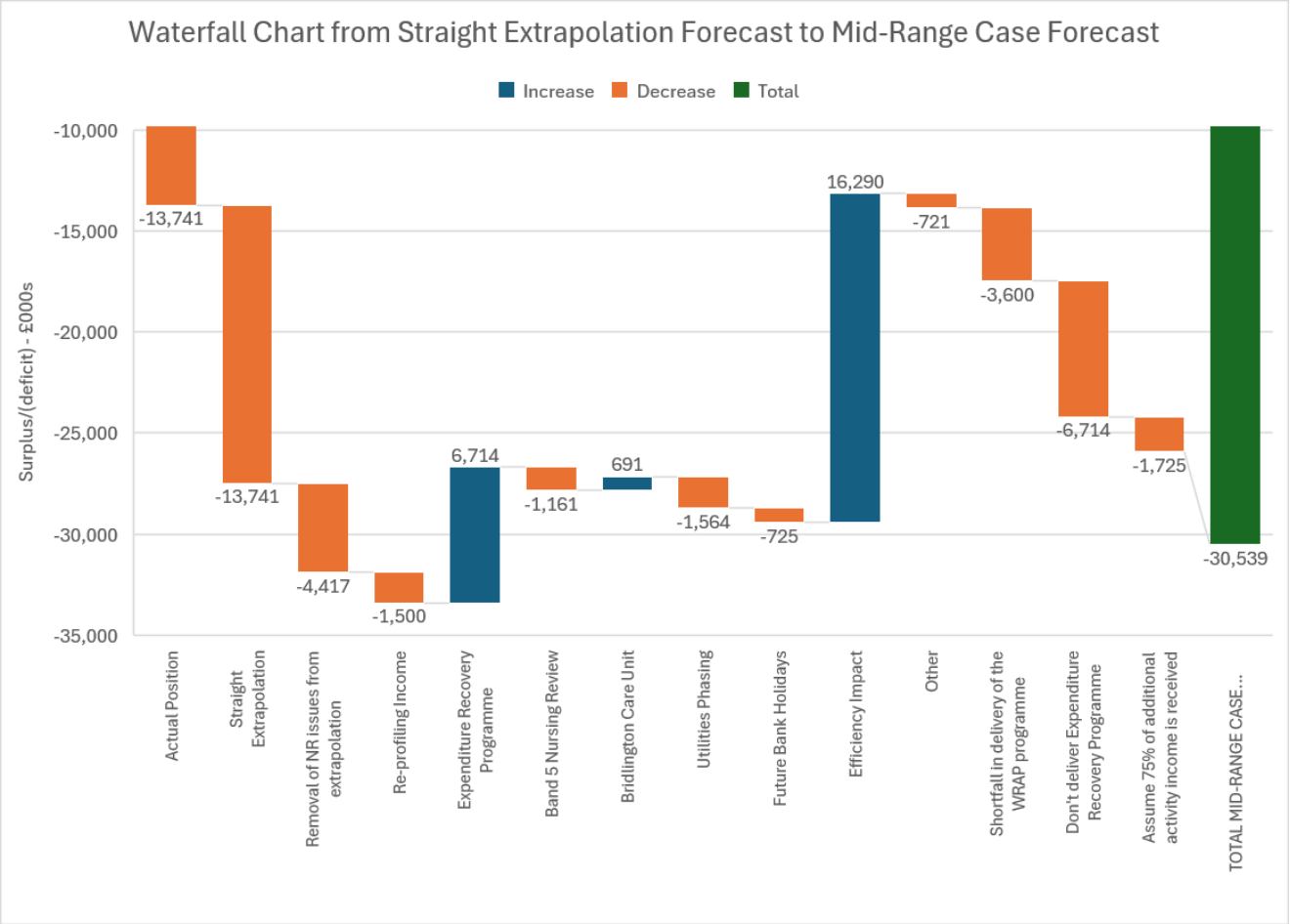


The graph above presents the forecast outturn deficit compared with the planned deficit (excluding DSF) of £18.5m. It presents the following 3 scenarios:

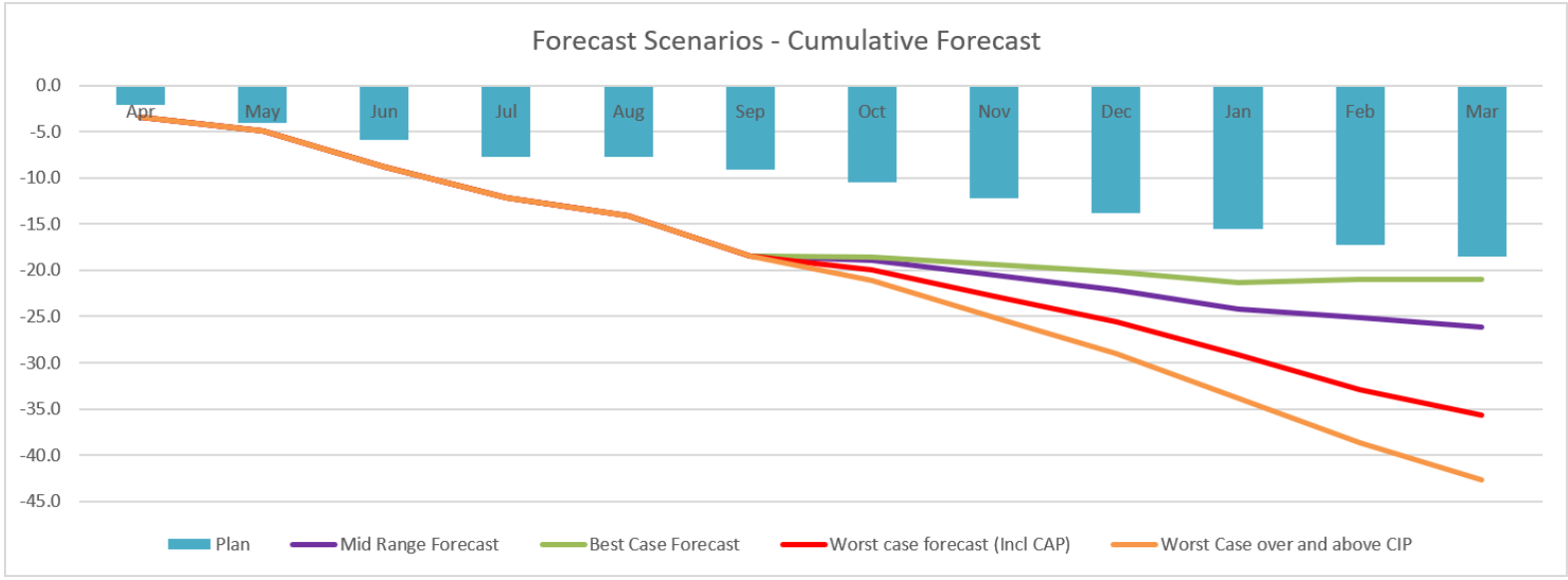
The best-case scenario assumes that the Trust recovers its financial position and delivers an outturn deficit of £18.5m, in line with plan. This assumes full delivery of the WRAP programme, achievement of financial recovery plans that deliver a further £6.7m of savings compared with the current run rate and payment in full for activity delivered ahead of plan (estimated at £6.9m in full year terms).

The mid-range scenario is an outturn deficit of £30.5m, which is £12.0m worse than plan. This assumes a shortfall in the delivery of the WRAP programme of £3.6m, non delivery of the additional £6.7m financial recovery plan and failure to secure 25% of the income linked to activity ahead of plan (£1.7m). The mid-range deficit risks worsening our NOF rating and undermining confidence in our financial management. It would increase cash pressures and reliance on cash support, with further potential delays to supplier payments. Failure to meet the conditions for the £18.5m DSF could result in funding being withheld, further worsening the deficit and cash position.

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 £45.5m which is £27m worse than plan.



The chart summarises the assumptions behind the mid range forecast, moving from the actual month 6 position (£13.7m deficit) to a straight-line extrapolated outturn position (£27.5m deficit) to the most likely position (£30.5m 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 £26.1m 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 £21.0m and the worst case over and above CIP is a deficit of £42.6m

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.

Recovery Plan – Version 1

Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Action	Comments	Target Savings Level	WRAP	Expenditure Recovery	Target Action Date	Actioned Date	Actioned by Who	Progress to Date
		£000	£000	£000				
Asset Revaluation Exercise - MEA Review	A Bertram evaluating proposal for external support	1,800	1,800	0	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	630	1,370	Aug26	Aug26	L Larcum/C Hansen	Process now in place - Specific schemes moved to WRAP as validated
Reduction in medical bank premium rates/WLI reductions/Insourcing/Outsourcing Reductions	Establishment of MAPS review meetings for all bank/agency shifts - with senior Care Group leadership. F Gunebakan preparing ToR and Process.	2,000	500	1,500	Sep26	Sep26	F Gunebakan	ToR and process shared and agreed. 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. £500k Surgery insourcing scheme included in WRAP
Community Bed Reduction Programme	Exec Cttee agreement to progress programme. Considering wider community prortfolio and opportunity from ESD.	1,000	175	825	Nov26		J Hague	Included PYE in WRAP programme for 2026/27
Prepare and evaluate withdrawel from Whitby - Maternity and Radiology and potential clinic offering	Outreach support to cease. Resource stretching and poor VFM	200		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		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		250	Sep26		K Stone	
Consider reduction in UTC opening hours	Review usage data to consider VFM	200		200	Oct26		C Hansen	
Consider opportunity for Cancer scheme funding Slippage	K Hinton to review	N/A	N/A	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	TBC	TBC			K Stone (Medical Staff) plus other Directors	
Consider the release of unspent/not yet committed CPD funding	Chief Nurse Team to evaluate opportunity	204		204	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.	228		228	Oct26		J Hague	
Discretionary expenditure review panel	At present all non-pay spend above £5k is reviewed. Reduce this to £500 with Exec Panel.	500		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.
Bank shift Break Review	Early evaluation underway of potential opportunity	619	619	0	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		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	690	690	0	Sep26		L Larcum	Embedded within existing WRAP scheme
Audio Typing Reduction	Exec Cttee agreement to progress programme	N/A	N/A	N/A	Oct26		J Hawkins	Embedded within existing Admin optimisation WRAP scheme
TOTAL		**10,191**	**4,414**	**5,777**				

Key Subjective Variances: Trust

Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHSE income	-£14.5m	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	£20.0m	ICB over trade linked to services which have been delegated from NHSE to ICBs to commission. The position also includes additional income to fund the increased agenda for change and medical staffing pay awards, overtrades on high-cost drugs and variable activity and deficit support funding paid for quarter 1	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27. Contract Management Board engagement re overtrade.
Other Income	£2.4m	£1.5 income brought forward 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	-£5.3m	Pay awards have been agreed and paid at a higher rate than originally funded in the plan/contract. This is currently contributing £3.7m 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).	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 now established to review, challenge and approve requests for temporary medical staffing.
Drugs and Devices	-£4.3m *Net of income: -£2.2m*	Drugs expenditure is £4.3m above plan. £2.1m 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 (£0.6m). 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 £0.4m 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	-£7.0m	Year to date savings of £24.7m have been delivered compared to a target of £31.8m. This is a shortfall of £7.0m. In full year terms, £34.5m 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	-£4.0m	Cost pressures relating to outsourcing costs particularly in CSCS in Histopathology and Surgery in Head and Neck and Theatres.	A reduction in outsourcing costs is being managed through the financial recovery programme.

Activity Related Investments	Reserve	Period
Total	**11,797**	
£3m plan adjustment	- 3,000	
Shortfall of WRAP - M6 YTD	- 1,500	
Revised Reserve	**7,297**	
Approved to date by specialty:		
Acute Medical Model	1,164	Q1-Q4
Audiology	312	Q1-Q2
Colorectal Surgery	331	Q1-Q3
Dermatology	115	Q2
Diagnostics	1,585	Q1-Q4
ENT	286	Q1-Q2
Gynaecology	179	Q2-Q3
Neurology	325	Q2 & Q4
Oral Surgery	87	Q1-Q2
Paediatric SaLT	507	Full Year
Pain Management	241	Q2
Renal	86	Q2-Q3
Respiratory	74	Q2-Q4
Urology	77	Q1-Q2
York Discharge BC	54	Q2-Q4
HOOH Business Case	223	Q2-Q4
Upper GI	435	Q1-Q3
Total approved as at 9th October 2026	**6,081**	
Remaining reserve	**1,215**	

*Note: The shortfall of WRAP adjusted against the reserve remains at £1.5m (from £2.1m in M4 & £1.5m in M5). The commitment remains to wind this back by the end of quarter 3, however we need to see further improvements in WRAP delivery and the expenditure recovery programme.

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 September 2026. Approvals recorded to date amount to £6.1m, leaving £1.2m available to support further specialty investments.

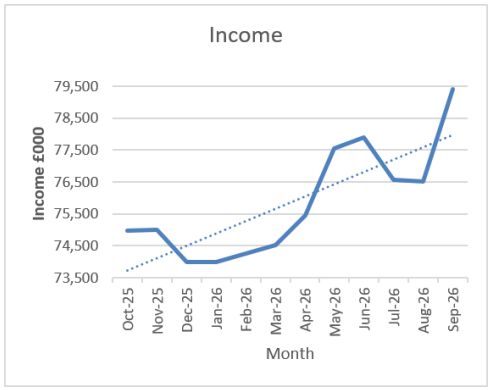
Investments continue to be agreed on a non-recurrent, quarter-by-quarter basis unless by exception.

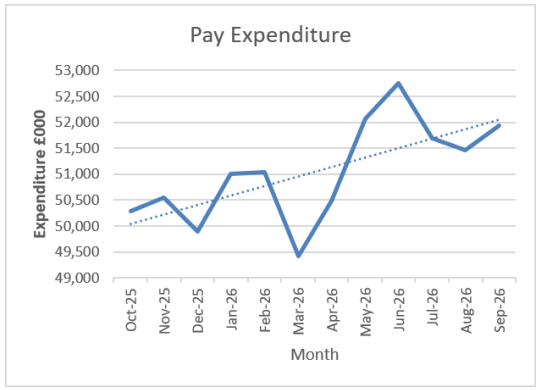
Recurrent investment in staffing is only supported following approval of a business case.

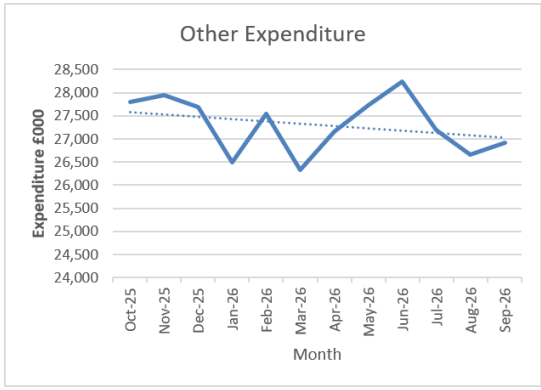
Recurrent investment in non pay is made on a case by case basis.

Income and Expenditure Run Rate

Finance







	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	YTD Average	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	74,981	75,011	73,986	74,000	74,268	74,525	75,442	77,557	77,887	76,580	76,502	79,396	75,522	3,874
Pay Expenditure	50,282	50,548	49,895	51,005	51,041	49,416	50,484	52,073	52,761	51,684	51,470	51,929	50,969	-960
Other Expenditure	27,807	27,945	27,683	26,486	27,538	26,333	27,156	27,718	28,248	27,190	26,666	26,917	27,343	426

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 September 2026 was £79.4m, which was £3.9m above the average monthly income for October 2025 to August 2026. This is due to the receipt of deficit support funding for the first quarter of the year being confirmed by NHSE (£4.6m).

Pay expenditure in September 2026 was £51.0m which was £1.0m above the average monthly pay expenditure for October 2025 to August 2026. The costs in September are consistent with the previous months in 2026/27 but are higher than the average costs for the previous 11 months due to pay awards paid in 2026/27.

Other expenditure was £26.9m in September 2026, which was £0.4m lower than the average monthly expenditure for October 2025 to August 2026. The reduction is across several expenditure groups including clinical supplies and services and provisions.

Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variable / Blended Activity Performance Report - Month 6

Commissioner	Value VAPR scope Indicative Weighted Values at 26/27 prices	VAPR Month 6 Phase (Av %)	Weighted Activity to Month 6 Actual	Variance - (Clawback Risk) M6
Humber and North Yorks	£464,467,479	£240,562,847	£244,017,002	£3,454,155
West Yorkshire	£1,954,676	£961,678	£1,133,975	£172,297
Cumbria and North East	£413,808	£205,277	£190,756	-£14,521
South Yorkshire	£190,159	£94,397	£142,089	£47,692
All ICBs	***£467,026,122***	***£241,824,199***	***£245,483,822***	**£3,659,623**
NHSE Specialist Commissioning	£41,389,000	£21,008,302	£23,140,641	£2,132,339
NHSE Other	£285,266	£143,302	£167,186	£23,884
All Commissioners Total	**£508,700,388**	**£262,975,803**	**£268,791,649**	**£5,815,846**

Note:- Position Includes High Cost Exclude Drugs/ Devices, Unbundled Radiology and Estimated 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 and blended 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 is monitoring contract performance via the Contract Management Board 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 6, across all commissioners, the weighted activity position is above the planned weighted value by circa £5.8m. This includes expected additional income for High Cost Excluded drugs (£2.13m) 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 planned original PoDs (Daycase and Non-Elective).The position includes provisional data and estimates so the reported variable position is subject to change until the 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 and to agree the final reconciled position

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

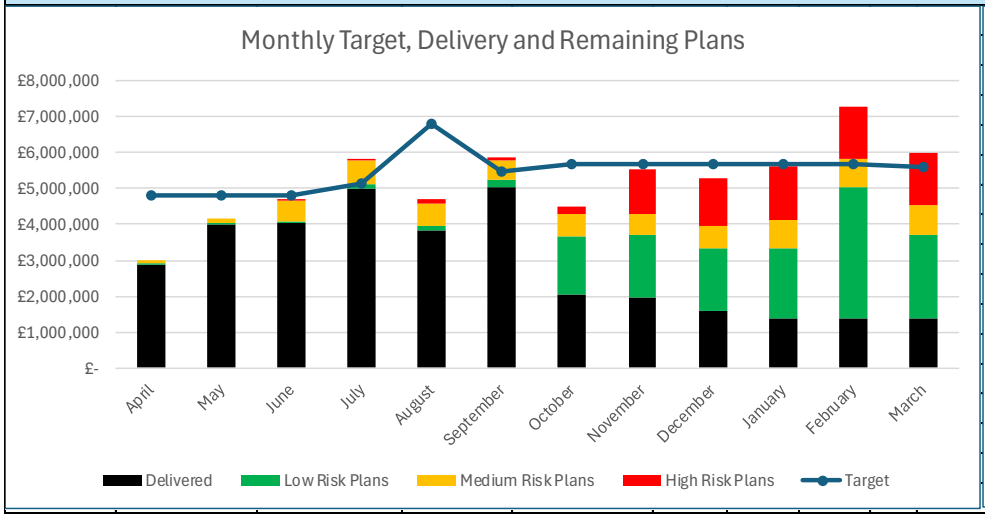
26/27 position • Reset: select All Care Groups | Care Group: **All Care Groups** | Directorate*: All Directorates

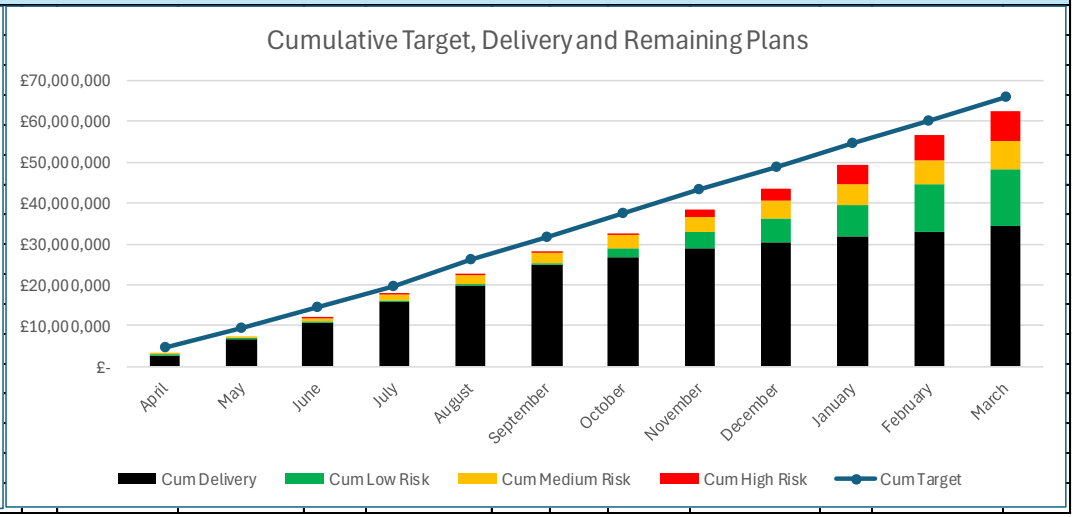
Executive Summary

Programme Summary Position		Full Year	YTD Position
Target		£65,785,699	£31,794,232
Delivered		£34,489,202	£24,748,336
Variance		**-£31,296,497**	**-£7,045,896**
Addititional Plans to be delivered			
Planned Low Risk		£13,657,538	£626,636
Planned Medium Risk		£6,860,430	£2,585,917
Planned High Risk		£7,430,510	£283,334
Total Additional Plans		**£27,948,478**	**£3,495,887**
(Planning Gap)/Over delivery		**-£3,348,019**	**-£3,550,009**
WTE Plan	239.34	**WTE Delivered**	47.91

Scheme Governance											
Total Number of Live Schemes						**153**					
EQIA Outstanding						56		37%			
Pre-Pipeline						3		2%			
Opportunity						37		24%			
Plan in Progress						9		6%			
Fully Developed						104		68%			
	Plans	**%**	**Delivered**	**%**		**Plans**	**%**	**Delivered**	**%**		
Recurrent	£38,875,859	59%	£19,773,243	30%	**Pay**	£28,564,837	43%	£13,979,897	21%		
Non Recurrent	£23,561,821	36%	£14,715,959	22%	**Non Pay**	£33,557,481	51%	£20,289,942	31%		
Total	**£62,437,680**	95%	**£34,489,202**	52%	**Income**	£315,363	0%	£219,363	0%		
					Total	**£62,437,680**		**£34,489,202**			
YTD Period Name						September 2026					

In Year Plan Profile





27/28 Indicative Waste Reduction and Productivity Programme Position

The 27/28 programme has £33.7m of plans against a £67.0m indicative Trust target, leaving a £33.3m planning gap and 50% coverage. Corporate Functions holds the largest Care Group plan value at £10.5m. Workforce & Pay is the largest TPR category at £15.2m.

TRUST ESTIMATED TARGET	PLANS IDENTIFIED	PLANNING GAP	TARGET COVERAGE
£67,031,568	£33,706,872	-£33,324,696	50.3%

CARE GROUP POSITIONS

Care Group	27/28 Target	Plans	Planning Gap	Coverage	Share of Plans
CSCS	£14,487,397	£4,043,910	-£10,443,487	27.9%	12.0%
Family Health	£7,356,571	£3,916,177	-£3,440,394	53.2%	11.6%
Medicine	£16,353,551	£8,838,298	-£7,515,253	54.0%	26.2%
Surgery	£17,044,739	£6,392,437	-£10,652,302	37.5%	19.0%
Corporate Functions	£11,789,309	£10,516,049	-£1,273,260	89.2%	31.2%
Trust Total	**£67,031,568**	**£33,706,872**	**-£33,324,696**	**50.3%**	**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	£15,243,025	45.2%
Procurement, Medicines & Non-Pay	£8,044,806	23.9%
Clinical Productivity & Pathways	£6,253,147	18.6%
Digital & Technology	£2,768,120	8.2%
Estates, Facilities & Energy	£1,286,582	3.8%
Income & Commercial	£91,000	0.3%
Corporate Services & Administration	£20,193	0.1%
Trust Total	**£33,706,872**	**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	35.6%
2	CIP2	NON RECURRENT NON PAY SAVINGS	Procurement, Medicines & Non-Pay	£3,858,696	11.4%
3	CIP203	ACUTE MODEL OF CARE	Clinical Productivity & Pathways	£3,066,000	9.1%
4	CIP240	MEA	Procurement, Medicines & Non-Pay	£1,800,000	5.3%
5	CIP174	RAMSEY REPATRIATION	Clinical Productivity & Pathways	£1,548,000	4.6%
Top 5 Total				**£22,273,126**	**66.1%**

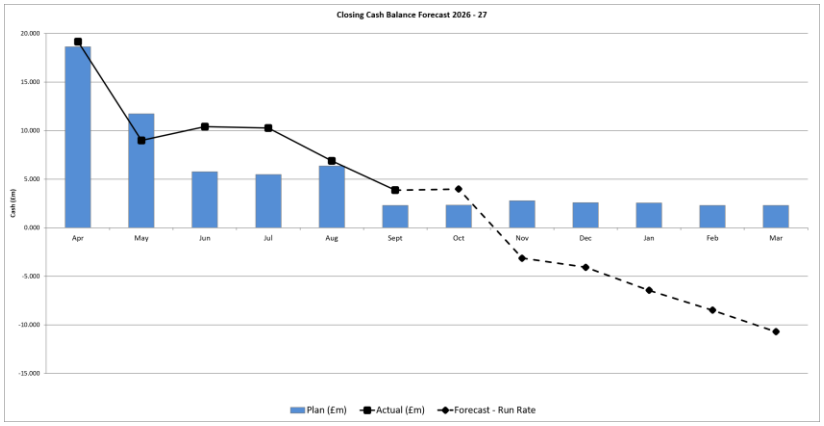
Current Cash Position and Better Payment Practice Code (BPPC)

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	3,887						



Closing cash was **£3.9m**, compared with a planned balance of **£2.3m**, resulting in a positive variance of **£1.6m**.

Similarly to the previous months, due to the uncertainty of cash receipts approaching month end & the timing of the final supplier payment run, £9m of invoices due for payment were held to ensure sufficient cash resources were available before payment could be released. This position has declined from prior month when £4m was held previously.

The favourable variance is due to timing of supplier payments described above 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.

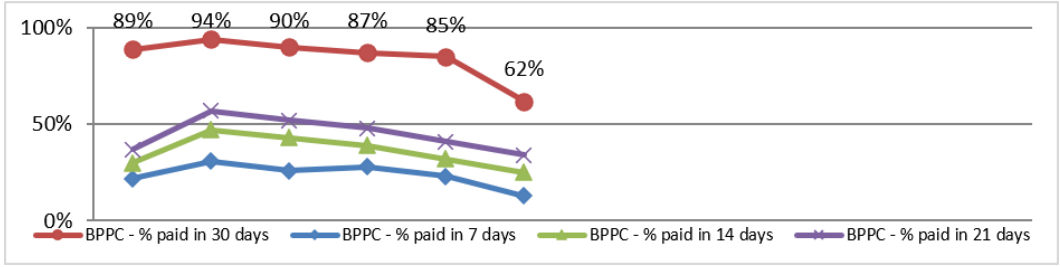
Approval to submit an £8m cash support application was approved at the September Board meeting. The application was submitted to the regional NHSE team and will progress to the national team. An outcome is expected on or before 6th November.

<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 September, the Group managed to pay 62% of its suppliers within 30 days, reducing from the previous month.

This reduction is due to holding supplier payments to navigate cashflow uncertainties over the month end. The metric is expected to decline further without cash support.



Current and Forecast Capital Position

Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

The board approved capital plan for 2026/27 is £63.4m. RAAC eradication & pathology build on the Scarborough site are the largest value schemes in the plan.

The forecast has reduced by £0.6m to £62.8m. This is due to a £1.9m decrease from the RAAC pathology scheme, with expenditure and PDC funding reprofiled between financial years. There is a £1.3m increase due to the Macmillan cancer care centre not completing in the previous financial year. This scheme is charitably funded and therefore does not impact on the overall capital program funding.

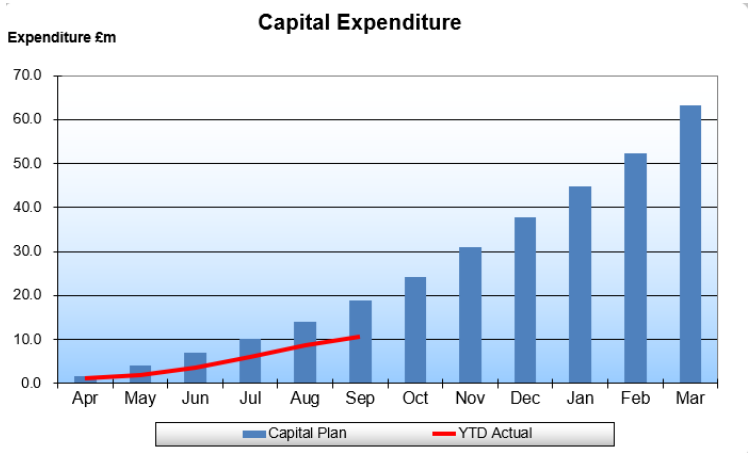
Capital Position	Plan	Forecast Outturn	YTD Plan	Actual YTD Expenditure	Variance to YTD Plan
	£000's	£000's	£000's	£000's	£000's
Internally Funded Schemes					
Electronic Patient Record (EPR)	7,200	7,200	953	876	- 77
York - PACU / Hybrid Theatre	2,850	1,700	1,050	1,401	351
Histopathology Refurb Completion	1,800	600	800	-	- 800
Salix Decarbonisation - Trust Contribution	1,459	1,459	-	-	-
Minor Works Schemes	559	559	50	113	63
Estates Backlog Maintenance & EDI	1,150	1,150	400	969	569
Y&S Digital Capital Projects	1,000	1,000	400	286	- 114
Medical Equipment Purchase/Lease	5,600	5,600	525	1,792	1,267
Capitalised Staff / Project Fees	2,100	2,100	894	1,035	141
Other Capital Projects	499	- 61	-	663	663
CIR - Refurb & Extension of SCBU York	-	1,080	-	161	161
Upgrade of CT (CT3) - York	-	700	-	476	476
Renal Ward York - Water ring upgrade	-	300	-	-	-
MRI 4 Relocatable	-	400	-	31	31
Ward 16 York	-	400	-	-	-
Total Internally Funding Schemes	**24,217**	**24,187**	**5,072**	**7,802**	**2,730**
PDC, Charitable and Grant Funded Schemes					
RAAC - Scarborough Pathology - PDC	16,458	14,604	9,816	-	- 9,816
RAAC - Scarborough Theatres - PDC	8,737	8,737	2,007	319	- 1,688
Constitutional Standards Schemes - PDC	6,150	6,150	-	-	-
Safer Estates Schemes - PDC	3,655	3,655	655	80	- 575
Charitable & Grant Schemes	4,160	5,460	1,353	2,493	1,140
Total Externally Funded Schemes	**39,160**	**38,606**	**13,831**	**2,892**	**- 10,939**
Total Capital Programme	**63,377**	**62,793**	**18,903**	**10,694**	**- 8,209**

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 M6 position is £8m behind plan.

This is mainly due to the RAAC schemes running behind the original planned phasing (£11m), offset by several schemes running ahead of the monthly planned phasing but within the total annual agreed allocations. These include 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**

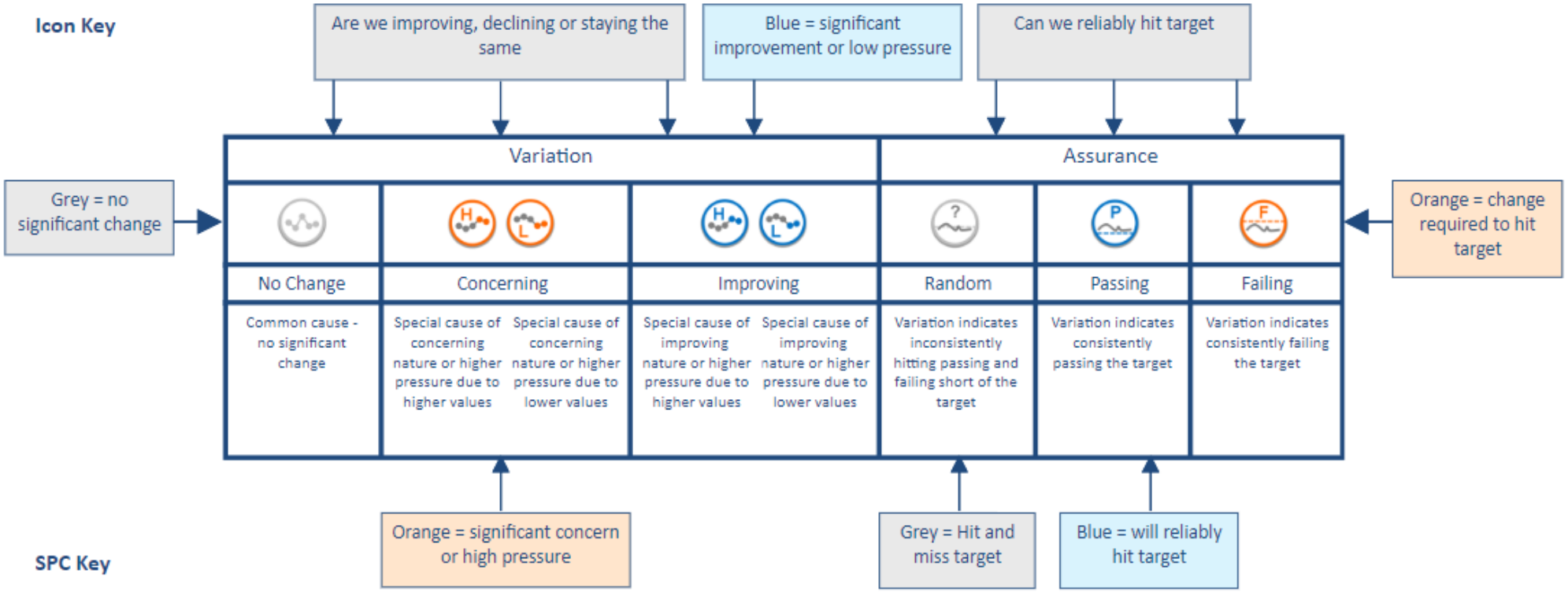
HNY Efficiency Summary - M5

			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)**

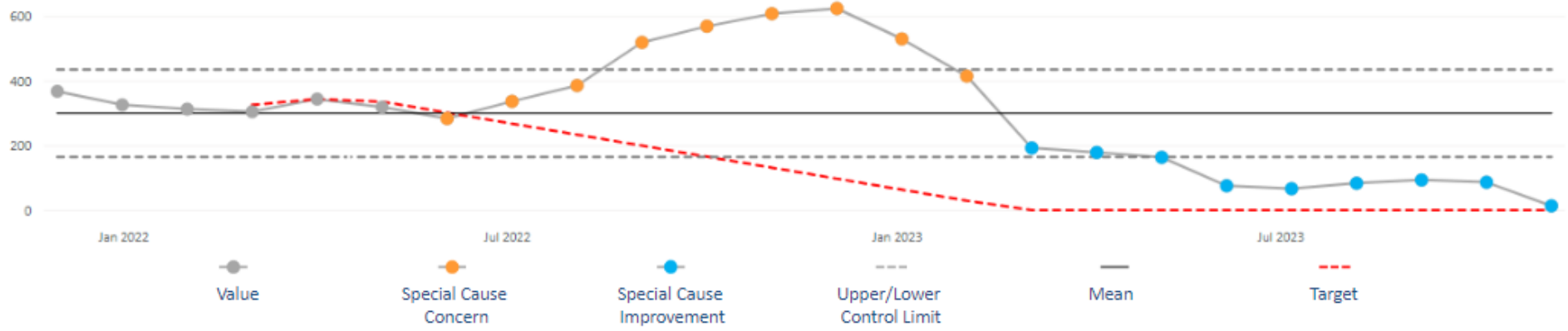
Keys

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
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NHS Foundation Trust

			
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 16

Report to:	Board of Directors
Date of Meeting:	28 October 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:

Since October 2025, the Trust has experienced significant CQC activity across several services. Recent developments include publication of the York and Scarborough maternity inspection reports, both rated Good, closure of the York Breast Screening Programme IR(ME)R inspection file, publication of the Easingwold Renal Unit report, rated Good overall; and the September 2026 inspection of Harrogate Renal Unit, for which the draft report is awaited.

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.

The requested supporting evidence was submitted to the CQC ahead of the 21 September 2026 deadline. The Trust is now awaiting receipt of the draft inspection report.

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. Following the submission of the updated action plan the IRMER inspector advised that the IR(ME)R inspection file is now closed. Compliance and completion of the action plan will be monitored during routine engagement.

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 CQC inspection report was published on 10 September 2026. The unit received an overall rating of Good, with Good ratings in Safe, Effective, Caring, Responsive and Well-led. The report can be found here: Easingwold Satellite Renal Unit.

A response to the breaches in regulation identified in the report will be provided to the CQC by the deadline of 21 October 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 was provided to the CQC by the deadline of 18 September 2026. The CQC approved the Trust responses to the breaches on 1 October 2026.

2. CQC Activity - Ongoing

2.1 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.

2.2 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.

2.3 Section 31: Care and Assessment of Patients with Mental Health Needs in the Emergency Department

An application to remove the conditions has been submitted to the CQC. At the time of writing, a response has not been received.

3. Ongoing CQC Engagement

Quarterly engagement meetings are planned with our CQC colleagues.

The onsite visit for Surgery is scheduled for 20 October 2026. The visit will focus of the fractured neck of femur pathway.

An update on Urgent and Emergency Care and the introduction of Nervecentre is also scheduled during the day.

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 1st October 2026, there are 14 open CQC cases. Five cases have had responses submitted, and we are awaiting feedback from the CQC. One further case 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 Recent Inspections

- **University Hospitals of Derby and Burton NHS Foundation Trust, published 4th September 2026 – Urgent and Emergency Care / Medical Care – Requires Improvement**

  Following inspections in February, the CQC downgraded both urgent and emergency care and medical care at Royal Derby Hospital from Good to Requires Improvement. At Queen's Hospital Burton, urgent and emergency care was rated Requires Improvement, while medical care achieved a Good rating. Both hospitals are operated by University Hospitals of Derby and Burton NHS Foundation Trust.

  Inspection of Royal Derby Hospital identified concerns across urgent and emergency care and medical services, including medicines management issues, significant staffing pressures, long waits in the emergency department, weaknesses in sepsis care, and a culture where some staff lacked confidence in reporting concerns. Inspectors also found challenges in delivering staff training and implementing improvement plans. Despite these concerns, patients were generally positive about their care, with inspectors highlighting effective care for children, young people and those in mental health crisis, strong multidisciplinary working, supportive security staff, and a positive learning culture within paediatric services.

  Inspection of Queen's Hospital identified concerns in urgent and emergency care relating to patient privacy, delays in sepsis treatment, and limited facilities for people experiencing mental health crises. In medical care, inspectors found weaknesses in medicines storage practices. Despite these issues, patients consistently reported kind and compassionate care, staff felt supported to raise concerns, leaders were well regarded and responsive, and there was strong evidence of a positive learning culture and service improvement.

- **Cumberland Infirmary, run by North Cumbria Integrated Care NHS Foundation Trust, published 4th September 2026 Urgent and Emergency Services – Requires Improvement**

  CQC carried out the inspection in February and March as part of its winter pressures programme. Inspectors found breaches of regulation regarding safe care and treatment, premises and equipment, staffing and how the service is managed.

Following the inspection of the emergency department, a warning notice was issued to the trust due to significant concerns about the safe care and treatment of people using the service. The notice required the trust to focus on making immediate improvements in this area. Following the inspection, CQC has dropped the rating from requires improvement to inadequate for being safe, caring has declined from good to requires improvement, and responsive, effective and well-led are rated as requires improvement again.

Inspectors identified concerns about cleanliness and infection prevention, including dusty and cluttered clinical areas and inconsistent hand hygiene practices. They also found gaps in personalised care planning, a backlog of unreviewed incidents, and inadequate facilities within the paediatric area.

5.2 Updates from the CQC

New Chair

The CQC has confirmed the Secretary of State's decision to appoint Baroness Julia Neuberger DBE as Chair of the CQC.

The role of CQC Chair is appointed by the Secretary of State for Health and Social Care in accordance with the Cabinet Office's Code of Governance for Public Appointments. Baroness Julia Neuberger was confirmed as the government's preferred candidate in July 2026. The Secretary of State has taken the final decision following confirmation from the Health and Social Care Select Committee on 9 September 2026.

State of Care

The CQC have advised that this year's State of Care, their annual assessment of health and social care in England, will involve a launch event on Friday October 23 2026. This can be watched on YouTube at this link: State of Care 2025/26.

Date: 1 October 2026

Item 17

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	Freedom to Speak Up Quarterly Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Stef Greenwood, Freedom to Speak Up Guardian

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:

Q2 2026/27 recorded 96 FTSU cases, compared with 52 in Q1 and 91 in Q2 2025/26. The main themes were patient safety, inappropriate behaviours, psychological safety and speaking-up culture, with material increases within Medicine and YTHFM, and at Scarborough.

The key organisational learning is that local response remains a material issue. 35 cases involved concerns that workers felt had not been adequately addressed through

other routes, and management or senior leadership behaviours featured in 26 cases. Patient-safety concerns frequently overlapped with staffing, workload, workplace behaviours and low confidence in local escalation, reinforcing the connection between patient safety and psychological safety.

Recommendation:

The Board is asked to:

- Note the Q2 activity, comparative trends and principal cultural and safety signals.
- Reinforce the expectation that leaders listen, respond and provide feedback when concerns are first raised, so that workers do not need to escalate through FTSU before significant issues receive appropriate attention.
- Support a consistent organisational approach to capturing learning, tracking agreed actions and evidencing improvement arising from all route speaking up routes.

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

No ☒ Yes ☐

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

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation

Freedom to Speak Up

1. Introduction and Background

The Freedom to Speak Up Guardian provides an independent and confidential route for workers to raise concerns where they may feel unable to use, or have not secured resolution through, other routes. This report provides an anonymised, theme-level overview of Q2 2026/27.

Data interpretation: A case may contain more than one theme. The figures show use of the FTSU route and the issues raised through it; they do not measure prevalence, establish causation or demonstrate whether culture has improved or deteriorated. Professional-group and location data are counts rather than workforce-adjusted rates.

2. Headline position

Measure	Q2 25/26	Q1 26/27	Q2 26/27	Q2 vs Q1	Q2 year-on-year
Number of FTSU cases	91	52	96	+44 (+84.6%)	+5 (+5.5%)
Raised anonymously	0	1	0	-1	No change

What the data tells us: Q2 2026/27 saw a substantial quarter-on-quarter increase, with cases rising by 44, from 52 to 96, an increase of 84.6%. The year-on-year position is much more stable.

3. Key Learning

- **Local response remains a material issue.** 35 cases involved concerns that workers felt had not been adequately addressed through other routes. Although this represented a smaller share of total Q2 activity than in Q1, it indicates continuing variability in how concerns are initially received, acted upon and fed back.
- **Leadership response affects psychological safety.** Management and senior leadership behaviours featured in 26 cases. How leaders respond when concerns are first raised can either strengthen confidence or contribute to delay, escalation and reluctance to speak up again.
- **Patient safety and staff experience cannot be considered separately.** Patient-safety themes frequently overlapped with staffing, workload, behaviours, psychological safety and confidence in local escalation. Where workers lack confidence that concerns will be acted upon, relevant safety intelligence may not reach established governance routes promptly.
- **FTSU is providing early-warning intelligence.** Intelligence relating to a specific clinical area is contributing to a targeted multidisciplinary review involving quality metrics, patient-safety data, workforce information, relevant CQC intelligence and anonymised FTSU themes.

4. Impact and Learning

Concern raised	Organisational response and impact	Learning / “so what?”
Workplace behaviour, staff	A workforce concern involving unacceptable workplace behaviour, staff wellbeing and	Staff reported that aspects of the concerns had previously been raised locally without achieving a

wellbeing and patient safety	patient-safety issues was escalated through FTSU. Management and HR reviewed the concerns and took prompt action to address the immediate risks. Wider issues identified through the response were also escalated through the appropriate organisational routes.	response that gave them confidence they were being addressed. The learning is therefore not only about the presenting concern, but about the importance of listening and acting when concerns are first raised. Staff should not need to use FTSU before significant concerns receive appropriate attention.
Staffing, patient safety and confidence to speak up	Concerns about staffing and the potential impact on safe patient care also highlighted low confidence in local escalation and fear of repercussions from speaking up. FTSU intelligence contributed to the decision to undertake a targeted multidisciplinary review of the clinical area. The review will consider quality metrics, patient-safety data, workforce information, relevant CQC intelligence and anonymised FTSU themes together.	Multidisciplinary review in progress. Findings to be considered through the appropriate governance route, and monitor any agreed actions. The review will test whether the different sources demonstrate a consistent or emerging pattern, identify any assurance gaps and determine whether further action is required.
Information governance and confidentiality	A confidential concern identified potentially inappropriate access to confidential records for reasons unrelated to an individual's duties. With the worker's agreement, the concern was raised confidentially with the appropriate Information Governance function. The wider issue was subsequently reinforced through Trust-wide communication by Executive colleagues.	The concern demonstrated how an individual FTSU case can identify an issue with wider organisational relevance. Learning was moved beyond the individual case into wider communication and awareness, reinforcing expectations around appropriate access to confidential information while maintaining the confidentiality of the person who spoke up.

The Board can take assurance that FTSU continues to provide an accessible additional route for workers, that concerns are being recorded and appropriately escalated, and that FTSU intelligence is contributing to immediate action, wider organisational learning and targeted multidisciplinary review. FTSU identifies and escalates intelligence but does not investigate concerns or determine findings. Where appropriate, the FTSU Guardian ensures that action is taken and appropriate feedback given to workers.

5. FTSU Themes

Theme	Q2 25/26	Q1 26/27	Q2 26/27	vs Q1	Year-on-year
Patient Safety / Quality	22	14	41	+27	+19

Worker Safety incl. Psychological Safety	74	45	81	+36	+7
Bullying / Harassment	45	22	21	-1	-24
Inappropriate Behaviour / Attitudes	24	17	42	+25	+18
Culture / Leadership	16	13	23	+10	+7
Policies / Procedures / Processes	9	8	18	+10	+9
Detriment	1	0	2	+2	+1
EDI	22	11	17	+6	-5
Sexual Safety	6	4	4	+0	-2
Speaking Up culture	-	5	44	+39	-

Patient Safety and system conditions overlap: Patient Safety / Quality featured in 41 Q2 cases, compared with 14 in Q1 and 22 in Q2 2025/26. Concerns included staffing and workload, delayed or missed care, senior review, supervision and escalation, operational processes and emergency preparedness. In a number of cases, patient-safety issues overlapped with psychological safety, workplace behaviours and low confidence in local escalation.

Psychological safety remains the dominant signal: 81 of 96 cases included worker safety or psychological safety. The volume indicates that staff experience and the conditions in which people raise concerns remain central to the risk picture. The FTSU Guardian is contributing to the Big Conversation to support the organisation in improving the overall culture.

Speaking-up culture: 44 cases were coded to speaking-up culture (+39 from Q1 26/27). Q2 correspondence repeatedly described concerns reaching FTSU where people felt unsafe raising concerns within their own teams, or where local routes had not produced a timely, trusted or visible response, therefore losing the opportunity for early resolution, learning and potentially preventing harm. This data is now being recorded due to colleagues raising this as a specific concern, rather than inferred.

Detriment remains low-volume but high-impact: Two Q2 cases included alleged detriment following speaking up. The individuals were supported to describe their concerns, consider available options and agree any appropriate escalation. These remain allegations unless and until considered through an accountable organisational process. The cases reinforce the need for a consistent approach to identifying, assessing, preventing and responding to potential detriment, including follow-up with workers after they speak up.

EDI and sexual safety remain live cultural indicators: EDI featured in 17 FTSU cases during Q2 2026/27, compared with 11 in Q1, an increase of 55%. However, this remains below the 22 cases recorded in Q2 2025/26. Sexual Safety featured in 4 Q2 cases, unchanged from Q1 and compared with 6 in Q2 2025/26. Appropriate support, signposting and escalation were agreed with the workers concerned, taking account of confidentiality and individual wishes.

Relevant themes continue to inform the Trust's wider sexual-safety work. Case-specific details and outcomes are not included to preserve confidentiality. Assurance is based on

evidence of appropriate referral and oversight rather than the outcome of any investigation or employment process.

6. Local resolution and leadership response

Of the 96 concerns received in Q2, 35 involved concerns that had not been adequately addressed through other routes, compared with 28 of 52 concerns in Q1. Management and senior leadership behaviours featured in 26 Q2 cases, compared with 20 in Q1. Although the absolute number increased in both areas, each represented a smaller proportion of overall FTSU activity: concerns not addressed through other routes reduced from 53.8% to 36.5%, while management and senior leadership behaviours reduced from 38.5% to 27.1%. The continued volume nonetheless indicates that confidence in local response, feedback and leadership behaviours remains an important cultural and assurance issue.

- Concerns not addressed through other routes: 28 in Q1, 35 in Q2
- Management and senior leadership behaviours: 20 in Q1, 26 in Q2

7. Who is speaking up

7.1 Professional Groups (Appendix 1)

- Estates and Ancillary showed the largest increase, from 2 in Q1 and 7 in Q2 2025/26 to 22 in Q2 2026/27.
- Medical and Dental increased from 11 to 15 quarter-on-quarter and from 9 to 15 year-on-year.
- Healthcare Scientists increased from zero to 7 quarter-on-quarter.
- Admin / Clerical increased from 10 to 15 quarter-on-quarter but remained below 28 in Q2 2025/26.
- 3 concerns received from Midwifery in Q2 26/27 and 0 in Q1 26/27.
- No Student concerns were recorded in Q1 or Q2 2026/27, compared with two in Q2 2025/26.

7.2 By Care Groups and site (Appendix 1)

- Medicine had the highest Q2 total at 35, up from 20 in Q1 and 19 in Q2 2025/26.
- YTHFM rose from 3 in Q1 and 11 in Q2 2025/26 to 23.
- Scarborough increased from 10 in Q1 and 17 in Q2 2025/26 to 37 in Q2 2026/27.
- York increased from 28 to 43 quarter-on-quarter but remained below 54 in Q2 2025/26.
- Malton remained at six quarter-on-quarter. Bridlington reduced from five to four quarter-on-quarter.

8. Summary

Q2 recorded a substantial increase in FTSU activity compared with Q1, although the total was broadly comparable with the same quarter last year. Patient Safety, inappropriate behaviour and psychological safety, were prominent and interconnected themes. Impact examples demonstrate direct action, triangulation and wider organisational learning.

Date: 20 10 2026

Appendix 1

Professional group	Q2 25/26	Q1 26/27	Q2 26/27	vs Q1	Year-on-year
Additional Clinical Services	5	8	11	+3	+6
Additional Professional Scientific & Technical	0	0	1	+1	+1
Admin / Clerical	28	10	15	+5	-13
AHP	6	1	4	+3	-2
Estates & Ancillary	7	2	22	+20	+15
Healthcare Scientists	7	0	7	+7	+0
Medical & Dental	9	11	15	+4	+6
Nursing / Midwifery	25	19	21	+2	-4
Students	2	0	0	+0	-2
Other	1	0	0	+0	-1
Unknown	1	1	0	-1	-1

Care group / directorate	Q2 25/26	Q1 26/27	Q2 26/27	vs Q1	Year-on-year
Medicine	19	20	35	+15	+16
Surgery	12	10	10	+0	-2
CSCS	17	12	16	+4	-1
Family Health	7	0	3	+3	-4
Community	2	2	0	-2	-2
Corporate	22	4	8	+4	-14
YTHFM	11	3	23	+20	+12
Other	1	0	0	+0	-1
Unknown	0	1	1	+0	+1

Site	Q2 25/26	Q1 26/27	Q2 26/27	vs Q1	Year-on-year
York	54	28	43	+15	-11
Scarborough	17	10	37	+27	+20
Bridlington	6	5	4	-1	-2
Malton	0	6	6	+0	+6
Hull	6	0	4	+4	-2
Unknown	0	1	2	+1	+2

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 18

Report to:	Trust Board of Directors
Date of Meeting:	28 October 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Sascha Wells-Munro (Director of Midwifery)
Author:	Jo Hadley (Deputy Director of Midwifery)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

☒ To provide timely, responsive, safe, accessible effective care at all times.
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☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
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☒ To be well led with effective governance and sound finance.

Board Assurance Framework

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

Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

This report provides the Trust Board with 'ward to board' oversight of maternity and neonatal safety, emerging concerns and improvement activity. It covers performance and quality metrics for August 2026 and workforce, maternity unit diverts and homebirth provision for September 2026. The Perinatal Quality Oversight Model supports monthly Board reporting and quarterly reporting to NHS England; the October national return will be presented to the Board in November 2026.

Key Assurance

- No neonatal deaths were reported in August, including babies born at York or Scarborough and subsequently transferred elsewhere. No MOSS safety signals have been reported since January 2025. There were no new MNSI referrals in August; one investigation remains ongoing.
- Workforce recruitment continues following the April investment. An additional 4% headroom will increase establishment by 5.50 WTE in October; 6.00 WTE newly qualified midwives are due to start in October and a further 7.00 WTE in February 2027.
- MIS Year 8 safety actions are reported as in progress and on track. Training is reported as on track against the minimum 90% requirement, with outstanding staff booked to attend. The final November position will be reported to the Board in January 2027. Saving Babies' Lives compliance has been maintained, and the Maternal Care Bundle implementation plan was approved by the Board in September.
- Triage red flags for assessment beyond 15 minutes decreased to 2.2% at Scarborough and stabilised at 6.6% at York. The new triage telephone system is live; a dedicated triage OPEL score and action plans addressing partial compliance with the national specification are being developed.

Key Risks

- Maternal care bundle may not be fully implemented by March 2027 due to elements of care bundle requiring a digital solution. This has been escalated regional/nationally and work to address this with system providers is ongoing with support of national team.
- Saving Babies' Lives Care Bundle compliance has maintained its position at 84% overall. Main risks are around implementation of the maternity tobacco dependency treatment service and funding for nicotine replacement therapy.

Key Concerns

- September service resilience remained constrained. There was one divert at each site: three women were affected at York and followed up to confirm outcomes and ongoing care plans; no women were affected at Scarborough. Homebirth cover in York and Selby remained variable, with one homebirth request not supported due to staffing. All options explored with women and attendance/care supported in the unit.
- Despite recruitment, September Band 5/6 substantive vacancies of 12.33 WTE and roster vacancies of 35.07 WTE demonstrate continuing staffing pressure. Maternity leave, sickness and supernumerary requirements contribute to reliance on bank and agency cover.
- Following Board agreement, Single Improvement Plan work is paused. Oversight is focused on the 10-Point Plan, Saving Babies' Lives Care Bundle version 3.2, the Maternal Care Bundle and MIS Year 8. Risks to delivery have been reviewed and scores updated.

Recommendation:

The Board is asked to receive the updates from the Maternity and Neonatal Service.

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**

York & Scarborough Teaching Hospitals NHS Foundation Trust
Perinatal Quality Oversight Model – Maternity and Neonatal Safety and Quality Report (October 2026)

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 August 2026, and data for September 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 is due to be submitted to NHSE in October 2026, which will be presented to the Trust Board in November.

Perinatal Deaths

There were no Trust reported neonatal deaths in August 2026. There were no neonatal deaths in August 2026 that delivered at York and Scarborough but were subsequently transferred to another hospital. There have been no MOSS safety signals since January 2025. Annual rolling mortality data is shown in Appendix 1.

The Perinatal Mortality Review Tool (PMRT) applies a standardised grade to each relevant phase of care as follows:

Grade A	No issues with care
Grade B	Issues that would have made no difference to the outcome
Grade C	Issues that may have made a difference to the outcome
Grade D	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. Phases of care cover:

1. care of mother and baby up to birth
2. care of baby from birth up to death
3. care of mother following death of the baby

There were two completed Trust reviews of perinatal deaths undertaken at the perinatal mortality meeting in August 2026.

CaseNo	PMRT Grading			Learning
	care of mother and baby up to birth	care of baby from birth up to death	care of mother following death of the baby	
1	Grade B	Grade B	Grade B	AAR – opportunities for clearer concise documentation supported by hot debrief in this situation.
2	Grade C	Grade D	Grade C	PSII – actions following strengthening clinical skills and education collaboratively with EMBRACE/ODN.

Maternity and Newborn Safety Investigations (MNSI)

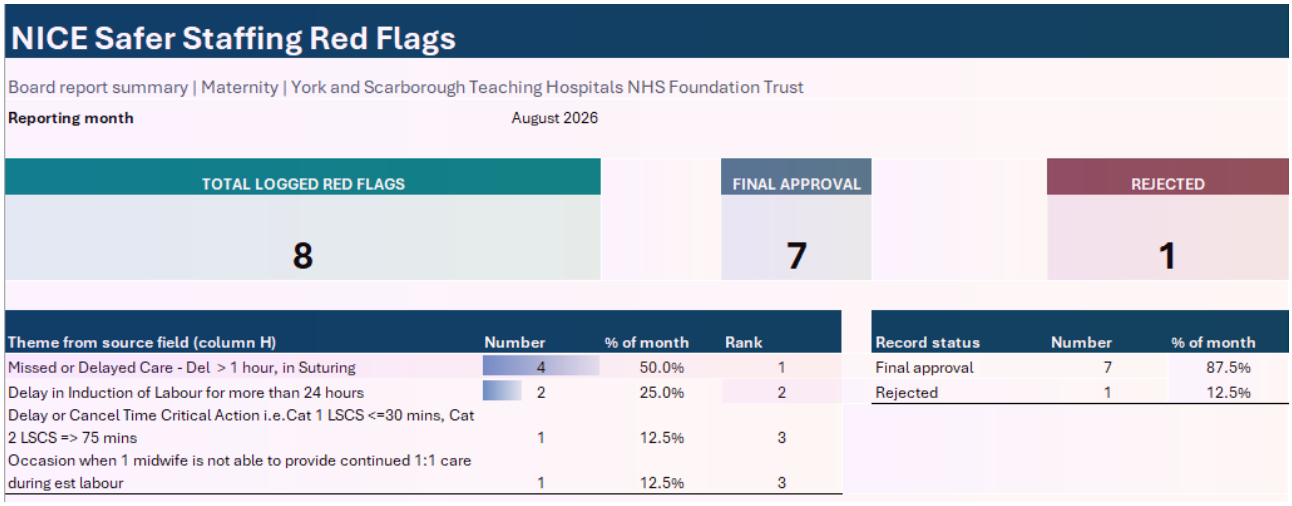
There were no cases referred to MNSI in August 2026. There is currently one ongoing MNSI case being investigated.

Moderate Harm Incidents and above

There were 20 incidents graded moderate or above in August 2026. Daily monitoring of the incidents takes place Monday to Friday by the Quality and Governance Team, Ward Managers and Matrons.

Red flags

In August 2026, 8 NICE safer staffing red flags were logged. The largest theme was missed or delayed care over one hour, followed by delays in induction of labour over 24 hours. Together the two leading themes accounted for 75% of all logged red flags. There was also one time-critical action delay and one occasion when continuous 1:1 midwifery care could not be provided.



NICE Safer Staffing Red Flags

Board report summary | Maternity | York and Scarborough Teaching Hospitals NHS Foundation Trust

Reporting month August 2026

TOTAL LOGGED RED FLAGS	FINAL APPROVAL	REJECTED
8	7	1

Theme from source field (column H)	Number	% of month	Rank
Missed or Delayed Care - Del > 1 hour, in Suturing	4	50.0%	1
Delay in Induction of Labour for more than 24 hours	2	25.0%	2
Delay or Cancel Time Critical Action i.e.Cat 1 LSCS <=30 mins, Cat 2 LSCS => 75 mins	1	12.5%	3
Occasion when 1 midwife is not able to provide continued 1:1 care during est labour	1	12.5%	3

Record status	Number	% of month
Final approval	7	87.5%
Rejected	1	12.5%

Maternity Unit diverts/ closures and suspension of services

In September there was one divert from Scarborough and one from York. 3 women were affected in the period of divert from York and all women were followed up to ascertain outcome and ensure appropriate follow up plans were in place. No women were impacted by the Scarborough divert.

Provision of the homebirth service is shown in the table below:

September 2026	East Coast	York and Selby
24hours Homebirth Service Provision Partial night cover either Team A or Team B Day service	No live homebirths	3 8 12 (at least 3 Earlies)
Number Homebirth completed by Community midwives	0	0
Number of attendances at home with transfer in (with reason)	0	1 x Team A only (delay in 1st stage)
Number of homebirths not supported due to staffing	0	1
Number of Homebirths where independent midwives have been engaged to provide service	0	0
Born Before Arrival (booked homebirth only)	0	0
Free Labour/Birth due to Homebirth services not available	0	0

Triage Audit Compliance

Triage assessment and wait times are monitored weekly. All cases where waiting is longer than 30mins are Datix and investigated with learning shared.

A dedicated Triage OPEL score is being developed to support timely escalation and operational oversight. The new triage telephone system is live this month to improve monitoring of access times and strengthen documentation through call recording capabilities.

Action plans are being developed to address areas of partial compliance agains the benchmarking exercise that has taken place using the new National Maternity Triage Specification and NHS England assessment tool.

Red Flags for "not seen within 15 minutes of arrival" at SGH have significantly decreased to 2.2%, remaining below the lower control limited for 2 consecutive months.

Red Flags at York have stabilised to 6.6%.

Midwifery Workforce

The midwifery and maternity support workforce continue to grow with active recruitment progressing to fill vacant roles following the investment on the 1st April 2026.

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.

September 2026 Band 6 to 3 midwifery vacancy and recruitment position:

	Band 5/6	Band 3/4
Establishment budget	174.61 WTE	42.96 WTE
Staff in post	162.28 WTE (of which 25.45 WTE are band 5)	41.65 WTE
Substantive Vacancy	12.33 WTE	0.31 WTE
Maternity Leave	8.08 WTE (4.76 WTE YH & 3.32 WTE SGH)	1.59 WTE (0.59 WTE YH & 1.00 WTE SGH)
Recruitment vacancy	20.41 WTE	1.90 WTE
Supernumerary	4.85 WTE	
Sickness	9.81 WTE	
Roster vacancy	**35.07 WTE**	

An additional 4% headroom will be added in October, which will increase the establishment by 5.50 WTE. 6.00 WTE Band 5 Newly Qualified Midwives are due to commence in October with a further 7.00 WTE are due to commence in February 2027.

Training and development

Compliance with training requirements for MIS is on track to be met with the first checkpoint for required staff groups meeting the minimum 90% requirement. 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 September 2026. A final November 2026 position will be reported in January 2027 to the Board.

Fetal Monitoring

Staff Group	Sept-26
Midwives	93% (249/268)
Obstetric Consultants/SAS Doctors	96% (26/27)
Obstetric Tier 2 (Reg/ST)	92% (12/13)

MDT Emergency Training

Staff Group	Sept-26
Midwives	93% (250/268)
Obstetric Consultants/SAS Doctors	100% (27/27)
Obstetric Tier 2 (Reg/ST)	92% (12/13)
Obstetric Tier 1 (F2/GP Trainees/SHO)	100% (2/2)
Anaesthetic Consultants	91% (21/23)
Obstetric Anaesthetic Doctors	90% (18/20)
MSWs (59)	92% (54/59)

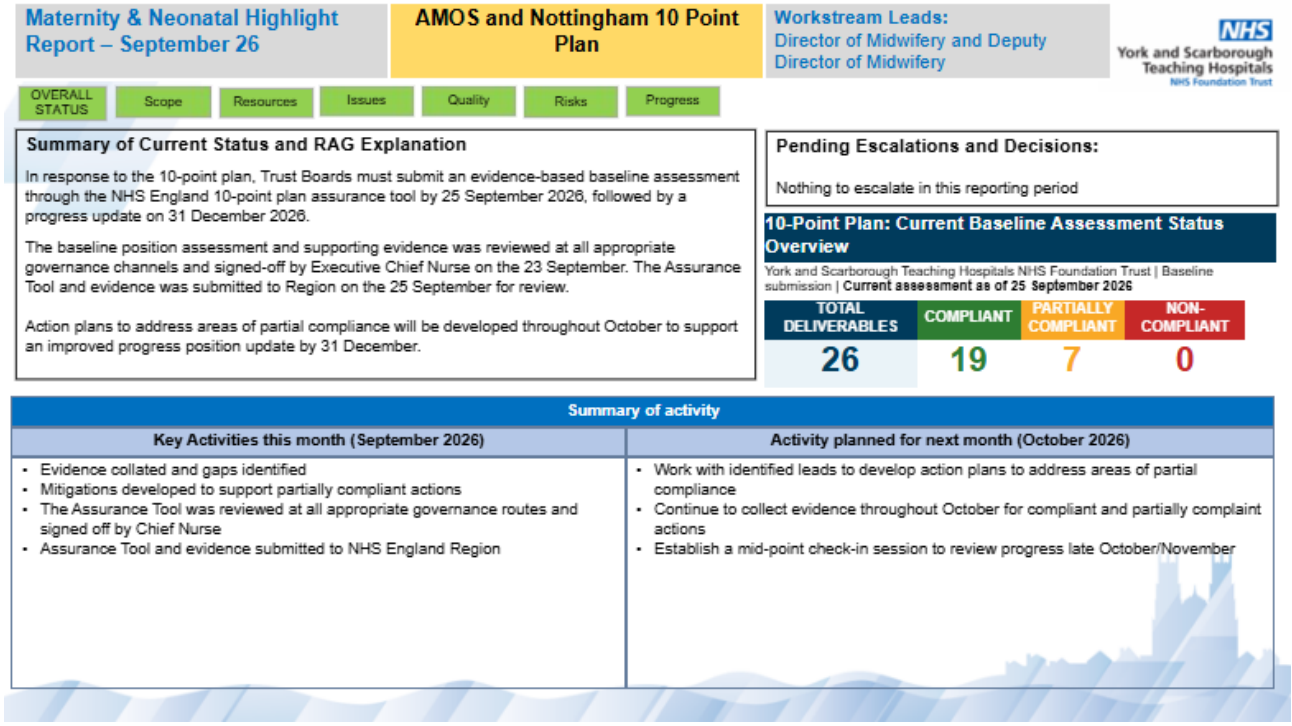
Neonatal Resuscitation Training

Staff Group	Sept-26
Midwives	90% (240/268)
Neonatal/Paediatric Consultants/SAS Doctors	100% (17/18)
Neonatal Tier 2 (Resident Doctors who attend any births)	100% (11/11)
Neonatal Tier 1 (who attend any births)	100% (20/20)
Neonatal Nurses (Band 5+)	90% (37/41)

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 – September 26

AMOS and Nottingham 10 Point Plan

Workstream Leads:
Director of Midwifery and Deputy Director of Midwifery

NHS 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.

The baseline position assessment and supporting evidence was reviewed at all appropriate governance channels and signed-off by Executive Chief Nurse on the 23 September. The Assurance Tool and evidence was submitted to Region on the 25 September for review.

Action plans to address areas of partial compliance will be developed throughout October to support an improved progress position update by 31 December.

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 25 September 2026**

TOTAL DELIVERABLES	COMPLIANT	PARTIALLY COMPLIANT	NON-COMPLIANT
26	19	7	0

Summary of activity

Key Activities this month (September 2026)	Activity planned for next month (October 2026)
• Evidence collated and gaps identified • Mitigations developed to support partially compliant actions • The Assurance Tool was reviewed at all appropriate governance routes and signed off by Chief Nurse • Assurance Tool and evidence submitted to NHS England Region	• Work with identified leads to develop action plans to address areas of partial compliance • Continue to collect evidence throughout October for compliant and partially complaint actions • Establish a mid-point check-in session to review progress late October/November

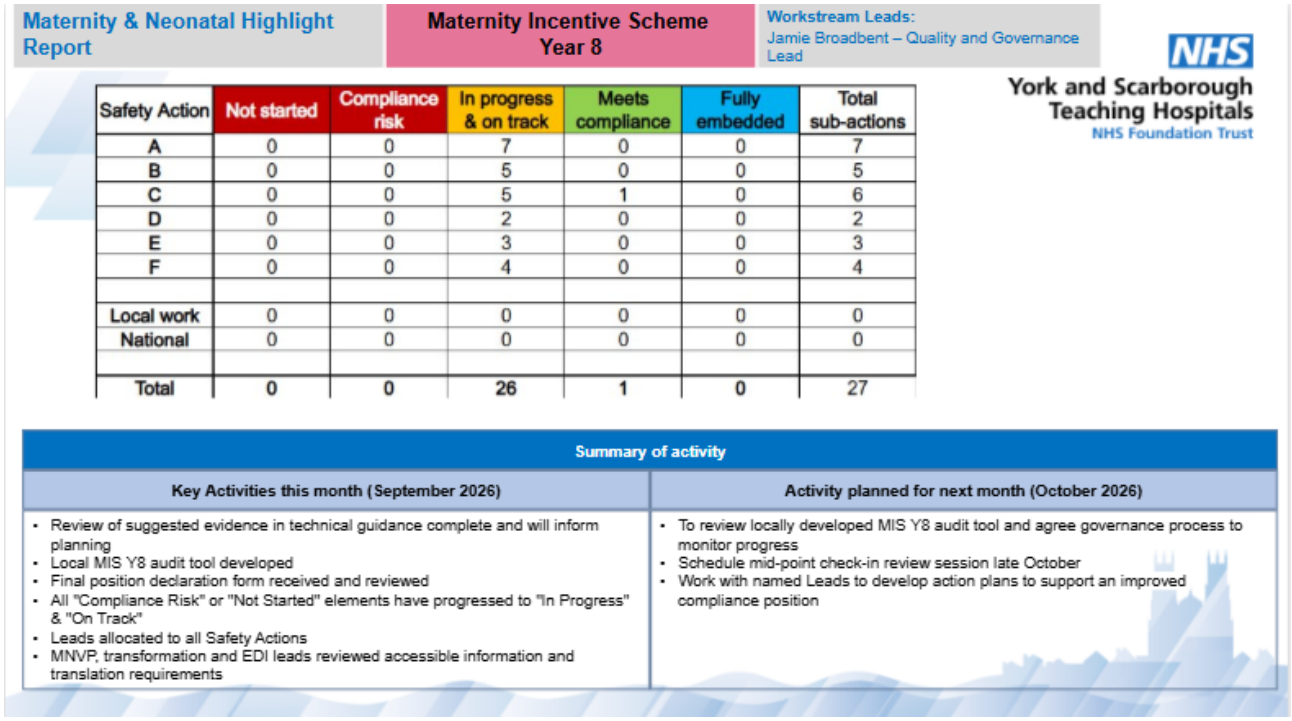
Saving Babies' Lives Care Bundle compliance has maintained its position at 84% overall. Main risks are around implementation of the maternity tobacco dependency treatment service and funding for nicotine replacement therapy.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)
Element 1	Smoking in pregnancy	Partially implemented	50%
Element 2	Fetal growth restriction	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	80%
Element 5	Preterm birth	Partially implemented	85%
Element 6	Diabetes	Partially implemented	83%
All Elements	TOTAL	Partially implemented	84%

The Maternal Care Bundle implementation plan has been reviewed and approved by the trust Board during September in line with MIS requirements. The oversight group is commencing 8th October, and a monthly highlight report will be developed following each oversight group meeting to provide assurance on progress with the implementation of the care bundle.

Maternity Incentive Scheme Year 8 has seen improved position with all safety actions in progress and on track:



Maternity & Neonatal Highlight Report | **Maternity Incentive Scheme Year 8** | **Workstream Leads:** Jamie Broadbent – Quality and Governance Lead

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	0	7	0	0	7
B	0	0	5	0	0	5
C	0	0	5	1	0	6
D	0	0	2	0	0	2
E	0	0	3	0	0	3
F	0	0	4	0	0	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	0	0	26	1	0	27

Summary of activity

Key Activities this month (September 2026)	Activity planned for next month (October 2026)
• Review of suggested evidence in technical guidance complete and will inform planning • Local MIS Y8 audit tool developed • Final position declaration form received and reviewed • All "Compliance Risk" or "Not Started" elements have progressed to "In Progress" & "On Track" • Leads allocated to all Safety Actions • MNVP, transformation and EDI leads reviewed accessible information and translation requirements	• To review locally developed MIS Y8 audit tool and agree governance process to monitor progress • Schedule mid-point check-in review session late October • Work with named Leads to develop action plans to support an improved compliance position

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: October 2026

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics

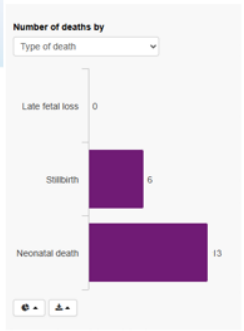
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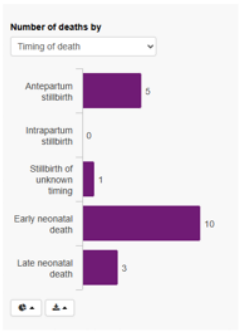
Maternity Quality and Safety Metrics

(Local trust data is reported for August 2026 with some measures July 2026;
MBRRACE data – September 2026)

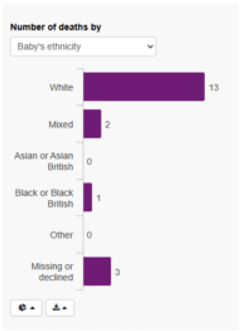
Perinatal Deaths – 1 year up to 30 September 2026

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Data: MBRRACE Register, National Perinatal Epidemiology Unit, University of Oxford

KEY MESSAGE

- There have been no MOSS safety signals since January 2025.
- Over the last 12m there have been no intrapartum stillbirths.
- 3 deaths occurred outside of the Trust but were born at YSTH. 11 were preterm and 8 term babies.

ACTION

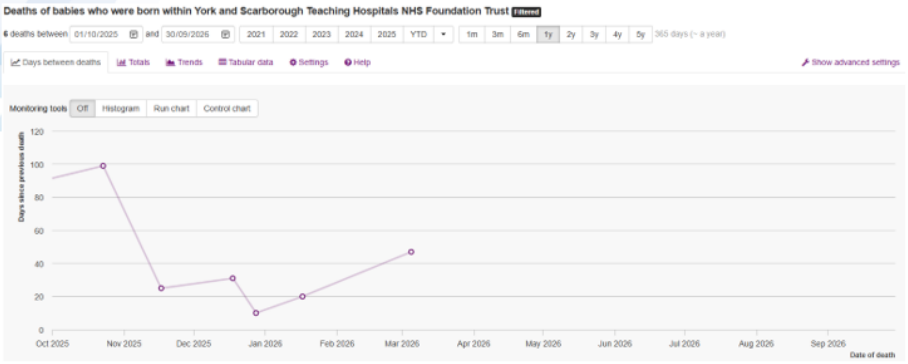
Continue to work towards full implementation of Saving Babies Lives Care Bundle v3.2.

Continue routine monthly monitoring

ASSURANCE

- All stillbirths undergo PMRT review and discussion at monthly Perinatal Mortality Meetings.
- Eligible cases go to MNSI for external investigation.
- Quarterly PMRT reports and action plans update Directorate, CG and Private Trust Board. This provides details of themes, trends and actions.

Stillbirths – September 2026



Data: MBRRACE Register, National Perinatal Epidemiology Unit, University of Oxford

KEY MESSAGE

There have been no stillbirths (meeting MBRRACE-UK reporting criteria) since March 2026.

ACTION

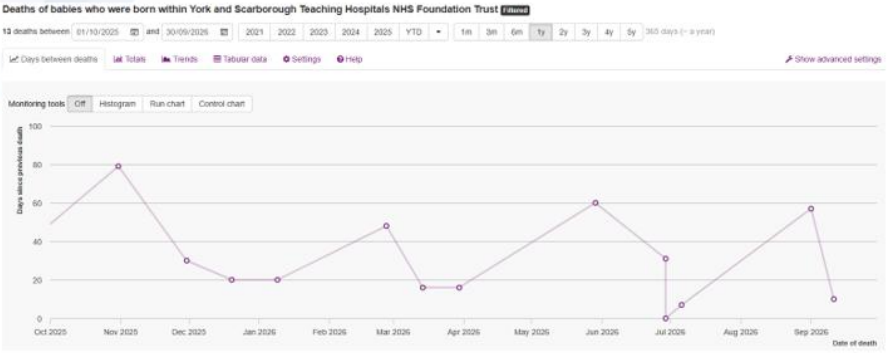
Continue to work towards full implementation of Saving Babies Lives Care Bundle v3.2.

Continue routine monthly monitoring

ASSURANCE

- All stillbirths are reviewed using the Perinatal Mortality Review Tool (PMRT) and are presented at the monthly Perinatal Mortality Meeting.
- Where the criteria is met, all stillbirth are reported to MNSI for external investigation.
- A quarterly PMRT report and action plan is presented via local Directorate, CG Board, and Private Trust Board. This provides details of themes and trends and assurance around actions taken.

Neonatal Deaths – September 2026



Data: MBRRACE Register, National Perinatal Epidemiology Unit, University of Oxford

KEY MESSAGE

- There were two neonatal deaths (meeting MBRRACE-UK reporting criteria) in September 2026.

ACTION

Continue to work towards full implementation of Saving Babies Lives Care Bundle v3.2.

Continue routine monthly monitoring

ASSURANCE

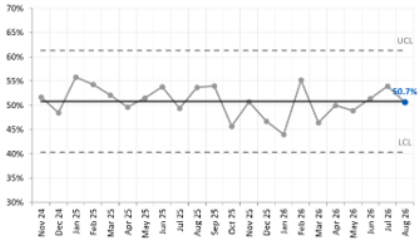
- All neonatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT) and are presented at the monthly Perinatal Mortality Meeting.
- Where the criteria is met, all neonatal deaths are reported to MNSI for external investigation.
- A quarterly PMRT report and action plan is presented via local Directorate, CG Board, and Private Trust Board. This provides details of themes and trends and assurance around actions taken.

Birth Mode Summary – York (August 2026)

Birth mode measures | Main SPC charts

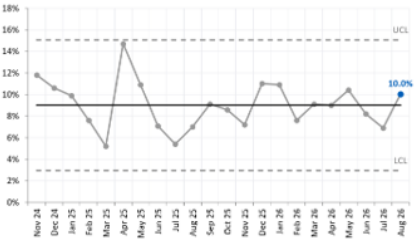
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Normal Births — LATEST **50.7%**



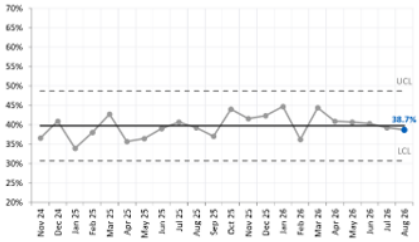
Mean 50.8% — Within Expected Variation

Assisted Vaginal Births — LATEST **10.0%**



Mean 9.0% — Within Expected Variation

Caesarean Births — LATEST **39.2%**



Mean 39.7% — 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
- No immediate corrective action required
- Review if an unusual pattern emerges

ASSURANCE

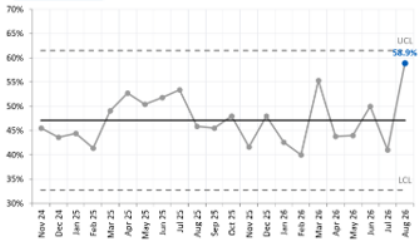
Normal and caesarean birth measures remain stable. The earlier assisted birth pattern should be understood in context, although the latest result remains within expected limits.

Birth Mode Summary – Scarborough (August 2026)

Birth mode measures | Main SPC charts

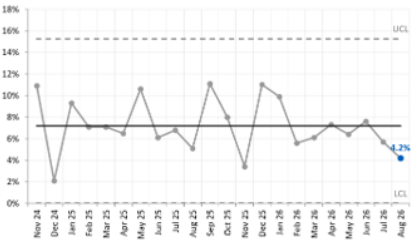
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Normal Births — LATEST **58.9%**



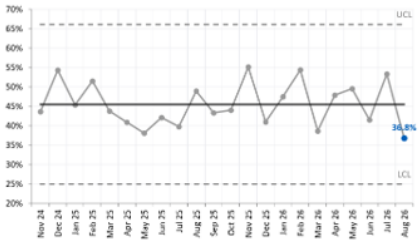
Mean 47.1% — Within Expected Variation

Assisted Vaginal Births — LATEST **4.2%**



Mean 7.2% — Within Expected Variation

Caesarean Births — LATEST **36.8%**



Mean 45.5% — 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.

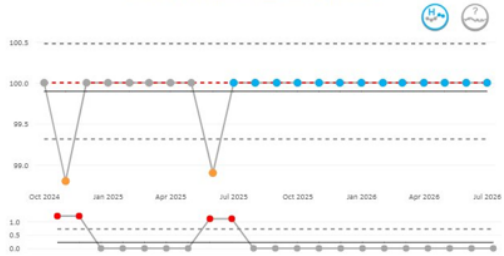
1:1 Care in Labour – July 2026

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Scarborough

LATEST
100%

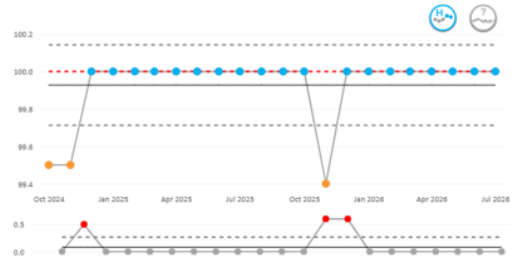
1 to 1 care in Labour - Scarborough: TOTAL



York

LATEST
100%

1 to 1 care in Labour - York: TOTAL



Data: Signal RCB DPI All Metrics V1.1 - Power BI

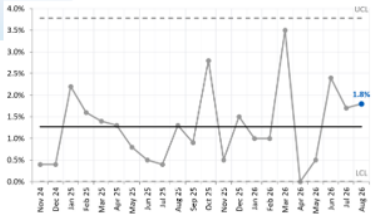
Summary:	Action:	Assurance:
Sustained special cause for improvement for 1:1 care in labour is seen across both sites.	Daily weekday huddles continue to monitor staff acuity and outcomes, alongside BirthRate + Acuity Tool. Specialist Midwives, Managers and Matrons are deployed to work clinically when 1:1 care cannot be provided. July data is latest position – work is ongoing to improve timely dashboard reporting.	In the event 1:1 care cannot be maintained an incident is completed and an investigation of the staffing and acuity is undertaken.

3rd/4th Degree Tears – York (August 2026)

Severe perineal trauma | Main SPC charts

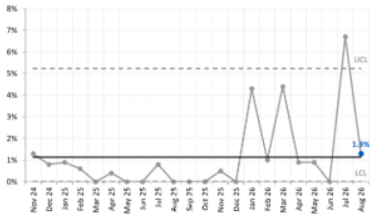
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Normal births



LATEST
1.8%
Mean 1.3%

Assisted births



LATEST
1.3%
Mean 1.1%

KEY MESSAGE

Normal-birth tears remain within expected variation at 1.8%. Assisted-birth tears increased to 6.7% in July 2026, above the upper process limit and indicating special-cause concern, August has returned to within control limits at 1.3% confirming July as an isolated special cause variation.

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

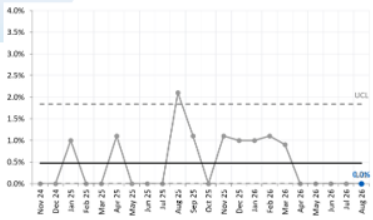
Normal-birth performance remains statistically stable. Existing case-review arrangements remain in place and continued monthly SPC monitoring determines the July assisted-birth result is isolated.

3rd/4th Degree Tears – Scarborough (August 2026)

Severe perineal trauma | Main SPC charts

York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal births

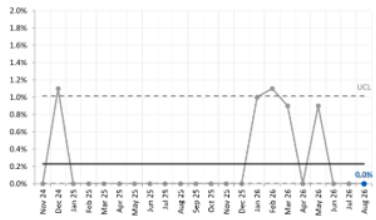


LATEST

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

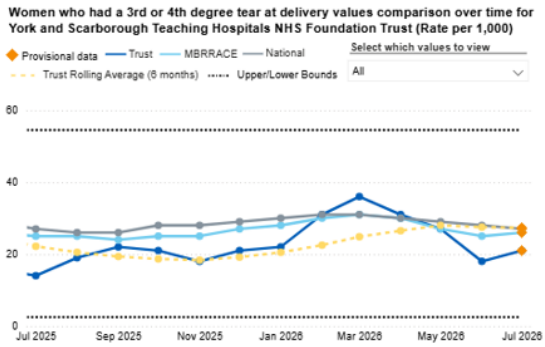
- Continue routine monthly monitoring and reporting
- Continue multidisciplinary review of all 3rd/4th degree tears
- Review if a further unusual pattern emerges

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 – Trust, National and MBRRACE Comparison (July 2026)

York and Scarborough Teaching Hospitals NHS Foundation Trust



Data: National Maternity Dashboard

The latest national data available as of October is Provisional July 2026 data

Summary:

The national maternity dashboard demonstrates the Trust (monthly rate 21/1000 births – 27.33/1000 births for rolling 6 months) is not an outlier compared to all Trusts in England (national monthly rate 27/1000 births / MBRRACE rate 26/1000 births).

PPH ≥1500mls (September 2026)

Postpartum haemorrhage over 1.5 litres | Main SPC charts

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Scarborough

LATEST
1.1%



Mean 3.22%

Within Expected Variation

York

LATEST
3.6%



Mean 3.52%

Within Expected Variation

Data: Intro - BI&IREF 10192 - PPH insights dashboard - Power BI

KEY MESSAGE

Latest PPH >1500ml rates are within expected variation at both sites: 1.1% in Scarborough and 3.6% in York (2.8% cross site). Results are within expected limits overall with isolated variation.

ACTION

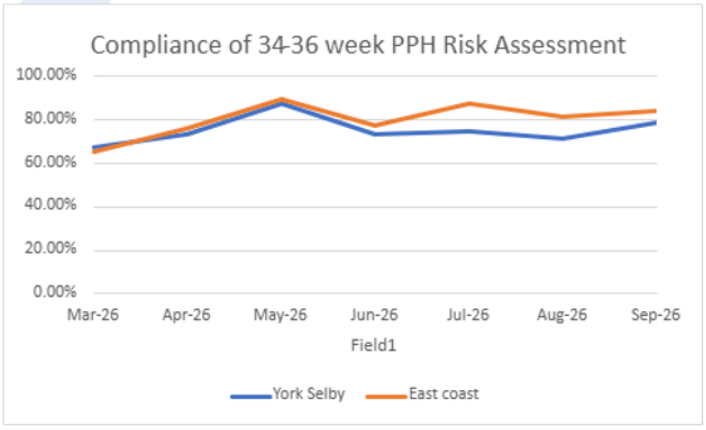
- Continue routine monthly monitoring and reporting
- Continue review of all PPH >1500ml cases
- Review if a further unusual pattern emerges

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 risk assessment compliance at 34–36 weeks' gestation (September 2026)

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Overview:

Since March 2026, team leaders have assessed compliance data weekly, identified themes and taken action to increase compliance.

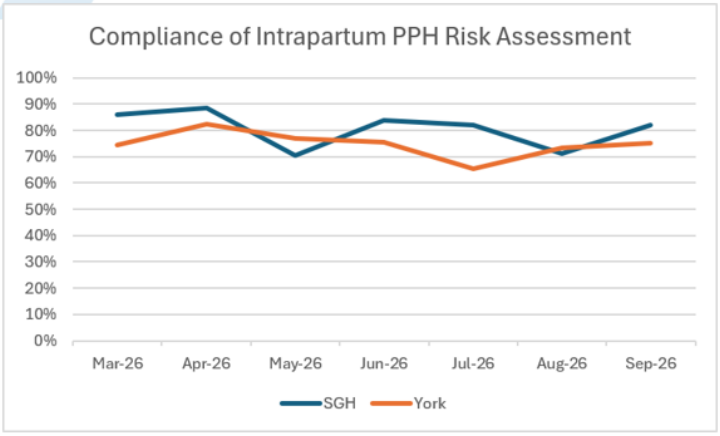
The team has reviewed the data with the digital lead and contacted other services when contact occurred in their area.

Actions:

Weekly audits continue when acuity allows, with immediate actions and learning from themes fed back to staff.

PPH risk assessment compliance - Intrapartum (September 2026)

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Overview:

The LW Management team have been asked to present compliance rates for the intrapartum PPH Risk Assessment

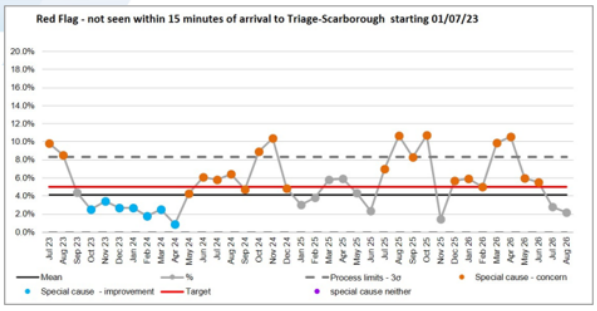
Actions:

This will be incorporated into the ward manager audits to maintain oversight, review themes and action plan any non-compliance

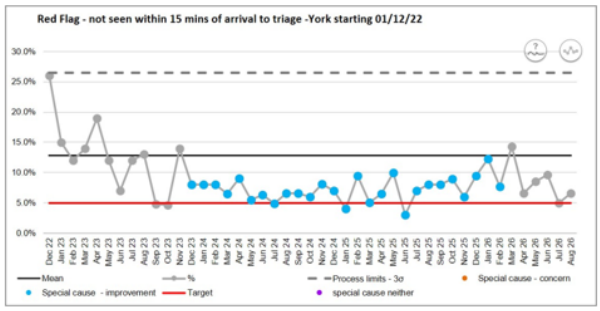
Maternity Triage (August 2026)

NHS
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NHS Foundation Trust

Scarborough



York



Summary:	Actions:	Assurance:
• Red Flags at SGH have significantly decreased to **2.2%** • Red Flags at York have stabilised at 6.6% Increased staffing from investment showing positive impact.	• 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. • Bank cover supported for reduced staffing levels until all recruitment has taken place and is filled.	• No escalation • Reporting compliance against the National Maternity Triage Specification through the 10 point plan.

Medical Review Wait times – York (August 2026)

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

DR Wait times	August	Overall Percentage
< 1hour	_108	52%
> 1 hour	_52	24.80%
> 2 hours	_32	15.30%
> 3 hours	_10	4.70%
> 4 hours	_7	3.30%
Self-discharged due to extended wait time for review	**N/A**	
	209	

DR wait-time comparison: August vs July

August shows a **clear improvement in length of waiting times, despite 24 more cases**.

- **Seen within two hours:** 76.4% in August versus 64.2% in July (**+12.2%**).
- **Waiting three hours or longer:** 8.0% versus 15.6% (**–7.6%**).
- Total Data recorded: **209 in August versus 185 in July**.

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NHS Foundation Trust

Item 18.1

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	MNVP Workplan Update – January to July 2026
Director Sponsor:	Joe Hague, Chief Nurse
Author:	Helen McConnell, MNVP Lead

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

☐ Approve ☒ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This report provides a summary of actions and work completed by the York and Scarborough Maternity & Neonatal Voices Partnership (MNVP) between January and July 2026, based on the 2025–26 workplan. The decision was made to terminate this workplan as of the 31st July 2026 in line with the cessation of the ICB commissioning of the MNVP. A new workplan is now in operation following the successful continuity of service plan, commissioned by York and Scarborough Trust in September 2026. The new workplan takes into consideration actions that align with national maternity strategies as well as the primary driver of local feedback. This report focuses on the operating period of January 2026 – July 26 workplan (attached).

The workplan focused on five themes: Choice and Personalised Care; Bereaved Families; Postnatal Care; Communication (EDI impacted by accessibility of information); and Estates. Progress included the launch of co-produced personalised care plans, development of supporting-choice guidance, postnatal pain-relief resources, maternity webpage co-production, and embedding service-user feedback in neonatal estates planning.

Several workstreams have been carried forward into the Sep 2026 – Sep 27 workplan where further development, implementation, investment or evaluation is required.

During the reporting period the MNVP structure included a Strategic and York engagement lead, a Scarborough engagement lead, a neonatal engagement lead until June 2026, and an East Riding engagement lead until May 2026.

Recommendation:

The Committee is asked to note the progress made by the MNVP during January–July 2026, the areas carried forward into the 2026–27 workplan, and the continued role of service-user voice in shaping maternity and neonatal improvement.

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
Family Health Care Group Board	19 October 2026	
Maternity & Neonatal Assurance Group	13 October 2026	
Maternity & Neonatal Directorate	12 October 2026	

York and Scarborough Maternity & Neonatal Voices Partnership (MNVP) – Bi-annual report (January to July 2026)

1. Introduction and Background

The York and Scarborough MNVP workplan for January–July 2026 identified five key areas informed by local feedback, the 2023 Better Births plan, local priorities in the high-level action plan and the CQC maternity survey action plan co-produced with the Trust. The five themes were: Choice and Personalised Care; Bereaved Families; Postnatal Care; Communication; and Estates.

2. Approach and methodology

The MNVP used service-user feedback, focus groups, surveys, engagement with Trust teams and participation in planning and improvement activity to influence maternity and neonatal service development. The updates below reflect the workplan's recorded position at the end of the reporting period.

Where actions were not completed within the period, they have been identified as continuing or moving into the 2026–27 workplan rather than being presented as completed.

3. Key findings

Choice and Personalised Care

Homebirth Service

Status: *Partially complete – moved to 2026–27 workplan*

- Staffing rota improvements made, but full investment required to reach sustainable capacity.
- MNVP continues gathering feedback demonstrating positive impact on service user experience.
- Further development dependent on Trust workforce planning.

Personalised Care Plans

Status: *Completed (launched), ongoing monitoring*

- Co-produced plans launched Feb 2026 across all sites.
- Early feedback positive: users value a single, comprehensive antenatal/postnatal document.
- Some users unclear on purpose → MNVP recommending improved staff signposting.
- No current demand for digital/app version; deprioritised.

Antenatal Education

Status: *Partially complete – moved to 2026–27 workplan*

- Feedback shows inconsistent quality and accessibility across geographic areas.
- Further work required to standardise offer and strengthen informed choice.

Birthing Outside Guidance – Supporting Choice

Status: *Completed, (ongoing monitoring)*

Focus group and survey feedback collated and shared with Trust leads.

- MNVP co-produced official “Out of Guidance Supporting Choice” document.
- Document passed through guideline, now used by staff to offer safe, supportive care when choices fall outside national guidance.

Bereaved Families

Feedback
Status: *Moved to 2026–27 workplan*
- Work to develop bespoke bereavement feedback mechanisms paused for next cycle.
- Review of existing mechanisms completed with the bereavement team, adjustments made to what is sent to families following a bereavement.
- Rainbow Clinic survey development to continue in 2026–27.

Support for Bereaved Families
Status: *Partially complete – remainder moved to 2026–27 workplan*
- Co-production of bereavement support resources ongoing. Several PIL reviews completed.
- Fridge acquired for bereavement suite York following the appointment of new lead bereavement midwife, action first identified in MNVP's 15 Steps feedback (2023).
- Strong collaboration with bereavement team driving improvements.

Postnatal Care

Golden Hour / Partner Access
Status: *Partially complete – moved to 2026–27 workplan*
- Hot Topics session held during May 2026 to initiate workstream.
- MNVP feedback emphasised balancing partner access with safety and behaviour expectations.
- Behaviour charter in early development.

Pain Relief
Status: *Partially complete – moved to 2026–27 workplan*
- "Postnatal pain relief ladder" and "Power of Paracetamol" poster approved and ready for use.
- Labour pain relief poster still in development.

Infant Feeding
Status: *Partially complete – moved to 2026–27 workplan*
- Increased posters/signposting in postnatal wards and day unit waiting areas.
- Further work required on clinic expansion, public organisation signposting, and SU feedback gathering.

Communication

Accessibility
Status: *Moved to 2026–27 workplan*
- Review and simplification of written materials deferred to 2026-27 workplan.

Maternity & Neonatal Communication Strategy
Status: *Partially complete – ongoing*
- Co-production of maternity webpages underway.
- Initial design drafted using personalised care plan content for consistency.
- Next step: review proposed content with MNVP and Trust teams.

Estates

SCBU Refurbishment

Status: *Completed (MNVP contribution)*

- Survey results shared with neonatal leadership and ODN.
- Service user voice embedded in planning process.

Signage & Wayfinding

Status: *Partially complete – moved to 2026–27 workplan*

- 15 Steps feedback shared with Trust, incorporated into single improvement plan.
- Planning adapted to incorporate MNVP recommendations.

4. Organisational and Management Responsibilities Update

In July 2026 the HNY ICB stopped commissioning the MNVP handing responsibility over to the Trusts, contravening national guidance. York and Scarborough Trust have worked to find a solution to this, and the MNVP team were able to re-commence operations from September 2026. During the hiatus period the Neonatal engagement lead has stepped down from post. We are currently without specialist Neonatal engagement and representation, existing team members are currently covering the gap but recruitment will be needed to sustain the appropriate specialist input.

The Scarborough engagement lead has also stepped into management responsibilities, leading on specific areas and workstreams. An organisational information chart has been included below (Appendix B).

5. Next steps

Continue workstreams carried forward into the 2026–27 MNVP workplan, including homebirth capacity, antenatal education, bereavement feedback/support, partner access, pain relief in labour, infant feeding, communication accessibility, and signage/estates. Continue gathering and using service-user feedback to inform service development, and monitor implementation and impact of completed actions such as personalised care plans, pain-relief information, supporting-choice guidance, communications work and estates planning.

Recruit a new engagement lead for neonatal that can comfortably cover cross site.

6. Summary

The January–July 2026 workplan demonstrates continued MNVP involvement in service-user engagement, co-production and improvement across maternity and neonatal services. Practical progress was made across all five themes, while several actions appropriately remain active in the 2026–27 workplan because further implementation, investment, feedback or evaluation is required.

Date: 07/10/2026

Appendix A: workplan 2025-26 V1 notes

Appendix B: organisational information chart



Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	Implementation of the National Maternity Early Warning Score across the Trust
Director Sponsor:	Sascha Wells-Munro, Director of Midwifery and Strategic Clinical Lead for Family Health
Author:	Sophie Keely, Labour Ward Matron; Sarah Harris, Digital Midwife; Jo Hadley, Deputy Director of Midwifery

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 Quality Impact Assessment identifies significant risk from retaining local MEOWS/NEWS2 or delaying implementation, including delayed recognition and escalation of maternal deterioration, unwarranted variation between settings, inequality for women cared for outside maternity, and weak organisational assurance. National MEWS is a standardised, evidence-based physiological track-and-trigger tool developed from data from 1,041 pregnant women, with escalation responses agreed by multidisciplinary expert consensus. It is more accurate than many existing tools and generates fewer unnecessary alerts.

The NHS England Maternal Care Bundle requires coordinated action across maternity, emergency, acute, ambulance and specialist services; current national data show persistent mortality and inequality, and reviewers considered that improvements in care could have made a difference for 45% of women who died in 2021–23. The proposed approach is therefore maternity-first implementation without delay, followed by controlled Trust-wide adoption for every eligible pregnant or recently postnatal woman, wherever care is delivered.

Recommendation:

The Committee is asked to make the following recommendations to the Board:
(1) approve immediate implementation of National MEWS within maternity services;
(2) approve National MEWS as the Trust standard for eligible pregnant and recently postnatal women in all clinical settings, with other Trust areas to follow through a phased implementation plan;
(3) authorise a time-limited paper National MEWS pathway outside maternity where digital delivery is not yet available;
(4) require joint executive and clinical ownership by the Chief Nurse, Medical Director, Maternity/Obstetrics and the Deteriorating Patient service; and
(5) receive regular assurance on delivery, exceptions, incidents, training, equality and residual risk until full implementation is achieved.

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
Deteriorating Patient Group	27 October 2026	
Family Health Care Group Board	19 October 2026	
Maternity & Neonatal Assurance Group	13 October 2026	
Maternity & Neonatal Directorate	12 October 2026	

National Maternity Early Warning Score: phased Trust-wide implementation

1. Introduction and Background

National Maternity Early Warning Score (MEWS) forms part of the NHS England maternity and neonatal deterioration workstream, designed to improve prevention, identification, escalation and response to deterioration. Pregnant and postnatal women have physiology and risk profiles that are not safely assessed using standard adult NEWS2 thresholds. The main safety vulnerability arises when women are managed in non-maternity pathways (ED attendance, un-booked presentations, medical/surgical admissions, critical care, and outlier beds), where NEWS2 is often the default and teams are less familiar with maternity escalation criteria. National MEWS provides a single, evidence-based standard intended to reduce unwarranted variation and improve recognition and escalation of deterioration, replacing variable local approaches with a common evidence-based standard.

The underlying research “Development of a national maternity early warning score: centile-based score development and Delphi-informed escalation pathways” was published in British Medical Journal (BMJ) in 2023. The 3-Year Single Delivery Plan published in March 2023 included reference to: "Trusts will implement best practice consistently, including the new “MEWS” and “NEWTT-2” tools by 2025". In May 2024, the National Institute for Health and Care Research announced, "The aim is that every organisation will have implemented MEWS across England by March 2026". The NHS England Maternal Care Bundle now sets best-practice standards across providers and commissioners and explicitly recognises that maternal safety depends on coordinated action beyond maternity services. The 2026 MBRRACE-UK report records a maternal death rate 20% higher than in 2009–11, with marked inequalities by ethnicity and deprivation. These findings increase the urgency of reliable recognition and escalation wherever pregnant or postnatal women present.

2. Considerations

Option	Assessment	Conclusion
1. Implement in maternity only	Delivers earlier safety benefit in maternity but leaves women in emergency, medical, surgical and critical-care settings exposed to inconsistent tools and escalation.	Not sufficient as the final Trust position.
2. Implement in maternity now, with National MEWS in other Trust areas through a controlled phased plan and interim paper charts where required	Lowest overall risk in the QIA; preserves implementation momentum, provides maternal-specific parameters across settings and enables digital solutions to follow safely.	**Preferred option.**

3. Delay all implementation until one digital Trust-wide launch	Significant patient-safety, clinical-effectiveness, equality and governance risks and loses existing training momentum.	Not recommended.

3. Current Position/Issues

The QIA scores non-implementation as significant risk, with scores of 25 for duty of quality, patient safety, clinical effectiveness, prevention and equality/workforce impact. The current digital position supports maternity implementation through BadgerNet and deterioration monitoring through Nervecentre, but a reliable cross-Trust pathway, pregnancy/postnatal identification, consistent escalation and full auditability require coordinated delivery.

The principal implementation risks are temporary dual systems, transcription or documentation omissions on paper charts, unfamiliarity among non-maternity staff, delayed digital integration, and ambiguity at transfers. Controls will include a single approved policy and escalation pathway; visible pregnancy/recent-postnatal status; paper National MEWS packs and version control; 24/7 maternity/obstetric specialist advice; MEWS-specific training and competency assurance; a transfer checklist recording the latest score; matron implementation checks initially; and monthly audit and incident review.

4. Summary

- National MEWS is the evidence-based standard for recognising maternal deterioration and provides a common escalation language.
- Maternity-first implementation delivers immediate benefit across the highest patient flow areas without waiting for all digital and training dependencies.
- Board approval is sought for the end-state of one Trust-wide standard, with temporary paper use of National MEWS outside maternity only where necessary.
- Pregnancy and maternity equality impacts require consistent access to the same safety standard in every setting.
- Joint maternity, medical, nursing, deterioration, digital and education governance is essential.

5. Next Steps

1. Establish an executive-led implementation group with named maternity/obstetric specialist advisors, acute-care, ED and critical-care clinical leads, deteriorating-patient, digital, education, governance and patient-safety leads.
2. Approve the immediate launch of National MEWS in maternity alongside local MEWS Observation and Clinical Escalation Guideline, ensuring staff readiness through monitoring of training compliance of 80% to give go/no-go assurance.
3. Introduce National MEWS pathway in other non-maternity settings according to risk and readiness.
4. Deliver digital configuration, testing and deployment across relevant systems, with a dated retirement plan for areas using paper MEWS tools.
5. Agree implementation assurance measures to monitor compliance and implementation sustainability.

6. Monitor implementation as agreed by the Executive Board to the responsible executive quality forum until full adoption and sustained compliance are demonstrated.

Date: 8 October 2026

Stage 2

Area of quality	Indicators	Risk (5 x5 risk matrix)			Risk Grade	Description of impact (Positive or negative)	Mitigation strategy and monitoring arrangements
		Impact	Likelihood	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?	5	5	25	Significant	The National MEWS should be used for pregnant and recently postnatal women in every setting. Continuing MEOWS/NEWS2 rather than implementing the evidence-based national standard would not secure continuous improvement and would retain avoidable safety risk.The 3 Year Single Delivery Plan published in March 2023 included reference to: "Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025". In May 2024, the National Institute for Health and Care Research announced, "The aim is that every organisation will have implemented MEWS across England by March 2026". As outlined in the recent Maternal Care Bundle the national maternity early warning score (MEWS) tool should be implemented across all settings for women who are or have been pregnant in the past 4 weeks.	Do not proceed with non-implementation. Approve National MEWS as the Trust standard; use paper National MEWS as a time-limited interim where digital delivery is unavailable, with a dated digital implementation plan.
	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?	5	5	25	Significant	Non-implementation would depart from national evidence-based practice and the Maternal Care Bundle expectation, with potential delayed recognition and escalation of deterioration.	Report the implementation plan and compliance to the appropriate quality governance forum and Trust Board; include progress, exceptions, incidents and residual risk.
	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?	3	4	12	High	Maintaining different tools across maternity and acute services creates uncertainty for staff, additional cognitive burden and reduced confidence when pregnant or postnatal women move between pathways.	Provide one Trust-wide standard, clear role accountability, an ED/outlier quick guide, induction and mandatory updates, supported by maternity/obstetric advice.
	What is the impact on strategic partnerships and shared risk?	4	5	20	Significant	The risk is shared across Maternity/Obstetrics, ED, acute deterioration services, critical care, wards, digital teams, the LMNS/ICS and regional assurance routes. Fragmented ownership would weaken control.	Establish joint ownership between Maternity/Obstetrics and the Deteriorating Patient service, with ED and ward clinical leads accountable for local compliance and regional assurance maintained.
	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	5	5	25	Significant	Pregnancy and maternity are protected characteristics. Pregnant and postnatal women have physiology not safely assessed by adult NEWS2 thresholds; those in ED, outlier, medical, surgical or critical-care pathways are particularly exposed to mis-scoring and delayed escalation.	Require identification and visible recording of pregnancy/recent postnatal status at triage and clerking, then use National MEWS for all observations with equitable access to maternity review in every setting.
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?	4	5	20	Significant	Without implementation, the organisation cannot demonstrate the minimum assurance metrics which may be requested by NHS England including: National MEWS recording, NEWS2-in-pregnancy incidents/themes, and handover documentation of the latest score.	Agree implementation and monitoring for National MEWS including NEWS2 exceptions/incidents; latest MEWS documented at transfer; training compliance; and escalation response. Review monthly and at 3 months.
	Will this impact on the organisation's duty to protect children, young people and adults?	5	4	20	Significant	The proposal could expose pregnant or recently postnatal adults to avoidable harm through missed deterioration, particularly from sepsis, haemorrhage, pre-eclampsia/eclampsia or cardiac disease.	Record the risk on the corporate/clinical risk register and implement the ED/outlier minimum control set: identification, correct tool, escalation route, transfer control, training and audit.
	Overall Area Risk			25	Significant	Overall Duty of Quality risk is significant because the proposal conflicts with the national evidence-based standard and leaves avoidable clinical, equality, governance and assurance risks.	Executive action: approve National MEWS in all settings, assign joint owners, agree audit metrics and implementation dates, and review residual risk 3 months after controls or sooner following an incident.
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)	3	5	15	Significant	Missed or delayed deterioration can lead to distress, loss of confidence, complaints, PALS contacts, incidents and adverse investigations for women and families, particularly during transfers outside maternity.	Include patient experience, complaints and incident themes in the implementation dashboard; use learning to refine escalation, communication and transfer processes.
	How will it impact on choice?	2	4	8	Medium	National guidance is for the introduction of a standardised tool, rather than variation across services, or variation by service user choice. Variation by location would mean the safe standard is not consistently available.	Make National MEWS the default for all eligible women regardless of location; explain the monitoring and escalation pathway and ensure access to maternity/obstetric review.
	Does it support the compassionate and personalised care agenda?	3	4	12	High	Use of an adult score that does not reflect pregnancy physiology risks care that is not sufficiently individualised, compassionate or responsive to the woman's clinical context.	Embed pregnancy/postnatal identification, clear explanations, escalation thresholds and timely maternity review within the pathway.
	Overall Area Risk			15	Significant	Overall Patient Experience risk is significant because inconsistent monitoring and delayed escalation may undermine confidence, communication, timely escalation and continuity of care.	Monitor complaints, incidents, transfer experience and feedback from eligible women; address themes through the joint implementation group. Work with MNVP to raise service-user awareness of implementation of the tool and use across the Trust- incorporate service-user awareness of escalation to maternity when cared for in settings outside maternity

PATIENT SAFETY	How will it impact on patient safety?	5	5	25	Significant	Failure to implement National MEWS in every setting creates a significant risk of delayed recognition and escalation of maternal deterioration. MNSI investigations into deaths in pre-hospital and acute care identify recurrent problems with use of NEWS2 rather than a maternity physiological track-and-trigger tool, failure to act effectively on pre-alert information, delayed involvement of maternity and other specialist teams, and unclear escalation outside maternity services. MBRRACE-UK confidential enquiries repeatedly identify delayed recognition of severity, inadequate response to abnormal observations and failure to escalate or obtain senior multidisciplinary review as avoidable contributors to maternal death. Coroners' Prevention of Future Deaths findings similarly highlight failures in risk recognition, timely treatment, escalation and staff training; a 2026 NHS England response to a maternal death specifically noted that use of a non-pregnancy NEWS matrix can delay recognition and confirmed National MEWS is intended for all settings from pregnancy to 4 weeks postnatal. Continuing NEWS2, local MEOWS or inconsistent systems therefore exposes women, especially in ED, ambulance, acute wards, critical care and transfers, to mis-scoring, fragmented response, cardiac arrest, severe morbidity or death from conditions including sepsis, haemorrhage, hypertensive disease, thromboembolism and cardiac disease.	Use National MEWS for all eligible women. Until digital integration is complete, stock paper National MEWS in all relevant areas with a defined escalation route and visible pregnancy/postnatal flag.
	How will it impact on preventable harm?	5	5	25	Significant	Potential consequences include failure to detect deterioration, delayed escalation and treatment, and avoidable harm/death from sepsis, haemorrhage, hypertension/eclampsia, thromboembolism, cardiac disease or other acute illness.	Implement the minimum control set, test escalation response times and on-call arrangements, review all NEWS2-in-pregnancy exceptions and feed learning back to ED, wards and the digital programme.
	Will it maximise reliability of safety systems?	5	5	25	Significant	Continuing MEOWS/NEWS2 would preserve variation, manual scoring risk, delayed escalation and unsafe dual-system working rather than maximising reliability across care settings. This will significantly increase patient risk.	Standardise National MEWS thresholds and escalation. Prioritise digital National MEWS with automated scoring, escalation and audit; control any temporary dual running explicitly.
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	4	4	16	Significant	Sepsis is a condition in which deterioration may be rapid and subtle. An inappropriate score could delay recognition and treatment, although the proposal does not directly change infection-prevention controls.	Ensure the National MEWS escalation pathway links to the Trust sepsis pathway and that audit includes delayed recognition or treatment of infection-related deterioration.
	What is the impact on clinical workforce capability care and skills?	4	5	20	Significant	Non-maternity teams may be unfamiliar with maternity physiology and escalation triggers. Different tools increase cognitive burden and the risk of incorrect scoring, missed triggers and delayed response. Caring for pregnant women outside of maternity requires a clear process to support the teams where escalations or concerns are raised.	Deliver role-specific training, induction content, huddle prompts and an aide-memoire; publish a single call tree with 24/7 maternity/obstetric support and monitor competency uptake.
	Overall Area Risk			25	Significant	Overall Patient Safety risk is significant: incorrect scoring or default NEWS2 use may cause missed or delayed recognition and escalation with avoidable harm.	Immediate control is paper National MEWS plus the full ED/outlier control set; the preferred end-state is digitally integrated National MEWS across all relevant systems.
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence-based practice?	5	5	25	Significant	National MEWS is evidence-based and nationally endorsed; continuing local MEOWS or adult NEWS2 would not implement the current evidence or national consensus standard.	Approve the national tool and escalation framework, update policies and clinical guidance, and remove superseded pathways through controlled implementation.
	How will it impact on clinical leadership?	4	4	16	Significant	Failure to implement would inhibit the ability to provide assurance and appropriate esclation pathways across all areas and implement evidence based care.	Name joint clinical owners, with ED and ward leads accountable for delivery; obtain Trust Board assurance that safe pathways are in place and followed.
	Does it support the full adoption of Right Care Value metrics?	4	4	16	Significant	Non-implementation would limit consistent measurement of pathway reliability, escalation and outcomes and would not support the national minimum audit metrics.	Adopt the specified metrics and use them for quality improvement, exception review and benefits tracking across maternity and acute pathways.
	Does it reduce/impact on variations in care?	5	5	25	Significant	Different tools by location create unwarranted variation, especially for un-booked women, ED attendances, outliers and transfers.	Apply one National MEWS standard across maternity, ED, assessment units, wards and critical care, with the latest score documented at every transfer.
	Are systems for monitoring clinical quality supported by good information?	4	5	20	Significant	Paper tools provide limited auditability. Use locally-adapted tools or multiple assessment tools create unwarrented variation and the ability to monitor and audit outcomes. The Trust cannot reliably identify MEWS exceptions, handover gaps or compliance by setting.	Build a common audit dataset and digital reporting capability; review compliance, incidents, handovers, training and residual risk at least monthly during implementation.
	Does it impact on clinical engagement / staff experience?	4	4	16	Significant	Staff may be confused or disengaged by prolonged uncertainty, retraining and competing scoring systems and differing escalation procesess, particularly where digital NEWS2 remains the default.	Engage maternity, ED, acute, critical-care, education and digital staff in pathway design; communicate the rationale, provide concise training and collect staff feedback.
	Overall Area Risk			25	Significant	Overall Clinical Effectiveness risk is significant because the proposal does not adopt the evidence-based standard and perpetuates variation, weak information and fragmented leadership.	Implement National MEWS under joint clinical governance, with standard policy, training, digital delivery, audit and a 3-month residual-risk review.
PREVENTION	Does it support people to stay well?	4	5	20	Significant	Early-warning systems prevent avoidable deterioration by prompting earlier assessment and treatment. Retaining a less appropriate tool reduces this preventive benefit for pregnant and postnatal women.	Use National MEWS to trigger timely escalation and treatment; audit response to triggers and resulting delays or harm.
	Does it promote self-care for people with long term conditions?			0	No Risk	No direct impact on self-care for long-term conditions is identified. The relevant issue is professional recognition and escalation of acute deterioration.	No specific mitigation required beyond ensuring women with long-term conditions who are pregnant or postnatal are included in the National MEWS pathway.
	Does it tackle health inequalities, focusing resources where they are needed most?	5	5	25	Significant	Women cared for outside maternity, including un-booked presentations and outliers, face greater risk because staff are less familiar with maternity physiology and NEWS2 is often the default. This may widen inequality in safety and access to specialist review. Women from vulnerable groups or those of particular ethnicity receive poorer outcomes-adoption of MEWS enables earlier identification of deterioration in pregnancy	Provide the same National MEWS pathway in every setting, mandatory status identification, visible prompts and 24/7 access to maternity/obstetric advice; audit compliance by location.

	Overall Area Risk			25	Significant	Overall Prevention risk is significant because non-implementation reduces early recognition and disproportionately affects women entering non-maternity pathways. Currently both maternity and non-maternity settings do not utilise a nationally endorsed tool, which may caused missed or delayed recognition with avoidable harm. Implementation in each setting would reduce this risk through provision of evidence based care that recognises the physiology of pregnancy and post birth	Prioritise controls in maternity where the highest patient flow is. Support the implementation of controls in ED, acute intake, assessment units, critical care and outlier wards; review compliance by setting and investigate variation.
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost-effective way?	3	5	15	Significant	Continuing multiple or superseded systems creates avoidable duplication, training burden, manual work and incident-management cost while not delivering the safest pathway.	Use paper National MEWS only as a controlled interim and agree a funded, dated digital National MEWS plan to reduce duplication and human error.
	Does it eliminate inefficiency and waste?	3	4	12	High	Parallel MEOWS/NEWS2/MEWS processes increase printing, version control, training, handover and audit effort and prolong inefficient dual-system working.	Standardise documents and supplies, retire superseded charts in a controlled way and implement digital National MEWS across all relevant systems.
	Does it support low carbon pathways?	2	3	6	Low	A prolonged paper interim would increase printing and chart handling, although the primary issue is clinical safety rather than carbon impact.	Keep paper National MEWS time limited, control printing/versioning and prioritise digital integration.
	Will the service innovation achieve large gains in performance?	3	4	12	High	Non-implementation would forgo gains from automated scoring, escalation, auditability and consistent handover offered by digital National MEWS.	Define benefits and performance measures for digital delivery, including compliance, exceptions, response times, incidents and transfer documentation.
	Does it lead to improvements in care pathway(s)?	3	5	15	Significant	The proposal would preserve inconsistent pathways between maternity and non-maternity areas and increase risk during transfers and outlier care.	Design one cross-Trust pathway with a single escalation flow and transfer checklist; ensure the paper chart travels with the patient until digital integration is complete.
	Overall Area Risk			15	Significant	Overall Productivity and Innovation risk is significant because non-implementation prolongs inefficient dual systems and delays the safer, auditable digital end-state.	Agree the interim paper pathway, digital roadmap, benefits measures and decommissioning plan for superseded tools.
RESOURCE IMPACT	Will the proposal result in additional/reduced accommodation requirements			0	No Risk	No additional or reduced accommodation requirement is identified as part of implementation	No specific accommodation mitigation required; ensure paper charts and quick guides are accessible in existing clinical areas.
	Will the proposal require an increase/purchase of IT products or services.	3	2	6	Low	Digital National MEWS is embedded within current EPR systems (BadgerNet and Nervecentre). Clinical safety governance, testing, training and possible procurement or contract changes may be required in other systems in use across outlier areas. Failure to resource this work would prolong clinical risk.	Engage digital suppliers early, agree scope, cost and timeline, and oversee delivery through Clinical Safety Officers and the Chief Nursing Information Officer.
	What impact will the proposal have on the cost of prescribing community equipment?			0	No Risk	No impact on community-equipment prescribing costs is identified.	No specific mitigation required.
	Will this proposal affect any existing partnership/commissioning arrangements when service is implemented			0	No Risk	No partnership/commissioning impacts.	No specific mitigation required.
	Overall Area Risk			6	Low	Overall Resource Impact risk is low because digital integration and interim controls are already in place.	Approve a resourced implementation plan covering paper interim controls and any other required training, audit or system integration.
WORKFORCE AND PEOPLE IMPACT	Does the proposal involve increasing or reducing staff posts? If so describe the impact this will have	2	1	2	Very Low	Implementation does not require an increase or reduction in posts, although implementation needs named clinical, education, audit and digital leads.	Confirm capacity and protected time within existing teams; escalate through the implementation plan if additional resource is required.
	Could services be negatively impacted by this workforce change for a short term, medium term or longer term?			0	No Risk	No workforce establishment change is proposed, so no direct service impact from changing staff numbers is identified.	Maintain service continuity by phasing training and implementation and monitoring any operational pressures.
	Could this proposal impact positively or negatively on the experience of our people? E.g. impact on morale, increase in turnover.	3	2	6	Low	Staff may experience confusion, anxiety or reduced confidence when using different tools or when maternity triggers are unfamiliar; training and change activity create a short-term burden. Once implemented it is anticipated that the provision of a clearer escalation process than the current model would be supportive to staff unfamiliar with caring for pregnant women.	Use co-design, clear communications, brief competency-based training, huddle prompts and accessible maternity/obstetric support; monitor staff feedback.
	Is the loss of posts likely to impact on the number of vacancies or the need for temporary workforce?			0	No Risk	No loss of posts, vacancy impact or additional temporary workforce requirement is identified.	No specific mitigation required; monitor implementation workload and temporary staffing only if pressures emerge.
	Could any colleagues or patients with a protected characteristic (Equality Act 2010) suffer detriment as a result of the proposal?	5	5	25	Significant	Pregnant and recently postnatal patients could suffer detriment if adult NEWS2 or inconsistent local tools are used, particularly in non-maternity pathways. Pregnancy and maternity are protected characteristics under the Equality Act 2010.	Complete/refresh the EQIA, implement National MEWS consistently across all settings, audit by location and pathway, and address any disparity in identification, scoring, escalation or specialist review.
	Overall Area Risk			25	Significant	Overall Workforce and People Impact is significant because the principal protected-characteristic risk is to pregnant and postnatal patients, with additional staff-confidence and training impacts.	Implement the EQIA actions and workforce training plan; monitor staff experience, training uptake and equity of pathway compliance.

Option 1 Continuation of using MEOWS and not Implementing national evidence based deterioration tool (MEWS) for pregnant and up to 4 weeks postnatal.

Stage 1

Category	Operational Plan	Date QIA complete		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).
Scheme Reference		Scheme Name	Continuation of using MEOWS and not Implementing national evidence based	
Care Group/Directorate	Chief Nurse	Department	Trust wide	
Scheme Lead		Job Title	Matron	
SRO		Job Title		

Area of Quality	Impact question	Positive/Negative	Impact	Likelihood	Score	Risk Grade	Full Assessment required	Stage 1=Stage 2
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?	N	5	5	25	Significant	YES	OK
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N	3	5	15	Significant	YES	OK
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?	N	5	5	25	Significant	YES	OK
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence-based practice, clinical leadership, clinical engagement, staff experience and / or high-quality standards?	N	5	5	25	Significant	YES	OK
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N	5	5	25	Significant	YES	OK
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?	N	3	5	15	Significant	YES	OK
Resourcing	Could the proposal impact positively or negatively on the number of vacancies or on the need for temporary workforce?	N/A			0	No Risk	NO	
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	5	3	15	Significant	YES	Check Scoring
People Experience	Could this proposal impact positively or negatively on the experience of our people? E.g. impact on morale, increase in turnover.	N	3	2	6	Low	NO	
Equality, Diversity and Inclusion	Could any colleagues or patients with a protected characteristic (Equality Act 2010) suffer detriment because of the proposal?	N	5	5	25	Significant	YES	OK
Overall Scheme Risk	This is the maximum risk score for all areas of quality				25	Significant		

Please describe your rationale for any positive impacts here:	

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	Maternity Incentive Scheme Year 8: Safety Action B Training Trust Selected Checkpoint Assurance Report
Director Sponsor:	Sascha Wells-Munro, Director of Midwifery
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:

This report provides assurance that the Trust achieved the September 2026 trust selected first checkpoint for Maternity Incentive Scheme (MIS) Year 8 Safety Action B. Combined Trust compliance met or exceeded 90% for every reported staff group across fetal monitoring, multidisciplinary emergency training and neonatal resuscitation training. Remaining individual staff have been identified and booked onto training, with the

November forecast, which is the final mandatory checkpoint showing sustained or improved compliance.

This report does not cover a full compliance position towards the achievement of MIS Year 8 scheme.

Recommendation:

The Committee is asked to note the September checkpoint position, receive assurance that Safety Action B requirements were achieved, and support continued monthly oversight through to the end of the reporting period on 30 November 2026. The final position will be reported to Trust Board in January 2027.

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
Family Health Care Group Board	19 October 2026	
Maternity & Neonatal Assurance Group	13 October 2026	
Maternity & Neonatal Directorate	12 October 2026	

Maternity Incentive Scheme Year 8: Safety Action B – Training Mandatory Checkpoint Report

1. Introduction and Background

MIS Year 8 runs from 1 April to 30 November 2026 and includes six core safety actions. Safety Action B is the training element and requires effective multidisciplinary training arrangements, appropriate local governance and assurance that relevant staff groups achieve the specified compliance threshold at the required checkpoints. There are two required checkpoints, one which is selected by the trust (September 2026) and one which is a MIS mandatory checkpoint (November 2026).

2. Considerations

The final mandatory checkpoint was assessed using September Trust-wide combined compliance data reported within the October 2026 Maternity and Neonatal Assurance Group report. Compliance was reviewed across fetal monitoring, multidisciplinary emergency training and neonatal resuscitation training. The Board should consider whether the reported position, supporting exception management and forward bookings provide sufficient assurance that compliance is embedded and can be sustained to 30 November 2026.

3. Current Position/Issues

September 2026 Trust-wide position

A minimum of ≥90% compliance must be achieved for every required staff group.

Fetal Monitoring	
Staff Group	**Sept-26**
Midwives	93% (249/268)
Obstetric Consultants/SAS Doctors	96% (26/27)
Obstetric Tier 2 (Reg/ST)	92% (12/13)
MDT Emergency Training	
Staff Group	**Sept-26**
Midwives	93% (250/268)
Obstetric Consultants/SAS Doctors	100% (27/27)
Obstetric Tier 2 (Reg/ST)	92% (12/13)
Obstetric Tier 1 (F2/GP Trainees/SHO)	100% (2/2)
Anaesthetic Consultants	91% (21/23)
Obstetric Anaesthetic Doctors	90% (18/20)
MSWs (59)	92% (54/59)
Neonatal Resuscitation Training	
Staff Group	**Sept-26**
Midwives	90% (240/268)
Neonatal/Paediatric Consultants/SAS Doctors	94% (17/18)
Neonatal Tier 2 (Resident Doctors who attend any births)	100% (11/11)

Maternity Incentive Scheme Year 8: Safety Action B Training Trust Selected Checkpoint Assurance Report

Neonatal Tier 1 (who attend any births)	100% (20/20)
Neonatal Nurses (Band 5+)	90% (37/41)

All combined Trust results met the 90% checkpoint threshold. Site-level exceptions remained at Scarborough for midwifery neonatal resuscitation training (83%), fetal monitoring for Tier 2 doctors (83%) and obstetric anaesthetic emergency training (86%). At York, obstetric Tier 2 emergency training was 86%. These exceptions did not reduce the combined Trust position below the threshold. Staff were booked onto available training, and the November projection indicates 100% fetal monitoring for medical groups, 93% or above for multidisciplinary emergency training groups, and 90% or above for reported neonatal resuscitation groups.

4. Summary

The Trust achieved the September 2026 mandatory checkpoint for Safety Action B. Training compliance was at least 90% across all reported Trust-wide staff groups. Improvement from August was evident in several groups, particularly obstetric and anaesthetic staff. Site-level variation remains under active management through named bookings and forward projections. No material EDI impact has been identified; continued monitoring should ensure equitable access to training across both sites, professions, working patterns and staff groups.

5. Next Steps

- Continue monthly multidisciplinary review of compliance and non-attendance, with prompt rebooking and escalation where required.
- Confirm the final 30 November 2026 position against the definitive staff-in-scope lists and retain supporting evidence for Board assurance.
- Report the final Safety Action B position to Trust Board in January 2027 as part of the MIS Year 8 declaration process.

Date: 9th October 2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board
Date of Meeting:	28 October 2026
Subject:	Thirlwall Inquiry Report – summary, initial Trust response and Board assurance position
Director Sponsor:	Joe Hague, Chief Nurse/Karen Stone, Medical Director Sascha Wells-Munro, Director of Midwifery
Author:	Adele Coulthard, Director of Quality, Improvement and Patient Safety. Jo Hadley, Deputy Director of Midwifery

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☒

Trust Objectives

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☐ Financial Balance
☒ Effective Governance

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

Lady Justice Thirlwall's final report, published on 15 September 2026, examined events at the Countess of Chester Hospital between 2015 and 2018 and identified profound failures in safeguarding, leadership, governance, escalation, use of data and organisational culture. NHS England subsequently required every Trust and ICB Board to review the report at its next available public meeting, consider whether similar events could occur locally and seek assurance that babies and children are protected in every care setting.

The Trust is in the process of completing a number of immediate actions and has established relevant governance and safety processes. These provide reasonable initial assurance that the organisation has recognised the national requirements and begun to respond. However, the Board cannot yet take substantial assurance that all recommendations and immediate actions are fully embedded, consistently understood or demonstrably effective. Where local evidence has not yet been validated, the paper identifies an assurance gap rather than assuming compliance. A structured Trust-wide gap analysis, evidence validation and testing of practice remain in progress and is pending further guidance from NHS England.

Recommendation:

The Board is asked to:

1. Receive and consider the findings and recommendations of the Thirlwall Inquiry.
2. Consider explicitly whether the circumstances and organisational conditions identified by the Inquiry could occur within this Trust.
3. Note the immediate actions and deadlines, including communication of the Sudden Unexpected Death in Childhood (SUDIC) process, installation of CCTV focused on neonatal insulin storage by 30 November 2026, and compliance with GIRFT insulin access-control and storage requirements by 31 March 2027.
4. Be assured that an initial Trust-wide response is underway, supported by executive oversight, staff and family engagement, and existing safety and safeguarding arrangements.
5. Note that the current assurance position is reasonable rather than substantial because full compliance, cost and resource implications have not yet been confirmed.
6. Support completion of a Trust-wide gap analysis, named executive and operational ownership, and regular reporting of progress, risks, exceptions and evidence of impact through the relevant committees and Board.

Report History

This paper has been reported to the following groups on the dates specified:

Meeting/Engagement	Date	Outcome/Recommendation

Board of Directors 28th October 2026
Thirlwall Inquiry Report – summary, initial Trust response and Board assurance position

1. Introduction and Background

The purpose of this report is to provide the Board with a public update on the findings of the Thirlwall Inquiry, the immediate actions required by NHS England, and the implications for this trust.

Firstly, it is important to recognise that the Inquiry's findings are deeply distressing and may cause renewed anxiety for bereaved families, parents whose babies have received neonatal care, and staff. We extend our sincere sympathies to everyone affected and are committed to listening with compassion, responding openly to concerns and ensuring that appropriate support is available.

The final Thirlwall Inquiry report - GOV.UK was published on 15 September 2026, following the inquiry into events at the Countess of Chester Hospital between 2015 and 2018. It contains 17 recommendations spanning patient safety, safeguarding, data, leadership, culture, death surveillance, speaking up, regulation and accountability.

NHS England described publication as a sobering moment for the NHS and emphasised that the learning extends beyond neonatal services. The central principle is that concerns about babies and children must be heard, triangulated and acted upon promptly, without fear or misplaced emphasis on organisational reputation.

The Inquiry found serious and sustained failures to recognise and act on warning signs, listen to concerns, bring together information about unusual patterns, and protect babies when deliberate harm was suspected. It also identified weaknesses in leadership accountability, safeguarding, medicines security, mortality review, bereavement support, professional challenge, external scrutiny and the coordination of information between organisations. At a high level the inquiry can be distilled into six interconnected failures:

1. Failure to recognise and act on deteriorating safety signals
   The Inquiry examined why concerns, unusual deaths and patterns were not acted upon sooner. It has consequently made specific recommendations about Board-level monitoring of deaths, escalation of concerning trends and better use of data

2. Failure of escalation and professional curiosity
   NHS England's response emphasises a culture in which Board members and staff are empowered and confident to speak up, challenge and raise concerns. Boards are specifically asked to consider whether similar events could happen in their organisation.

3. Safeguarding was not sufficiently central to the response
   The recommendations strengthen safeguarding training and the response to concerns that a member of staff may be deliberately harming patients.

4. Leadership and governance did not provide an effective safety barrier
   Thirlwall goes beyond clinical practice into management accountability, including proposals for a barring system for NHS managers, an individual duty of candour and explicit expectations that managers put patients first.

5. Data existed, but the system did not reliably turn signals into action
   The Inquiry makes specific recommendations on hospital mortality surveillance, neonatal data reporting, real-time review and predetermined escalation routes

6. Processes alone are insufficient assurance
   That principle is particularly visible in the recommendations to CQC: inspectors should test whether processes are effective, rather than simply whether processes exist.

The 17 recommendations are therefore intended not only to introduce specific controls, but to strengthen the culture, systems and accountability needed to identify risk early and act decisively.

NHS England wrote to Trusts and ICBs on 22 September 2026 NHS England » Thirlwall Inquiry report and recommendations with immediate actions, while the government considers the inquiry's recommendations in full, requesting that at the next available public Board meeting, every Trust Board should consider whether similar events could occur in its own organisation and to test whether governance, culture, professional curiosity, escalation and safeguarding arrangements are sufficiently robust.

2. Considerations

The Inquiry is not solely a neonatal service review. Its wider significance is the risk that weak signals, professional concerns, unusual mortality patterns, safeguarding information and staff experience are considered separately, discounted or not escalated with sufficient urgency. The report demonstrates how policies and committees can coexist with serious failure where information is not connected and leaders do not test whether controls work in practice.

- patient safety and safeguarding concerns must take precedence over organisational reputation or employment considerations;
- concerns raised in good faith require prompt, objective action even where the person raising the concern is uncertain;
- Boards need intelligence capable of identifying unusual patterns, not simply aggregate performance reporting;
- escalation routes must be predetermined, understood and capable of rapid senior action;
- professional curiosity, speaking up and constructive challenge must be visible in leadership behaviours; and
- assurance should be based on evidence of effective practice and outcomes, not the existence of a policy alone.

3. Summary of the 17 Inquiry Recommendations

No.	Theme	Summary
1	**CCTV and monitoring**	All neonatal cots and incubators to have baby monitors with livestreaming capability for parents; NHS England roadmap by 31 March 2027.
2	**Insulin**	Digital/biometric controls and auditable access to insulin; GIRFT compliance by 31 March 2027; interim CCTV over storage with 28-day retention.
3	**Bereavement care**	National Bereavement Care Pathway for neonatal death implemented in all Trusts by 31 August 2027.
4	**Safeguarding and employment**	Role-appropriate safeguarding training for all staff and Board members, including deliberate harm; safeguarding obligations reflected in employment arrangements.
5	**Interoperability**	A timed national route to harmonised NHS computer systems and a mandatory information standard.

6	**Monitoring deaths**	Effective Board-level monitoring of all deaths of babies and children, with predetermined senior escalation routes, by 31 March 2027.
7	**Data reporting**	Named neonatal lead reporter; at least weekly data input and real-time review; reporting to the Board at least six-monthly and immediately where action is required.
8	**SUDIC**	Clear application of SUDIC processes to sudden and unexpected deaths of babies who have never left hospital.
9	**Suspicion of deliberate harm**	A national one-page protocol and short guidance, to be embedded locally, for immediate protective and safeguarding action.
10	**Independent experts**	Consideration of a national panel able to undertake swift, independent technical investigation.
11	**Medical examiners**	Strengthened neonatal death processes, direct safeguarding questions and access to neonatology expertise.
12	**Pathology workforce**	Expansion of paediatric and perinatal pathology training capacity.
13	**Manager accountability**	Barring arrangements, fit and proper person controls, individual candour and explicit patient-first duties.
14	**CQC**	Unannounced, expert-led inspection focused on whether safety processes are effective in practice.
15	**CQC oversight**	Regular external review of CQC performance.
16	**Whistleblowing oversight**	Transfer and strengthening of national whistleblowing oversight functions.
17	**Implementation**	Independent audit of implementation of statutory inquiry recommendations.

4. Immediate national requirements and current Trust position

Requirement	National expectation	Current position and assurance	Status	
Public Board review	The Board must review the report, consider whether similar events could occur locally and seek assurance on safety, culture, escalation and safeguarding.	This public paper commences that review. Further evidence validation is required.	**Amber**	
SUDIC communication	NHS England require all Trusts with a neonatal unit to communicate by 28 September 2026 that the SUDIC process applies to every sudden and unexpected death, or collapse leading to death, of a person under 18 where death was not reasonably expected 24 hours earlier and no pre-existing medical cause is apparent, including events in neonatal units.	On 28 September 2026, a Patient Safety Bulletin (Issue 157) was sent to all staff outlining the immediate actions in relation to SUDIC reporting requiring staff to check training is up to date and they are familiar with SUDIC protocol and safeguarding procedure. Evidence of dissemination exists; testing of awareness and practice should continue.	**Amber/ Green**	

Bereavement care	The provider and ICB should evidence implementation and improvement of the National Bereavement Care Pathway for stillbirth and neonatal death, including equitable access, compassionate communication, follow-up, staff competency and family feedback. The Inquiry's national recommendation is full implementation by 31 August 2027.	A benchmark assessment against the Bereavement Care Pathway was completed in July 2026. 9 out of 9 of the bereavement care standards were identified as partially implemented. An improvement plan is in place to address gaps to work towards full implementation. Full implementation is not yet assured.	**Amber**
Insulin access and storage	By 31 March 2027 neonatal units must meet the GIRFT requirements for safe insulin access and storage. Pending biometric access, CCTV focused on insulin storage fridges, cupboards or units is required by 30 November 2026, with recordings retained for at least 28 days. Local assurance is required from Neonatology, Pharmacy, Estates, Digital, Information Governance and Security on specification, lawful operation, access to footage, retention, procurement and implementation.	Benchmarking and delivery work are under way. Compliance, lawful operation, procurement and implementation evidence are not yet complete. Pharmacy, Estates and clinical teams are assessing secure storage, controlled access and CCTV options. The work must also establish whether requirements extend to other areas where babies and children are cared for. Existing wiring, recording, monitoring, Wi-Fi resilience, privacy, information governance and operational ownership will form part of the assessment.	**Amber/ Red**
Safeguarding	The Trust and ICB must assure themselves that all staff and Board members have role-appropriate safeguarding training and know how, and to whom concerns, including suspicions of deliberate harm by staff, should be escalated. Safeguarding of babies and children must be sufficiently prominent in Board reporting and decision-making.	Established safeguarding arrangements provide a foundation. A full compliance and effectiveness review, including Board/NED training and staff understanding, remains required.	**Amber**
Families and staff	Local communication should provide families with clear	In collaboration with MNVPs social media posts	**Amber**

	assurance about safety arrangements and accessible routes to ask questions or raise concerns. Psychological and wellbeing support for staff working with very sick babies should be reviewed. Communications should be open, compassionate and avoid overstating assurance before evidence is validated.	published on 2 October around Thirwell Inquiry, raising concerns and implementation and use of Martha's Rule. Personalised care plans planned to be updated with details of both communications, alongside development of information to be displayed in ward and clinical areas. The effectiveness and reach of support require evaluation.	
Mortality and data	Board-level monitoring of deaths, trend detection and predetermined escalation; neonatal lead reporter arrangements.	Perinatal mortality review and reporting arrangements exist. A formal gap analysis against Recommendations 6 and 7 is required, including Board reporting frequency, real-time surveillance and escalation testing.	**Amber**

5. Equality, diversity and inclusion

Implementation should test whether bereavement support, communication, safeguarding and routes for raising concerns are accessible and equitable across language, disability, ethnicity, faith, health literacy, digital access and socioeconomic circumstances. Equality impacts should be monitored through service-user feedback and outcome data, with reasonable adjustments and interpreting support provided where required.

6. Summary

Core arrangements are in place and immediate action has commenced. Material evidence gaps and delivery dependencies remain. Assurance should therefore be treated as provisional until actions are completed, controls tested and sustained compliance demonstrated. The available evidence supports reasonable initial assurance, rather than substantial assurance. The Trust has relevant governance, mortality review, safeguarding, medicines and communication arrangements, and has taken identifiable immediate actions. However, several requirements are time-critical, some local evidence has not yet been validated, and the full implications of all 17 recommendations have not been assessed across clinical and corporate services.

7. Next Steps

By 30 November 2026: implement compliant CCTV coverage of neonatal insulin storage, with at least 28 days' recording retention, or formally record and escalate obstacles with an interim risk control.

By 31 March 2027: evidence compliance with GIRFT insulin access and storage requirements and the expected safeguarding-related employment and training actions arising from the Inquiry and national response.

By 31 August 2027: evidence full implementation of the National Bereavement Care

Pathway for neonatal death.

Governance: report progress through the Quality Committee, with overdue or high-risk actions escalated immediately. Identify a clear Executive Sponsor Lead, senior responsible owners and a multidisciplinary implementation group. Return to the Board with a validated closure report and a separate assessment of the full Inquiry recommendations when the national response is confirmed.

8. Conclusion

The Trust has acted promptly on several immediate requirements and has existing systems that provide a foundation for assurance. Nonetheless, Thirlwall requires the Board to look beyond the existence of systems and test whether they would reliably identify, connect and act on concerning signals. The appropriate current position is therefore reasonable / partial assurance, with a clearly governed programme of work and continued public Board oversight until evidence demonstrates that required controls are implemented, effective and sustained.

Date: 15 October 2026

National Bereavement Care Pathway

Across all five bereavement care pathways

Standard	Met/not met	Current Position
Provision of personalised bereavement care	Partially implemented	Bereavement care plans in place. Project underway to develop and co-produce care plans to fully meet the needs of bereaved parents and families across all departments who may come into contact with bereaved service users.
Provision of appropriate bereavement environment	Partially implemented	Accessible bereavement rooms are available on both sites (Butterfly and Snowdrop) in maternity. An audit at Scarborough is planned to establish the frequency in which the Snowdrop Suite is used by Labour Ward to support periods of high acuity or isolation. The Butterfly Suite at York opened in 2023; the design was co-produced with service users. The Snowdrop Suite at SGH opened in 2016 and was also co-designed with service users. Following a 15 steps walk around with the MNVP at SGH, service user feedback was reviewed and recommendations actioned where possible. Further investment was made into both suites in March 2026 which included: 2x new sofa beds, 2x Bosten waterfall recliner chairs, 1x fully reclining chair, 1x patient locker, 2x crystal lights, 1x cold cot and tea/coffee canisters and cups. Artwork co-produced with staff members was commissioned and installed at SGH. The Snowdrop Suite is co-located on LW, it has a separate entrance/exit however it does share the same corridor as SCBU and LW. There is an estates plan in place which addresses this. The Butterfly Suite is opposite LW, an estates project is underway to enable bereaved families to receive all of their care within the room.
Opportunities to make memories	Partially implemented	Processes are embedded cross-site to support bereavement memory making with Maternity with improvement work planned to review processes in other care settings within the Trust. Taking Baby Home guideline and PIL has recently been approved through local governance processes to enable our families to spend time at home with their baby if they wish. Awaiting delivery of Privacy Prams, Cuddle Cots also available. A review is planned to understand staff confidence and knowledge to support memory making within maternity and other care settings within the Trust. Additional cross-site bereavement training (which includes memory making) is planned for Q4 2026.
An available pathway offering emotional and specialist mental health support	Partially implemented	A review of all emotional support and specialist mental health support services locally and nationally is underway. Following completion of an options appraisal, bespoke training will be rolled out to staff to ensure staff can confidently refer families.
Interdisciplinary communication following a bereavement and coordinated care transitions	Partially implemented	A process is embedded within maternity to notify a bereavement has taken place. A review is planned to ensure the SOP is followed in other care settings. Transition between settings and mechanisms for digital support being explored. Work is planned to review process for capturing bereaved family's status across all EPRs.
Parents involved in follow up and learning	Partially implemented	PMRT families are informed of the duty of candour process in line with national requirements. An exploratory exercise will commence with local Governance team to establish capacity to allocate a named governance contact and review process for sharing information with bereaved parents.
Appropriate multidisciplinary staffing	Partially implemented	There is a dedicated B7 Bereavement Lead Midwife 5 days a week in place cross-site. A review of the B7 Bereavement Lead Midwife role was complete with plans to replicate the same exercise with the whole bereavement team. There is no dedicated Bereavement Consultant Lead in post. All midwives complete dedicated Bereavement Care training in line with the Core Competency Framework. The structure for coordinating care across non-maternity pathways needs strengthening.
Access to bereavement training and resources for all staff	Partially implemented	Midwifery bereavement care training is delivered monthly on mandatory training. Bereavement training is also provided to new starters, MSWs, students and Gynae nurses. Clarification is being sought regarding requirement to deliver training via a specialist training provider. Funding was awarded to support supplementary bereavement training out of hours. Current bereavement resources are under review.
Staff support, wellbeing and trauma inform approach in place	Partially implemented	A review of all available staff wellbeing and trauma informed support is planned as well as a review of staff feedback. Hot Debriefs and PMAs are embedded cross-site.

Date published: 22 September, 2026
Date last updated: 22 September, 2026

Thirlwall Inquiry report and recommendations

Publication (/publication)

Content

- Thirlwall Inquiry report and recommendations
- Recommendations
- Actions needed now
- Health and wellbeing
- Next steps

Classification: Official
Publication reference: PRN02660

To:

NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc.

NHS England regional teams:

- regional directors
- chief nursing officers
- medical directors

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's report (https://thirlwall.public-inquiry.uk/) is a sobering moment for all of us working in the NHS. From the devastating failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

This is not just a matter for trusts with neonatal services. It is a matter for every single trust and integrated care board (ICB) board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the government considers the inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this.
- Go further on new guidance (https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/04/GIRFT-guide-to-safe-insulin-use-in-neonatal-services-FINAL-January-2026.pdf) on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death.
- Undertake a review of the Working together to safeguard children (April 2026) and safeguarding training nationally.
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities.
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every trust and ICB board to review the Thirlwall report and to consider its findings at the next available public board meeting**: Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children (SUDIC)**: The inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol (https://www.rcpath.org/static/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf) is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. **All trusts with a neonatal unit must urgently communicate to all relevant staff and the board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026**. It is important to note that SUDIC reporting runs alongside your own internal reporting processes.
- **National Bereavement Care Pathway for stillbirth and neonatal death**: ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the Medium Term Planning Framework (October 2025) (https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/).
- **Insulin**: By 31 March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology guide to safe insulin use (https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/04/GIRFT-guide-to-safe-insulin-use-in-neonatal-services-FINAL-January-2026.pdf). Until access to insulin requires the provision of biometric data, each trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.
- **Safeguarding**: Trusts and ICBs should ensure that all staff and board members are compliant with safeguarding training requirements at the

appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, trusts are reminded that the Insightful provider board guide (https://www.england.nhs.uk/publication/the-insightful-provider-board/) is intended to help boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and neonatal care 10 point plan (https://www.england.nhs.uk/publication/maternity-and-neonatal-10-point-plan-assurance-process/) must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

The findings of this crucial report will be a key focus of our next Chief Executive Officer (CEO) leadership event tomorrow (22 September 2026). It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,

Duncan Burton, Chief Nursing Officer for England
Sarah-Jane Marsh, NHS England Chief Operating Officer

Date published: 22 September, 2026

Date last updated: 22 September, 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust

Item 20

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	Patient Experience Report - Quarter One 2026/27
Director Sponsor:	Joe Hague, Chief Nurse
Author:	Krishna De, Head of Patient Experience and Involvement Vicky Mulvana-Tuohy, Chief AHP

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:

Patient experience activity has continued at pace during Quarter 1, with notable progress in health inequalities, accessible information, volunteering, carer engagement and the continued embedding of digital Friends and Family Test processes.

Complaints reduced by 8% compared to Quarter 4, demonstrating early signs of improvement in some services. However, concerns increased by 29%, highlighting ongoing operational pressures and the continued impact of communication, access and pathway delays on patients and carers. Complex complaints also increased slightly.

Whilst considerable improvement work is underway, complaint response performance remains below organisational expectations, with only 57% of concerns, 65% of complaints and 54% of complex complaints meeting Trust response standards. Communication remains the dominant theme across all feedback routes and continues to be the single greatest determinant of patient experience.

Whilst significant progress has been made across health inequalities, accessibility, volunteering and patient involvement, the most significant strategic risks are:

- Challenges in achieving NHSE Accessible Information Standard requirements due to delays in the implementation of Reasonable Adjustment Flags
- Continued delays in the interpretation and translation procurement programme
- Ongoing challenges in complaint response timeliness and investigation capacity.

Recommendation:
Board members are asked to accept the highlight report, note the risks and mitigations, and support action where needed.

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

Meeting/Engagement	Date	Outcome/Recommendation
Patient Experience Sub Committee	12/08/2026	To table at Quality Committee
Quality Committee	18/08/2026	

Quarter 1 (Q1) Patient Experience Report 2026/27

1. Introduction and Background

The Trust's vision is to 'deliver an excellent patient experience every time.' This Q1 report updates the Subcommittee of progress against key priorities and highlights emerging good practice and risks in relation to delivery of the patient experience agenda. Members are asked to note the progress within Q1 and support actions as required.

2. Progress Against Key Priorities

Below provides an overview of progress made during Q1 against the key priorities within the Patient Experience Improvement Plan. It summarises delivery against agreed actions, highlights areas of good practice and identifies where progress has been delayed or risks remain. The section demonstrates continued focus on improving communication, accessibility, carer involvement, volunteering, complaint handling and the care environment, while recognising the impact of operational pressures, digital dependencies and capacity constraints on delivery.

Quarter 1 Actions	Outcome
Effective Communication	
• Empower you and involve you in decisions about your care and services -we will provide health coaching training to clinically facing staff across the Trust to enable staff to have "what matters to you" conversations	101 staff attended Health Coaching/Person Centred Care training sessions between 1.4.2026 and 30.06.2026. 21 staff completed the full Health Coaching 8-hour programme between 1.4.2026 and 30.06.2026.
• Defining and embedding what good communication looks like	A pilot programme for administrative staff on how effective communication can improve patient experience was delivered to 16 staff in June. This will be further expanded in Q2.
• Explore process for Trust Members interaction to be involved/ engaged in quality improvement work, to ensure we listen to concerns and suggestions and collaborate to make sustainable changes, and we will capture people interested in codesigning	During Q2 we will be exploring with NHS Elect the delivery of communications training for Ward Managers, Matrons, AHP leads and resident doctors in relation to improving patient experience through compassionate communications. Training has also been developed for our non-registered and admin roles to enable all to understand their role in patient experience and the need for effective communication.
• Provide complaints training to our staff to enable high-quality communication and	The process has been defined and will be implemented in Q2. This was deprioritised given the reduced

responses of concerns and complaints	resources in the corporate Patient Experience Team following the consultation process. Following the delivery of complaint letter writing training during 2025/26, the focus is now on ensuring that all Investigating Officers complete the Parliamentary and Health Service Ombudsman (PHSO) complaints training. Recognising the operational pressures currently being experienced across care groups, the Chief Nurse Team has agreed that completion of this training should be completed by the end of Q2. To support this work, the Chief AHP has planned an Investigating Officer meeting to take place in Q2. The session will provide an opportunity to reinforce the role and responsibilities of Investigating Officers, promote a consistent approach to complaint investigations, and highlight the standards expected when responding to patients and families. The meeting will also be used to identify and address barriers to effective complaint handling, including challenges relating to timeliness, quality of investigations, communication with complainants, and the implementation of learning. Investigating Officers will be encouraged to share concerns and examples of good practice, helping to strengthen capability and improve performance across all care groups. This will support continued progress towards delivering high-quality investigations that meet both Trust and Ombudsman expectations.
Unpaid Carers • Recruit, train and embed the role of Volunteer Carer Champions at Scarborough and York Hospitals	The Volunteer Carer Champion role, Carers Charter, Trust Carers Information Leaflet and associated training continued to be promoted throughout Q1. Recruitment activity was undertaken through volunteer engagement routes and awareness raising activity. Six volunteers participated in the new Carer Awareness training alongside Trust staff.
• Continue promotion of the Carer Charter and strengthen identification and support for Carers	Education and visibility of the Carers Charter have continued through ward walk arounds across all the Trust sites during Q1.
• Involve Carers in the codesign and development of new builds and services, seeking ongoing feedback as we make changes	During Carers Week 2026 (8-14 June 2026), we delivered a programme of awareness and engagement activities aligned to the national theme of "Building Carer Friendly Communities". Activities included information stands in York and Scarborough promoting the Carers Charter, carers leaflet, Carers Hub and the support available through partner organisations.

	In addition, we launched and promoted the Trust's carers experience survey. The Patient Experience team worked alongside the Staff Carers Network, Carers Plus and local carers organisations to raise awareness of support available to carers. Carer and carer representative organisations continued their participation in Trust access audits during Q1, helping to identify opportunities to improve accessibility and experience. Carer representatives also continued to contribute to service improvement through participation in the York and Scarborough inpatient menu redesign task and finish group
• Embed Carer case studies with carer training and communications	Carer case studies are embedded within the new Carers Awareness training to support learning through lived experience.
• Implement a process that ensures carer involvement within discharge planning as required by the Care Act	This will be integrated into the “Coming off Corridors” programme, which will commence in Q2.
• Explore the opportunity for Care Groups to provide unpaid carers, and those who rely on unpaid carers, with multiple same day appointments where possible and appropriate (outpatient transformation)	This will be scoped once implementation of Nervecentre tranche 3 has been completed in 2027.
• Explore the opportunity to include recording/flagging unpaid carers status on new EPR (and those reliant on others for care)	This will be explored as we look at digital flags as part of the development of Nervecentre in Q3 in 2027.
• Use patient experience information to triangulate with other intelligence across wider quality agenda enabling themes and trends to be identified which indicate where a service may not be delivering to the expected standard or quality	Where system and service changes are planned for or service improvement is required, services are directed to patient experience information including FFT, national patient surveys, local intelligence, Healthwatch reports, health inequalities, incidents and concerns and complaints data. A programme of work led by the Director of Quality, Improvement and Patient Safety will commence in Q2 to triangulate the data.
Volunteering	During Q1 we onboarded 9 new volunteers.

• Improving patient experience through the recruitment, training and retention of Volunteers	National Volunteer Week was celebrated in June 2026, with appreciation and engagement events held at York and Scarborough Hospitals. The contribution Volunteers make to the Trust was recognised, and volunteers were gifted a notebook and pen branded 'Proud to be a Volunteer'. The updated E-Learning for Health modules were rolled out via the Learning Hub. Reviewed and updated the training for Ward Support volunteers with the Dietetic Lead and amended the role description to ensure that they are compliant with Trust guidelines re the responsibilities of Volunteers relating to hydration and nutrition.
Managing Concerns and Complaints Improve visibility and access to the PALS service, including telephone and walk-in support, to enhance patient and carer experience.	Recruitment to the vacant Complaint and Concerns Officer post will strengthen PALS capacity and resilience. The role, part of the agreed establishment and vacant due to long-term sickness, will improve patient and carer access through telephone and walk-in support, reduce response delays, and increase timely advice. Work will continue to raise awareness of the service and appropriate access routes. The postholder will join in Q2.
Continue to improve complaint response times.	Response time performance improved across all case types in Q1 compared with Q4 2025/26. 57% of closed concerns were responded to within the Trust's 10 working-day target, an improvement from 47% in Q4 2025/26. 65% of closed complaints were responded to within the 30 working-day target, up from 58% in the previous quarter. 54% of closed complex complaints were closed within the 45 working-day target, compared with 49% in Q4 2025/26. While performance remains below the Trust's expected standards, the improvement indicates that actions taken to strengthen complaint and concern management are beginning to have a positive impact. Care Group performance remains a key priority for 2026/27, with a continued focus on strengthening

	accountability, supporting Investigating Officers, and improving oversight of overdue cases.
Healing Environment	
• Complete the review of Patient Led Assessments of the Care Environment (PLACE) audit outcomes and identify priority actions.	Work continues to ensure all actions identified as part of PLACE 2025 are assigned to a named lead. The number of assigned actions increased over Q1, with this being a key request and where barriers are identified, that these are recorded clearly within the action plans. Financial constraints are noted as a barrier to completion of actions, with alternative revenue streams being considered where appropriate.
• We will support patients with their spiritual needs by increasing referrals to the chaplaincy service supported by education of clinical staff by Chaplaincy.	Chaplaincy referrals reduced by 15% in Q1, from 810 in Q4 to 685. This reduction was linked to technical issues with CPD following the transition to Nervecentre, as 71% of chaplaincy referrals are made through CPD. This has been added to the Patient Experience Risk Register.
Accessibility	
• Complete the Accessible Information Standard (AIS) gap analysis and develop an action plan to address identified gaps.	Elements of the AIS are already reflected in the reasonable adjustment flags guidance. To bring this together, a single action plan has been developed to address both reasonable adjustments and AIS standards. Due to Reasonable Adjustment flags not being available until tranche 3 of Nervecentre in June 2027, we will not be able to deliver against the national requirements for going live with digital flags in September 2026. This has been added to the corporate risk register.
• Introduction of open visiting for families and carers.	The visiting policy has been finalised with input from across Care Groups. This will be reviewed for approval by the Executive Committee in Q2.
• Ensure that patients facing crisis have access to clothing and care packs.	Clothes and care packs have been sourced through donations from local organisations. A process is being established to distribute these to wards, initially at York Hospital from Q2, supported by Trust volunteers.
• Review of patient letters inviting to appointments to ensure that they are clear, accessible and include directions on how to attend the appointment.	Outpatient letters are in a clear and accessible format. The new letter format includes a statement signposting patients to the accessibility hub if they require this support

3. Highlights to Note

3.1 Interpretation and Translation contract update

During Q1, the Yorkshire and Humber Procurement Collaborative progressed the contract award following tender re-evaluation, with a preferred supplier identified. Award letters remain subject to legal review, so the standstill period has not yet commenced. Letters are expected to be issued in Q2, after which the standstill period will begin.

Further legal challenge remains anticipated and continues to present a risk to implementation timelines. The current provider's contract extension remains in place until December 2026 to ensure service continuity.

Following the Q4 Interpretation audit, Q1 work reviewed interpretation spend, avoidable waste and the need to replace end-of-life tablets to improve value for money, access and reliability. Recommendations will be presented to the Patient Experience Subcommittee in Q2 for consideration and implementation.

3.2 Equality Diversity and Inclusion- Equality Delivery System

Progress against the 2025/26 EDS2 Domain 1 action plan continued in Q1, with updates from the three reviewed services showing ongoing work on MSK digital and accessibility improvements, speech and language therapy communication support, and actions relating to access, complex needs and patient voice.

A revised 2026/27 approach was developed, proposing antenatal care, York Acute Frailty Unit and York Audiology as focus areas, with a staggered review cycle and greater Care Group ownership supported by Patient EDI Lead guidance.

The proposed approach was supported in principle during Q1, with the reporting cycle to be confirmed following discussion and agreement in September 2026.

3.3 Widgit Online Communication Tool

Widgit is now being used to support Easy Read materials and accessible communication in Trust engagement activity, Children's Therapy Services and Complex Care Teams.

Rollout has been delayed due to Patient Experience Team priorities; in Q2 we will focus on promotion, advice and support for services embedding the tool.

3.4 Friends and Family Test (FFT)

The new digital FFT system continued to be embed in Q1, supported by guidance, training, QR codes, service-specific links and tailored questions. A dedicated Teams channel with a bespoke AI agent to assist staff in navigating, using and embedding the platform, alongside staff training had been delivered. This included guidance on QR code generation and non-digital survey options.

High SMS (Short Message Service or text messaging) uptake resulted in the messaging cap being reached, so SMS distribution was temporarily paused while alternative access routes, including web links, QR codes and paper surveys, remained available.

FFT intelligence continued to support local ownership, demographic reporting, health inequalities insight and recognition of positive patient experience.

A new organisational FFT dashboard will be developed in Q2 to support performance monitoring against key priorities.

4. Complaints and Concerns

This remains an area of concern requiring focused improvement to support the Trust's objective of delivering excellent patient experience every time. Rising complaints and concerns provide valuable insight into where patients and carers experience barriers, delays or poor communication. The organisational focus must be on preventing escalation by improving communication, resolving concerns earlier, strengthening local ownership and using feedback to drive service improvement.

4.1 New concerns and complaints received in Q1

A total of 1,213 concerns were received, representing a 29% increase on Q4. Of these, the Patient Advice and Liaison Services team (PALS) registered 306 on Datix for investigation and resolution by Care Groups, while the remaining 907 were managed directly by PALS the on behalf of Care Groups, corporate services, and Facilities Management. Whilst the increase in concerns may partially reflect greater awareness and use of PALS services, the thematic analysis suggests that access, communication and pathway delays continue to be significant contributors and remain areas requiring improvement.

A total of 292 complaints were received, a decrease of 8% compared with Q4. Emergency Medicine accounted for 27% of all complaints received (80 cases).

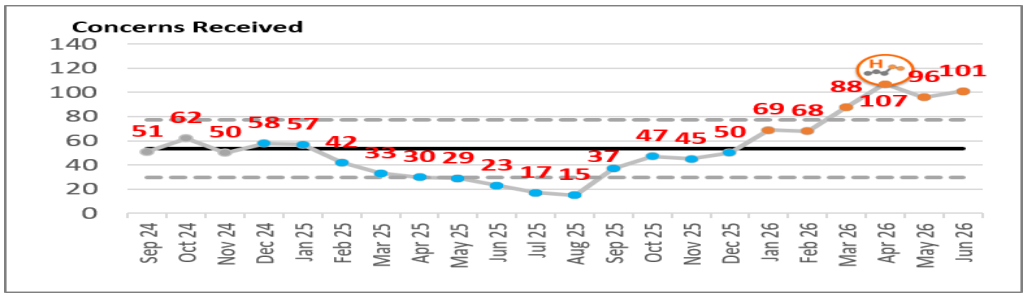
The number of complex complaints increased slightly, with 105 received compared with 101 in Q4, representing a 4% increase.

New cases Q1	Concerns	Complaints	Complex Complaints	Total
York Hospital (including Community)	210	201	78	**489**
Scarborough Hospital	87	88	27	**202**
Bridlington Hospital	9	3	0	**12**
Total	**306**	**292**	**105**	**703**

New cases by Care Group in Q1	Concerns	Complaints	Complex Complaints	Total
Medicine	115	134	54	303
Surgery	105	81	20	206
CSCS	44	35	10	89
Family Health	34	26	21	81
Corporate Services	8	16	0	24
	306	**292**	**105**	**703**

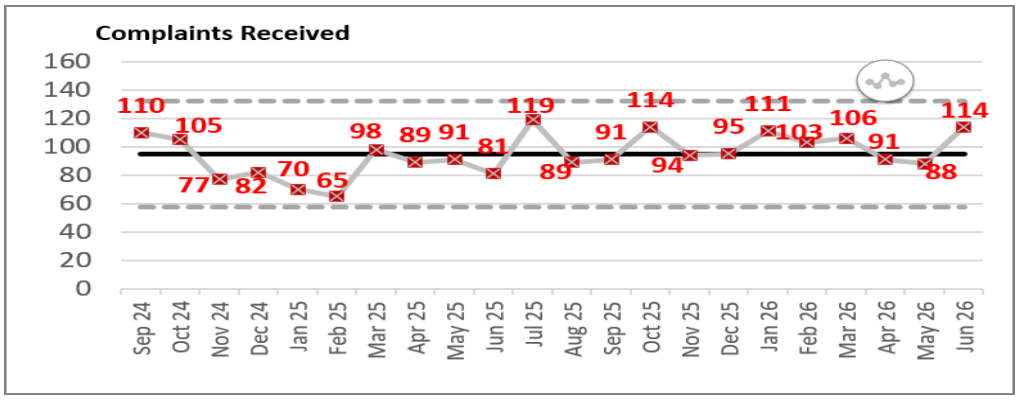
Concerns Received (306 logged on Datix)

Concerns received increased notably during Q1 2026/27. Volumes rose from 68 in February 2026 to 88 in March, peaking at 107 in April and remaining high in May and June. This represents a sustained shift above the expected range, putting additional demand on PALS and Care Group resolution processes.



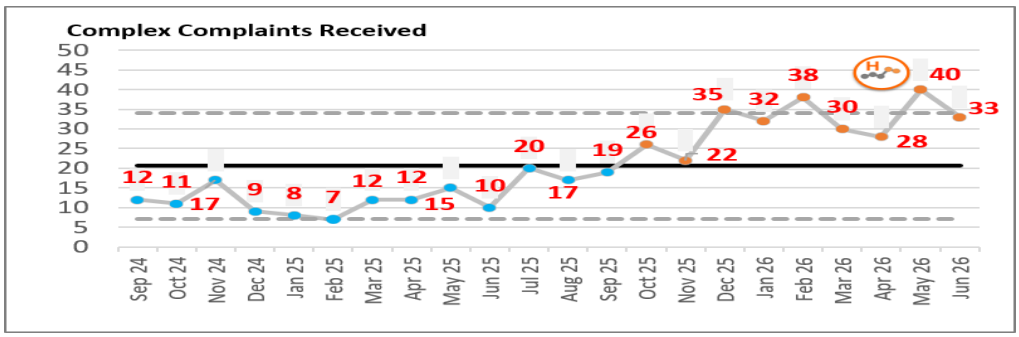
Complaints Received

While there is month-to-month variation, the data does not suggest a sustained upward or downward trend. Instead, complaint volumes appear relatively consistent over time, with recent months continuing to fluctuate around the long-term average.



Complex Complaints Received

Complex complaints have increased notably since September 2025, with monthly volumes generally sitting above the earlier 2024/25 position and peaking at 40 in May 2026. Although June 2026 reduced to 33, activity remains high.



4.2 Main themes of complaints and concerns

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

Complaints	Concerns	Complex Complaints
Delay or failure in treatment or procedure	Communication with patient	Delay or failure in treatment or procedure
Communication with patient	Access to services	Delay or failure to diagnose
Attitude of nursing staff/midwives	Referral issues	Emergency Dept/MIU waiting time
Attitude of medical staff	Delay or failure in treatment or procedure	Arranging/undertaking diagnostics
Emergency Dept/MIU waiting time	Delay or failure to diagnose	Communication with relatives/carers

Communication remains the most significant and recurrent theme across complaints and concerns and represents a key driver of patient experience, confidence and trust. Across all Care Groups, feedback indicates that patients and families continue to experience inconsistent information, insufficient updates and difficulty accessing services. Recurring issues include delayed communication of results, unanswered calls or messages, conflicting advice, limited communication with relatives and insufficient explanation of diagnosis, treatment decisions, discharge plans and waiting times. The impact described by patients is material, with communication failures increasing anxiety, reducing confidence in care and contributing to escalation through PALS and formal complaint routes.

Delays in diagnosis, treatment and follow-up continue to present a significant patient experience and pathway risk. Complaints describe delays across referrals, investigations, outpatient appointments, surgery, specialist review, communication of results and treatment planning. The themes indicate continued pressure across pathways, with patients reporting repeated attendances, prolonged waits, cancelled procedures and delayed escalation. These concerns require continued oversight because of the potential impact on timely intervention, patient confidence and perceived quality of care.

Staff attitude, empathy and professionalism remain important indicators of the quality of patient and family experience. A notable proportion of complaints describe patients feeling dismissed, unheard, judged, patronised or treated without compassion. Concerns span medical, nursing, midwifery, reception and administrative interactions. The feedback demonstrates that the way care is communicated and delivered has a lasting impact, particularly for patients who are vulnerable, in pain, anxious or seeking reassurance. This reinforces the need for sustained focus on compassionate communication, professional standards and local leadership accountability.

Basic care, dignity and personalised support remain areas requiring assurance in inpatient settings. Complaints highlight delays in responding to call bells and support with toileting, pain management, hydration, nutrition, wound care and personal care. Patients and relatives also raise concerns regarding dignity, privacy, reasonable adjustments, support for people with disabilities or neurodiversity and end-of-life care. These themes indicate the need for continued triangulation with quality, safeguarding, patient safety and care environment intelligence to ensure improvement actions are targeted and sustained.

System, administrative and coordination failures continue to contribute to poor patient experience and reflect risk across pathway ownership and operational processes. Complaints describe fragmented pathways, poor communication between teams, inaccurate records, appointment management issues, referral delays, missing follow-up arrangements and unclear ownership of care. Patients often report having to coordinate their own care, repeatedly chase information or navigate multiple services without a clear plan.

The findings support the need for strengthened Care Group oversight, clearer accountability for pathway coordination and continued use of complaints intelligence to inform improvement priorities.

4.3 Care Group Themes

Medicine: Complaints most commonly related to delays in diagnosis, investigations and treatment, particularly through emergency pathways, acute medicine and specialty services. Patients frequently described poor communication about results, discharge plans and ongoing management, alongside concerns about staff attitude, waiting times and lack of continuity. Several complaints highlighted basic care concerns, medication issues and patients feeling unsupported during prolonged admissions.

Surgery: Key themes included long waits for operations and outpatient reviews, delays in diagnosis and treatment, cancelled procedures, poor follow-up arrangements and communication failures throughout the surgical pathway. Trauma and Orthopaedics, Urology and ENT generated a high volume of complaints relating to delayed care, conflicting advice and dissatisfaction with clinician communication. Patients frequently reported significant impacts on mobility, pain and quality of life while awaiting treatment.

Family Health: Complaints commonly focused on maternity and paediatric services, with recurring concerns about patients or parents not feeling listened to, delayed escalation of clinical concerns, inconsistent information and poor communication during pregnancy, labour and postnatal care. Staff attitude, compassion and reassurance featured strongly, alongside concerns about delayed diagnosis, follow-up and coordination of care for children and young people.

Cancer, Specialist and Clinical Support Services: Patients frequently reported delays in receiving results, follow-up appointments and specialist treatment. Complaints highlighted poor coordination between services, communication failures, uncertainty regarding diagnoses and treatment plans, and difficulties accessing specialist advice. Many patients described anxiety and distress caused by fragmented pathways and a lack of clear ownership of care.

Corporate Services: Themes centred on access and administrative issues, including difficulties contacting services by telephone, appointment management concerns, parking and access problems, record accuracy, and communication failures. These complaints often reflected frustration with processes that patients perceived as barriers to accessing care.

Across all Care Groups, complaints demonstrate that patient experience is influenced as much by communication, coordination, compassion and timely access as by the clinical care provided. The recurring nature of these themes indicates that improvement cannot be addressed through isolated actions alone and requires sustained Care Group ownership, visible leadership accountability and stronger triangulation with wider quality, safety, operational and workforce intelligence.

The key assurance requirement is that Care Groups are using complaints and concerns intelligence to identify recurring risks, take targeted action, evidence learning and monitor whether improvements are reducing avoidable escalation to PALS and formal complaint processes. Strengthening communication, pathway coordination, timely access, dignity, basic care and compassionate interactions therefore remain central to improving patient experience and providing the Subcommittee with assurance that learning is being embedded and sustained.

4.4 Complaints Reopened

The Trust remains committed to responding to complaints in an open, transparent, and compassionate way. Through the complaint review process, efforts are made to ensure responses address the issues raised, explain findings clearly, and identify learning where appropriate.

During this quarter, 21 closed complaints (5%) were reopened following further contact from complainants requesting additional review or investigation.

The most common reasons for reopening complaints were:

- dissatisfaction that all concerns raised had not been fully addressed
- requests for clarification or further explanation of findings
- disagreement with the outcome of the investigation.

4.5 Parliamentary and Health Service Ombudsman (PHSO)

As part of the complaints process, complainants are advised of their right to refer their complaint to the PHSO if they remain dissatisfied with the Trust's response or the way their concerns have been handled.

During Q1, the PHSO did not open any new investigations relating to the Trust.

One case, originally registered by the PHSO during 2024/25, was concluded in Q1. The Ombudsman's findings partially upheld the complaint.

Case 112 Elderly Care, Scarborough Hospital: The Trust issued an unreserved apology for failings in pressure ulcer management and discharge planning, which contributed to patient harm and distress. An action plan has been implemented to strengthen prevention, assessment, specialist referral, documentation, nutrition and continence assessment, discharge processes, multidisciplinary communication and governance oversight. Key improvements include enhanced electronic documentation, mandatory discharge skin checks, strengthened audit, clearer escalation routes and improved action tracking to support sustained compliance and patient safety.

5. Concerns and Complaint Performance

On average in Q1:

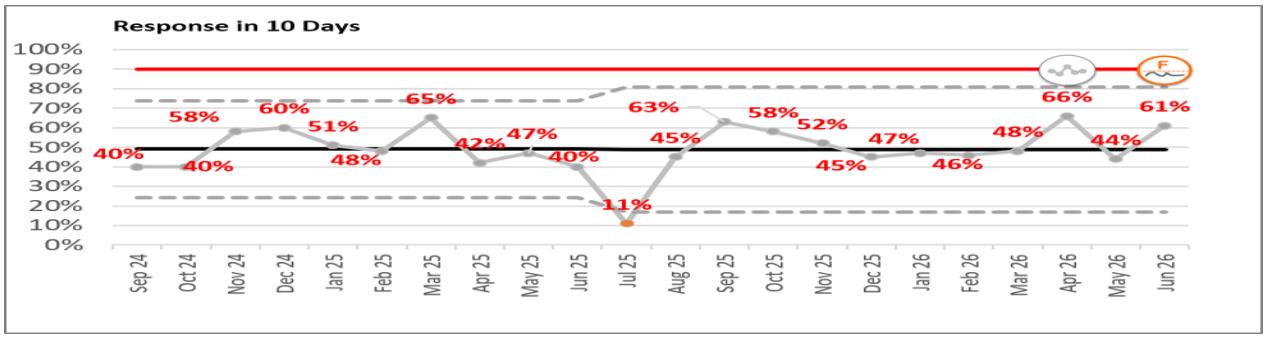
- 57% of closed concerns met the Trust's 10 working-day response target.
- 65% of closed complaints met the Trust's 30 working-day response target.
- 54% of closed complex complaints met the 45 working-day response target.
- PALS acknowledged 703 formal complaints and concerns within an average of two working days, in line with the national 3-working day target.
- PALS provided timely resolutions of 907 concerns on behalf of Care Groups, achieving an average response time of two working days, below the internal target of five working days.

Performance remains below the Trust's 90% standard; however, Q1 improvement across all case types indicates that actions to strengthen oversight, accountability and capacity are beginning to have a positive impact.

To support improvement, Care Groups have continued to strengthen oversight of complaints and concerns through more robust governance arrangements, regular performance review, and a greater focus on ownership of investigations. Efforts are also underway to improve the quality and timeliness of responses through enhanced monitoring, targeted support for Investigating Officers, and escalation of overdue cases to ensure accountability and sustained progress against response targets.

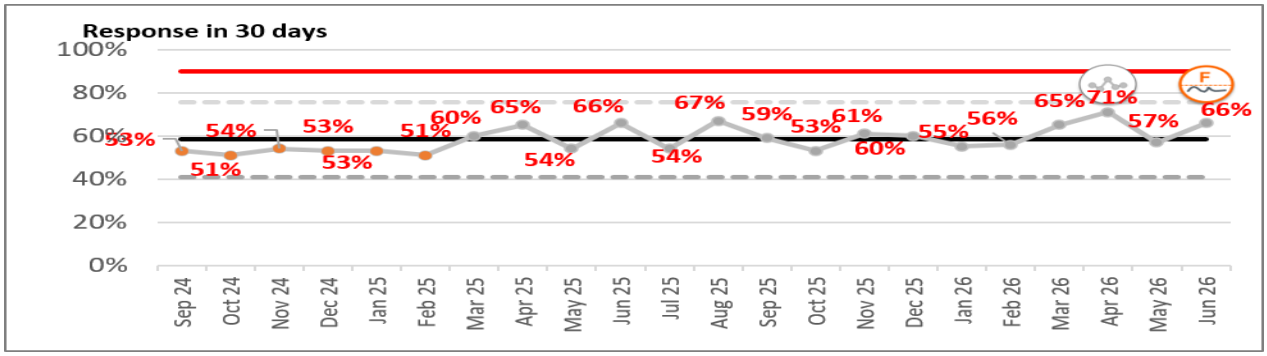
5.1 Concerns Closed Response Rate

During Q1, performance against the 10-working day response target for closed concerns remained below the Trust's 90% standard. Compliance averaged 57% across the quarter, with performance fluctuating from 66% in April to 44% in May, before improving to 61% in June. Although the June position shows some recovery, the quarter demonstrates that timely resolution of concerns remains inconsistent and requires continued focus. Improving response times is important to ensure patients, families, and carers receive prompt feedback and maintain confidence that their concerns are being listened to and acted upon.



5.2 Complaints Closed Response Rate

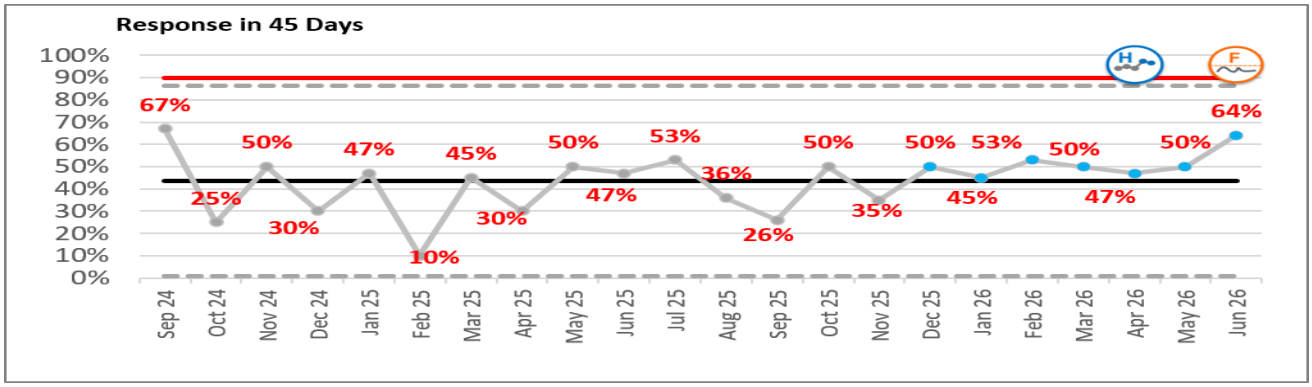
During Q1, 65% of closed complaints were responded to within the Trust's 30 working day target. Performance peaked at 71% in April, fell to 57% in May, and recovered to 66% in June. While the recovery in June is encouraging, performance remained below the Trust's 90% standard throughout the quarter. Delays in complaint investigations continue to affect a significant proportion of complainants and there is a need for continued focus on investigation timeliness, capacity, and accountability across Care Groups.



5.3 Complex Complaints Closed Response Rate

54% of closed complex complaints were responded to within the Trust's 45 working day target in Q1. Performance improved steadily across the quarter, increasing from 47% in April to 50% in May and 64% in June. While this upward trend represents the strongest performance seen during 2026, compliance remained significantly below the Trust's 90% standard. Continued

focus is required to reduce delays in the investigation of complex complaints and improve the timeliness of responses provided to patients and families.



6. Examples of service improvements made in response to complaints

Complaints provide valuable insight into where services need to improve. During Q1, learning from complaints led to a number of local actions, including improvements to communication, signage, access arrangements, complaint handling training, and escalation routes. These actions demonstrate how patient and carer feedback is being used to reduce repeat concerns, support earlier resolution, and improve the quality and experience of care. Examples of learning and responding to complaints are detailed below.

CSCS Care Group

A number of Investigating Officers who regularly respond to complaints have now completed the required training. While 100% compliance was not achieved by the end of Q1, compliance is being monitored through the weekly complaint's performance meeting, with full compliance expected by the end of Q2.

CSCS has completed a thematic review of complaints and concerns received during the previous year to identify recurring themes, emerging trends, and opportunities for improvement. The findings will be presented at the Care Group Board on 5 August 2026 and subsequently shared across specialties and services within the Care Group to share learnings and identify improvement opportunities.

The Care Group is continuing to evolve its complaints improvement plan to ensure learning is embedded and sustained. This includes strengthening the use of Friends and Family Test (FFT) feedback and developing a Care Group quality and experience data pack to support oversight, triangulation of data and targeted improvement discussions at governance meetings.

Targeted quality improvement initiatives are being refined in response to the themes identified, including specialty-specific work within Dermatology at Bridlington. During its first year, the service provided specialist dermatology care closer to home for the coastal population that has historically faced barriers to access. More than 1,000 patients were seen, and patient feedback was consistently rated as Good or Excellent over a seven-month period, demonstrating both the quality of the service and its positive impact for the community.

Surgery Care Group

The communication promise continues to work well from a ward level on all sites, with reduced formal complaints because of inpatient stays. These are picked up at ward and matron level

and predominantly resolved “in the moment.” Our main themes and complaints in general are around waiting times and communication (essentially around diagnosis and delays).

There has been positive feedback from patients relating to surgery being undertaken at Bridlington Hospital (Kent ward, theatres, and all staff). Those cared for in Bridlington are very complimentary of their surgical pathway and care.

YTHFM

During Quarter 1, learning from complaints resulted in a number of service improvements across YTHFM:

- Following feedback regarding out-of-hours access arrangements, a review of signage and instructions at the main entrance of York Hospital was undertaken to improve the visibility, positioning, and clarity of information available to visitors using the intercom system.

- In response to concerns regarding communication associated with planned works at Malton Hospital, communication arrangements were strengthened to ensure staff, visiting clinicians and external clinic providers receive timely information regarding planned disruption and escalation routes.

Learning from complaints continues to be reviewed through governance and quality processes and shared with service leads to support continuous improvement.

Complaint handling training was delivered through the YTHFM One Team Leadership Programme, focusing on recurring complaint themes, converting learning into sustainable improvement actions, and improving the quality of complaint responses. Colleagues have also been signposted to Trust complaints training and PHSO online resources.
Taking the learnings from the ward-based poster and business card initiative is not directly applicable to YTHFM services, in Q2 consideration will be given to whether additional local signage, contact information or service-specific communication materials could support the early resolution of concerns and improve the overall customer experience.

7. National Patient Surveys

The National Inpatient Survey 2025 was received in Q1, with the June report embargoed until public release in August 2026. Findings have been shared internally with Care Groups and relevant leads, with high-level themes presented to Patient Experience Subcommittee in July. Following publication, actions will be incorporated into existing Care Group and corporate improvement plans.

8. Health Inequalities

A 0–3-year programme of work has been developed to address the Health Inequalities (HI) Self-Assessment Framework recommendations, delivered through four workstreams: Health Inequality Enablers, Health Promotion, Accessible Information, and Continuous Improvement. Governance and reporting arrangements have been established, with key activities progressed in Q1 as below:

Health Inequalities Enablers	Progress
Health Inequalities Programme	• A new workstream 'Person-centred care' has been added to the programme to include health coaching, what matters to me and health literacy. Person-centred care helps reduce health inequalities by addressing wider social and economic determinants, tailoring support to marginalised groups, and empowering individuals through shared decision-making.
Defining data to support health inequalities	• Following the introduction of Nervecentre, we now have an Emergency Department (ED) dashboard with the functionality to search by age, sex, deprivation and Index of Multiple Deprivation (IMD) score. • The NHSE statement for health inequalities has a set of core metrics. Due to poor definition, this work is ongoing to build a suite of health inequalities core metrics. We are engaging with external organisations to observe good practice that we can adopt.
Health Inequalities Training matrix	• Health inequalities online learning can now be accessed on the Learning Hub at 2 levels. Foundation level is an introductory level for all staff and an intermediate level for patient-facing clinical staff, ward managers, team leaders and operational leads and service managers.
Pathways to engage with communities / pathway redesign work with system partners	• Continue to share data on high intensity users (HIU) of emergency departments with primary care. Selby PCN and York Medical Group are now in the process of designing a process for an MDT with key system partners to manage a cohort of 10-15 HIU patients. Scarborough CORE PCN are also reviewing data on high intensity user patients to select a small cohort to pilot care co-ordination. • Patient engagement with the homeless community commenced in April to include communities in York, Scarborough and Bridlington to understand their experience of using our ED and as an inpatient. The work has been supported by City of York Council and Voluntary, Community and Social Enterprise (VCSE) organisations. The feedback will provide insight into their experiences of using our hospital and will identify key areas for improvement.
Apply HI Framework into QI and research programmes	• A VCSE showcase event was held in Scarborough with 9 VCSE organisations showcasing their services to staff, the support they can offer our patients and how to refer – in collaboration with Scarborough Coastal Health and Care Research Collaborative (SHARC). The VCSE organisations offer support for people, and the event was to raise awareness so our staff can start to signpost patients to this level of support to improve health outcomes for patients. • SHARC held an annual event with 80 community members, health, academics and VCSE, showcasing research and health inequalities projects. • An 'Introduction to research' session was delivered at Bridlington with VCSE, primary care, community members and local authority by SHARC to promote research around health inequalities on the east coast.

	• SHARC presented to the Cancer Alliance at their showcase event to encourage collaboration and potential future research projects. • SHARC presented at the Institute for Health and Care Improvement at York St John around health inequalities across the Trust geography. • Links to Health Inequalities education on the hub to be shared through QSIR training.
Embed Health inequalities into all organisational priorities, strategic documents	• An initial meeting to discuss the requirements for a data sharing agreement across systems to support collaborative working has taken place. Data sharing across organisations is essential to the development of neighbourhood-based care and the reduction of health inequalities. By linking information from different services, organisations can build a more complete understanding of the needs of their local population, identify people at greatest risk of poor health outcomes, and coordinate support around individuals rather than organisational boundaries. Shared data enables earlier identification of unmet need, supports proactive and preventive interventions, reduces duplication, and improves continuity of care for people with complex needs.
Health Promotion	**Progress**
Alcohol	• An Alcohol Specialist Nurse is working clinically on pilot areas (ward 36, AMU and ED), identifying patients using a screening tool. Alcohol screening enables the early identification of patients whose alcohol use may be contributing to their admission, current health condition, or future risk of harm. Screening supports timely assessment, management of alcohol withdrawal, delivery of brief interventions, and referral to specialist services where appropriate. • Comprehensive resource files have been developed for pilot areas to include all alcohol guidance /referral guidance, prescribing guidance. Awaiting final approval. • Information sharing agreements for system partners in place (York in recovery / Change, grow, live) to share patient level information across organisation supporting joined up care. • Inclusive recovery event was held on the 29th of April – YSTHFT was represented. The purpose of York's Inclusive Recovery City event was to launch York's ambition to become an official Inclusive Recovery City by uniting over 150 local partners to sign the Inclusive Recovery City Charter, challenge the stigma around drug and alcohol addiction, and champion fair access to employment, housing, and education for people in recovery.
Tobacco dependency	• Trust-wide communication is planned on the smoke-free environment policy to increase awareness and compliance. • Patient experience survey completed for patients using the Tobacco dependency service to gather feedback for any improvements in the service. • Re-launched smoke-free information for staff and contractors. Also re-strengthening the message on smoke-free environments for patients.

	• Consultation with senior team as part of the consultation period for the Tobacco and Vapes Bill.
Reasonable adjustment (RA) / Accessible Information Standards (AIS)	**Progress**
Accessible information enablers	• Deep dive gap analysis for letters and the external website to understand the adherence to AIS guidance. • Driver diagram completed for RA/AIS so all areas of improvement are represented. • Identified eight internal Trust websites for review in Quarter 2 to ensure they comply with AIS requirements. • Draft of accessible information standard descriptor for our public facing website so patients have an awareness of expectations. • Accessible information is planned to be a topic as part of the year of quality with screensavers planned to promote • Preceptorship sessions now include RA/AIS education for new staff. • A staff pocket quick reference guide has been developed as a quick education guide for RA /AIS.
Identifying needs	• A review of the accessibility hub has been completed by 'MySight York' and 'Healthwatch' with recommendations to further improve the Accessibility Hub on the Trust website. • Patient groups have approved a new accessibility statement that includes a link to the Accessibility Hub. This will help patients find information about accessibility and support available before they come to hospital. The statement will be included in all patient letters and patient information leaflets. • The pilot of the patient experience training for administrative staff included a section on asking patients questions around their accessible information requirements to support the identifying and meeting the needs of patients. • Arrangements have been made for the Waiting List Team to signpost patients to the Accessibility Hub and identify any reasonable adjustments required before surgery, helping to ensure that appropriate support is in place ahead of admission.
Recording Needs	• It has been confirmed with Systems Development that RA flags will not be live in Nervecentre until tranche 3 in June 2027. This is a delay against the NHSE required timescales of Sept 2026 and has been added to the risk register. • Attended CLiC (Clinical Leaders in Care - senior nurse forum) and PALF (Professional AHP Leaders Forum) to raise awareness of reasonable adjustments/ accessible information so leaders can disseminate information to staff groups.
Meeting and reviewing the needs of patients	• Initial review of the guidance provided for staff to meet the needs of patients e.g. how to book an interpreter. Work will continue in quarters 2 and 3 with staff engagement on what staff feel they need to be able to support patient needs.

	• Review of the hearing loop locations across the Trust and effectiveness and functionality. Hearing loop functioning showed 100% compliance York, Scarborough, Bridlington, Malton and Selby.
Continuous Improvement	**Progress**
Care Group health inequalities projects	• CG CSCS – Pilot of pre outpatient appointment calls to reduce DNA in paediatric ophthalmology. Initial results showed 84% attendance (72 patients out of 84). • CG CSCS – reviewing Dermatology service provision through a health inequalities lens. • CG Surgery - MSK Community Appointment Day held ensuring flexibility for patients to attend appointments with future appointment days planned. • CG Surgery - 1st Paediatric surgical list (multi-specialty) at Bridlington in place and now planned every 8 weeks. • CG Family – Children's therapy teams now attending toddler groups in deprived areas with low referral rates to raise awareness with parents. • CG Family - Circle by the sea – research packs provided for research project. • CG Medicine – supporting Selby HIU MDT & inclusion health education for emergency department staff.
Care Group Champions	• HI champions have been agreed in most Care Groups – Care Group CSCS is outstanding.

9. Key risks

The principal risks to delivery of the patient experience strategy remain as:

- Communication failures affecting patient confidence and satisfaction
- Delays in complaint resolution reducing organisational responsiveness
- Inability to fully meet accessible information requirements pending digital flag functionality.

Plans to mitigate these risks have been developed and are being implemented.

10. Next steps

The programme of work over the next year will align to the Trust's patient experience framework and focus on six key areas to enhance responsiveness, strengthen accountability across Care Groups, and embed a culture of early intervention and learning. These are:

1. **Education**, to equip staff with the confidence and capability and personal accountability to communicate effectively.
2. **Culture and communication**, promoting a Trust-wide shift towards addressing concerns in the moment to prevent escalation and improve patient experience.
3. **Triangulation and prevention**, using themes and insights to drive patient-centred improvements, reduce avoidable harm, and address health inequalities.
4. **Timely resolution**, ensuring that any concerns or complaints that cannot be resolved immediately are managed within policy timescales.

5. **Co-production and stakeholder engagement**, hearing and embedding the voice of patients and carers.
6. **Improving overall patient experience** – enabling holistic care.

Date: 3 August 2026

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	NHS Workforce Race Equality Standard (WRES) Annual Report, 2026
Director Sponsor:	Lydia Larcum, Interim Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Diversity and Inclusion

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 Board is asked to receive the WRES Annual Report 2026, Infographic (Appendix 1) and 2025-2027 Action Plan (Appendix 2) for assurance and approve publication by 31 October 2026. The report covers York and Scarborough Teaching Hospitals NHS Foundation Trust and YTHFM and is a mandated annual reporting requirement. The 2026 data shows improvement across most findings, including increased BME workforce representation, improved disciplinary likelihood, equitable access to CPD, improved staff-to-staff harassment, bullying or abuse, and improved reported discrimination from managers, team leaders or colleagues. Key areas requiring continued focus are appointment from shortlisting, harassment, bullying or abuse from patients, relatives or the public, and Board ethnicity representation, which remains static.

Key Assurances:

Compliance with the NHS Standard Contract reporting requirement; 2026 analysis completed using ESR and 2025 Staff Survey data; positive movement across the majority of findings; the Race Equality Network has been engaged; the 2025-2027 Action Plan continues to be implemented.

Key Risks:

Failure to sustain delivery of the Action Plan could reduce progress and assurance.

Key Concerns:

The relative likelihood of white staff being appointed from shortlisting compared with BME staff has deteriorated and remains outside parity. Continued inequity could affect workforce confidence, recruitment fairness and delivery of improvement commitments. Harassment, bullying or abuse from patients, relatives or the public has deteriorated. Board ethnicity representation remains static.

Next Steps

- Continue to deliver the 2025-2027 WRES Action Plan.
- Publish the annual report and the 2025-2027 Action Plan on the Trust's website by 31 October 2026.
- Utilise the WRES data to inform evidence-based actions to implement the Race and Health Observatory's 7 Anti-racism principles.

Recommendation:

The Board of Directors is asked to: (1) note the WRES Annual Report 2026 and the progress made; (2) receive assurance on continued delivery of the 2025-2027 WRES Action Plan; (3) support targeted action on appointment from shortlisting and harassment, bullying or abuse from patients, relatives or the public; and (4) approve publication of the annual report and Action Plan on the Trust website by 31 October 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**
Resources Committee	22 September 2026	N/A

NHS Workforce Race Equality Standard Annual Report, 2026

1. Introduction and Background

The Workforce Race Equality Standard (WRES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospitals Facilities Management (YTHFM) are required to comply with. This is mandated in the NHS Standard Contract; organisations are required to use this data to develop action plans aimed at improving the experiences of Black and Minority Ethnic (BME) colleagues. This report and action plan is for both organisations.

The WRES covers 9 Indicators/Metrics (used interchangeably) regarding the career progression and work experiences of BME colleagues. The data was collected for the period of 1 April 2025-31 March 2026 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey. Where metric dictates snapshot data, this is as of 31 March 2026. The Staff Survey data is from the 2025 Staff Survey.

Considerations

The terminology used throughout this report reflects the language used by NHS England (NHSE).

The relative likelihood focuses on a figure of 1 being equity of opportunity. The non-adverse range of 0.8-1.25.

Due to changes in the question wording in 2025's Staff Survey, a comparison with previous years' results for Metric 7 cannot be not made.

Summary of Findings

This report provides the results of the Trust's 2026 data analysis, which is in the format of an Infographic found at Appendix 1. It is recommended that Appendix 1 is read in conjunction with the summary report. The co-created 2025-2027 action plan, is at Appendix 2.

The 2026 WRES data shows that:

1. The percentage of BME staff has increased from 17.92% in 2025 to 19.26% in 2026. Growth is consistent across all staff groups.
2. Relative likelihood of white staff being appointed from shortlisting compared to BME staff has seen a slight deterioration in relation to the experience of BME staff. (2.54 in 2025 to 2.60 in 2026). White staff are more than twice as likely to be appointed from shortlisting than BME staff.
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff has slightly improved. (1.30 in 2025 to 1.23 in 2026).

4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff is equitable in relation to the experience of BME staff. (0.77 in 2025 to 0.85).
5. The percentage of BME staff experiencing harassment, bullying, or abuse from patients, relatives or members of the public in the last 12 months has significantly deteriorated. (30.98% in 2025 to 34.06% in 2026).
6. The percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months has significantly improved. (29.75% in 2025 to 24.97%).
7. For Metric 7, 48.12% of BME staff reported that they believe the Trust provides equal opportunities for career progression or promotion. However, due to changes in the Staff Survey question wording in 2025, this result cannot be directly compared with previous years. The 2026 figure should therefore be used as a new baseline, with a meaningful year-on-year comparison available in 2027 once two years of data have been collected using the revised wording.
8. The percentage of BME staff who have personally experienced discrimination at work from manager, team leader or other colleagues has significantly improved. (22.57% in 2025 to 17.17% in 2026).
9. The percentage difference between the organisation's Board voting membership and its organisations overall workforce was -13% in 2025 and is -18% in 2026. The slight increase is due to the number of BME staff in the workplace. It remains that there are no BME voting members on the Board.

Positive improvement across the majority of the WRES findings is evident from this year's analysis. This clearly demonstrates the implementation of the WRES Action Plan is producing positive outcomes for our BME colleagues. However, it is imperative that complacency is avoided as continuous improvement is required to drive sustainability.

2025-2027 WRES Action Plan

An update on the implementation of the 2025-2027 WRES action plan was provided to the Board of Directors in April 2026. The actions continue to be implemented by teams.

An engagement event was held with the Race Equality Network members and wider colleagues on 30 July 2026. Here the progress made with the 2025-2027 action plan was shared along with the above 2026 data. The Lord Mann Review was also discussed.

There was positive discussion in relation to the agenda with specific focus being placed on the metrics that had either deteriorated or where the percentage of colleagues exposed to negative experiences remained high. These were metrics 2 and 5. The two actions within the 2025-2027 plan to address these metrics are yet to be fully implemented.

Attendees felt that progress was being made and suggestions were discussed.

Next Steps

- Continue to deliver the 2025-2027 WRES Action Plan.

- Publish the annual report and the 2025-2027 Action Plan on the Trust's website by 31 October 2026.
- Utilise the WRES data to inform evidence-based actions to implement the Race and Health Observatory's 7 Anti-racism principles.

Date: August 2026

Workforce Race Equality Standard (WRES) Data Analysis 2026

Changes from 2025 to 2026 | Black and Minority Ethnic (BME) and White staff comparison

York and Scarborough Teaching Hospitals NHS Foundation Trust

Introduction

The WRES covers 9 Metrics regarding the career progression and work experiences of BME colleagues. The data is collected for the period of 1 April 2025-31 March 2026 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey.

+ **Metric 1**

Workforce representation

BME staff increased from 17.92% in 2025 to 19.26% in 2026 (+1.34 percentage points). Growth is reported across all staff groups.

Improved representation

! **Metric 2**

Appointment from shortlisting

Relative likelihood of White staff being appointed from shortlisting compared to BME staff deteriorated slightly, from 2.54 in 2025 to 2.60 in 2026.

Slight deterioration

+ **Metric 3**

Formal disciplinary process

Relative likelihood of BME staff entering the formal disciplinary process compared to White staff improved slightly, from 1.30 in 2025 to 1.23 in 2026.

Slight improvement

+ **Metric 4**

Access to non-mandatory training and CPD

Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff is equitable in 2026, moving from 0.77 in 2025 to 0.85.

Equitable in 2026

! **Metric 5**

Harassment, bullying or abuse from patients/public

BME staff experiencing harassment, bullying or abuse from patients, relatives or the public deteriorated from 30.98% in 2025 to 34.06% in 2026 (+3.08pp).

Significant deterioration

+ **Metric 6**

Harassment, bullying or abuse from staff

BME staff experiencing harassment, bullying or abuse from staff improved significantly, from 29.75% in 2025 to 24.97% in 2026 (-4.78pp).

Significant improvement

i **Metric 7**

Career progression or promotion

48.12% of BME staff reported that the Trust provides equal opportunities. Direct comparison is not available because the Staff Survey question wording changed in 2025.

New baseline for 2026

+ **Metric 8**

Discrimination at work

BME staff personally experiencing discrimination at work from manager, team leader or other colleagues improved significantly, from 22.57% in 2025 to 17.17% in 2026 (-5.40pp).

Significant improvement

= **Metric 9**

Board ethnicity representation compared to the overall organisation

In 2025 -13% compared to -18% in 2026.

Relatively Static

Overall message: positive improvement is evident across the majority of the 2026 WRES findings, while continued focus is needed on appointment from shortlisting and harassment, bullying or abuse from patients, relatives or members of the public.

Source: Highlighted Summary of Findings from WRES Annual Report 2026.docx.

Workforce Race Equality Standard Action Plan 2025-2027

APPENDIX 2

Red	Not yet begun
Amber	Begun but not complete
Green	Complete
Blue	New

York and Scarborough Teaching Hospitals NHS Foundation Trust

Objective	Analysis	WRES Action	Executive Director Lead	Operational Lead	Commence Date	High Impact Actions*	RAG Rating
Metric 2 Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts							
Improve the relative likelihood of being appointed from shortlisting from 2.5, to a ratio of 1.	There is a trend of year on year deterioration from 2.33 likelihood in 2024 to 2.54 in 2025.	Breakdown metric data to identify areas where colleague are less likely to be appointed from shortlisting to identify areas of opportunity for improvement. Work with recruiting managers to review shortlisting and interview practice, promoting best practice and explore ways to increase diversity of recruitment panels across the organisation. **(amended from last action plan)**	Director of Workforce and Organisational Development	Deputy Head of Resourcing	Q3 2025-2026	2	
		Implement a process for BME representation on recruitment panels at band 7, expanding to band 8a and upwards in the future.	Director of Workforce and Organisational Development	Deputy Head of Resourcing	Q1 2026-2027	2	
Metric 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months							
Reduce colleagues experiencing harassment, bullying or abuse from patients, relatives and the public to be better than the benchmark average of 28.27%.	The percentage of colleagues receiving unwanted behaviour has increased from 29.4% in 2024 to 30.98% in 2025.	Develop a campaign promoting No Excuse for Abuse internally, within external organisation and communities. E.g. Sending campaign posters to GP surgeries etc, Healthwatch, community groups to raise awareness.	Director of Communications	Communications Team	Q3 2025-2026	6	
		Raise awareness of the Managing Violence and Aggression policy including Exclusion section.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	6	
		Engage with internal stakeholders re colleagues uptake onto enhanced conflict management training.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	6	
		Review Statutory and Mandatory training Conflict Resolution Training against enhanced conflict management model to ensure receive the essential training they need in this field.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	6	
Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months							
Reduce the percentage of people experiencing, harassment, bullying or abuse to better than the benchmark average of 24.78%.	2025 has seen less than 1% decrease in unwanted behaviour since 2024. The current percentage is 29.75%, which is above the benchmark average of 24.78%.	Proactive and timely communication about the Trust values and support available when there is societal unrest and riots.	Director of Communications	Communications Team	Q3 2025-2026	6	
		Management fundamentals training to be delivered to line managers via HR Business partners.	Director of Workforce and Organisational Development	Operational HR Team	Q3 2025-2026	6	
Metric 7 Percentage believing that the Trust provides equal opportunities for career progression or promotion							

Demonstrate equal opportunities for all through promoting career opportunities and promotion. To exceed the benchmark average of 49.70%.	The percentage of colleagues that believe the Trust is an equal opportunity employer has continued to deteriorate year on year. 2025, 40.56% 2024, 42.26% 2023, 43.25%	The Staff Network Chair and Vice Chair have been added to the OD Team's weekly email bulletin, promoting development opportunities.	Director of Workforce and Organisational Development	Race Equality Network	Q4 2025-2026	2	
		Feature BME colleagues (along with other colleagues with protected characteristics) in the new EDI section of Staff Matters, raising awareness promoting good practice and role models, shadowing, acting up, what's it like being in a senior role.	Director of Communications	Communications Team	Q3 2025-2026	2	
		Explore career pathways through BAPIO as a means to increase opportunities for BME colleagues.	Director of Workforce and Organisational Development	Lead for Workforce Planning and Development and Head of Resourcing	Q4 2025-2026	2	
		Provide support to colleagues wishing to further their career within the Trust with information about, and access to, appropriate learning and development opportunities to better prepare individuals for their next steps. Building relationships with the Race Equality Network, targeting marketing through this link.	Director of Workforce and Organisational Development	OD Team	Q3 2025-2026	2	
Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months and Metric 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague							
		Workforce Leads to work with those responsible for local Staff Survey Action plans in triangulating data from Freedom to Speak Up and Anonymous Reporting Tool reporting HBA and discrimination to target interventions at a local level, e.g. awareness training and support.	Director of Workforce and Organisational Development	Workforce Leads Care Group Quad HR Business partners Freedom to Speak Up Guardian	Q4 2025-2026	6	
Metric 8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague.							
Reduce the percentage of people experiencing, discrimination to be better than the benchmark average of 15.72%.	There has been an increase from 22.08% in 2024 to 22.57% 2025.	Staff Survey action plans to include standing action on reducing discrimination in the workplace.	Director of Workforce and Organisational Development	Workforce Leads Care Group Quad	Q4 2025-2026	6	
		Blogs/videos/story telling about the impact of discrimination on colleagues and patient care.	Director of Workforce and Organisational Development	EDI Team	Q4 2025-2026	6	
		Promote best practice in the line manager training, which is aligned with the NHS Management & Leadership Framework & Curriculum (launch November 2025)	Director of Workforce and Organisational Development	OD Team Operational HR	Q3 2025-2026	6	

		Continue promotion of the anonymous reporting tool through the No Excuse For Abuse Campaign, to increase awareness of the tool and appropriate reporting of incidents.	Director of Communications	Head of Employee Relations Communications Team	Q3 2025-2026	6	
		Civility and Respect policy to be reviewed and republished.	Director of Workforce and Organisational Development	Head of Employee Rela	Q4 2025-2026	6	
		EDI is a feature of, and best practices embedded into, all Trust internal management and leadership programmes and aligned with the NHS Management & Leadership Framework & Curriculum (launch November 2025)	Director of Workforce and Organisational Development	OD team	Q3 2025-2026	6	
Metric 9 BME Board members – Percentage difference between the organisation's Board voting membership and its overall workforce							
Increase the number of ethnically diverse Board members to be more reflective of the organisation.	The % difference in 2025 is -18%. (There are no BME Board members).	Applications for Non-Executive Director appointments encouraged from a visibly diverse background. (Carried forward from last action plan).	Associate Director of Corporate Governance	Associate Director of Corporate Governance	Q3 2025-2026	2	
All Metrics							
To improve the employment experiences of our BME colleagues. (A Trust Equality Objective)	The majority of the metrics show a deterioration in the workplace experiences and career progression of BME colleagues.	Implement the Race and Health Observatory's 7 Anti-Racism Principles as a strategic framework: 1. Demonstrate leadership by naming racism 2.Understand and acknowledge 3. Meaningfully involve racially minoritised individuals and communities 4. Collect and publish data 5. Identify racial bias 6. Apply a race critical lens 7. Evaluate and reflect.	Chief Executive	Anti-Racism Steering Group	Q3 2025-2026	1-6	
		Update the Trust's Anti-Racism Statement to cover Anti-Semitism.	Director of Communications	Anti-Racism Steering Group	Q3 2025-2026	6	

*** High Impact Actions**

1, Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

2, Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

3, Develop and implement an improvement plan to eliminate pay gaps

4, Develop and implement an improvement plan to address health inequalities within the workforce.

5, Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

6, Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Author: Head of Equality, Diversity and Inclusion
Senior Responsible Officer: Director of Workforce and Organisation Development
Publish and Submission Date: 31st November 2025
Note: BME staff were engaged with via a staff network meeting. These actions are designed to address the Workforce Race Equality Standard.
Where an action has been given a Green RAG rating to indicate complete, the action, where necessary, will be continuously implemented.

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	NHS Workforce Disability Equality Standard (WDES) Annual Report, 2026
Director Sponsor:	Lydia Larcum, Interim Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Diversity and Inclusion

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 Board is asked to receive the WDES Annual Report 2026, Infographic (Appendix 1) and the 2025-2027 Action Plan (Appendix 2) for assurance and approve publication by 31 October 2026. The report covers York and Scarborough Teaching Hospitals NHS Foundation Trust and YTHFM and is a mandated annual reporting requirement. The 2026 data shows positive progress across most metrics, including increased disability declaration, improved appointment from shortlisting, improved formal capability likelihood and improved staff engagement. Areas requiring continued focus are harassment, bullying or abuse from patients, reduced satisfaction with the extent to

which the organisation values disabled staff, and a deterioration in reported adequate adjustments.

Key Assurances:

Compliance with the NHS Standard Contract reporting requirement; 2026 analysis completed using ESR and 2025 Staff Survey data; most metrics show improvement; active Enable Staff Network and governance routes support colleague voice; the 2025-2027 Action Plan continues to be implemented.

Key Risks:

Failure to sustain delivery of the Action Plan could reduce progress and assurance.

Key Concerns:

Deterioration in reasonable adjustments, staff feeling valued and harassment, bullying or abuse from patients remaining high and has deteriorated slightly. This could affect colleague experience, retention and confidence.

Next Steps

- Continue to deliver the 2025-2027 WDES Action Plan
- Publish the annual report on the Trust's website by 31 October 2026

Recommendation:
The Board of Directors is asked to: (1) note the WDES Annual Report 2026 and the progress made; (2) receive assurance on continued delivery of the 2025-2027 WDES Action Plan; (3) support targeted action on worsened metrics; and (4) approve publication of the annual report on the Trust's website by 31 October 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
Resources Committee	22 September 2026	N/A

NHS Workforce Disability Equality Standard Annual Report, 2026

1. Introduction and Background

The Workforce Disability Equality Standard (WDES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospitals Facilities Management (YTHFM) are required to comply with. This is mandated in the NHS Standard Contract; organisations are required to use this data to develop action plans aimed at improving the experiences of Disabled colleagues. This report and action plan is for both organisations.

The WDES covers 10 Indicators/Metrics (used interchangeably) regarding the career progression and work experiences of disabled colleagues. The data is collected for the period of 1 April 2025-31 March 2026 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey. Where metric dictates snapshot data, this is as of 31 March 2026. The Staff Survey data is from the 2025 Staff Survey.

Considerations

The terminology used throughout this report reflects the language used by NHS England (NHSE).

The relative likelihood focuses on a figure of 1 being equity of opportunity. The non-adverse range of 0.8-1.25.

Due to changes in the question wording in 2025's Staff Survey, a comparison with previous years' results for metric 5 cannot be not made.

Summary of Findings

This report provides the results of the Trust's 2026 data analysis, which is in the format of an Infographic found at Appendix 1. It is recommended that Appendix 1 is read in conjunction with the summary report. The co-created 2025-2027 action plan, is at Appendix 2.

The 2026 WDES shows that:

1. There has been a positive increase in the percentage of disabled staff across the organisation (from 5.08% in 2025 to 6.33% in 2026). Growth is consistent across all staff groups, which in 2026 also includes Medical and Dental staff.

2. There continues to be an improvement in the relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting (1.03 in 2025 to 0.92 in 2026). This equates to parity for disabled staff.

3. There is no inequity in the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure (2.05 in 2025 to 1.01 in 2026). This shows significant improvement for disabled staff.

4. Harassment, bullying or abuse (HBA) from patients, relatives or the public continues to deteriorate (27.93% in 2025 to 28.18% in 2026. It has significantly improved from Mangers (16.28% in 2025 to 12.40% in 2026) and there has been a slight improvement from colleagues (25.87% in 2025 and 24.56% in 2026). Reporting of (HBA) by disabled staff and their colleagues has slightly improved (48.90% in 2025 to 49.76% in 2026).

5. For Metric 5, 47.41% of disabled staff reported that they believe the Trust provides equal opportunities for career progression or promotion. However, due to changes in the Staff Survey question wording in 2025, this result cannot be directly compared with previous years. The 2026 figure should therefore be used as a new baseline, with a meaningful year-on-year comparison available in 2027 once two years of data have been collected using the revised wording.

6. There continues to be an improvement in the percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. (25.14% in 2025 to 22.08% in 2026). 2026 has seen a significant improvement.

7. There has been a slight deterioration in the percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. (32.57% in 2025 to 31.72%). It is important to acknowledge that in 2024 there was over a 2% increase, which was positive.

8. The previous year saw almost a 3% improvement in the percentage of disabled staff saying that their employer had made adequate adjustment(s) to enable them to carry out their work. However, there has been a deterioration in 2026. (79.05% in 2025 to 76.81% in 2026).

9. There has been a slight improvement in the staff engagement score comparison between disabled staff and non-disabled staff. (5.97 in 2025 to 6.11 in 2026).

9b. This metric asks if the organisations has taken action to facilitate the voices of disabled staff to be heard. The Trust answered yes to this as there is an active Staff Network, representatives from the network attend and update the EDI Workstream and Inclusion Forum. The Committee works closely with their Executive Director Sponsor and network members attend the Equality Delivery System 2022 engagement events.

10. The percentage difference between the organisation's Board voting membership and its organisation's overall workforce was -5% in 2025 and is now 0% in 2026, which is an improvement. The improvement is due to the increase in the number of disabled staff in the workplace. It remains that there are no disabled voting members on the Board.

There has been a notable improvement in the experiences of disabled staff across the majority of the metrics, for example; harassment, bullying and abuse from managers and colleagues, pressure to work when unwell and capability. This could possibly be attributed to the actions implemented, (i.e. No Excuse for Abuse Campaign and Management Fundamentals training. Continuous implementation of the Action Plan at a Trust and local level is required to promote sustainability.

2025-2027 WDES Action Plan

An update on the implementation of the 2025-2027 WDES action plan was provided to the Board of Directors in April 2026. The actions continue to be implemented by teams.

An engagement event was held with the Enable Staff Network members and wider colleagues on 19 August 2026. Here the progress made with the 2025-2027 action plan was shared along with the above 2026 data.

There was a positive discussion in relation to the progress being made with agenda and the deteriorated Metrics, 4a, 7 and 8 were also discussed. Attendees raised concerns around reasonable adjustments not being implemented and the lack of support from managers.

Next Steps

- Continue to deliver the 2025-2027 WDES Action Plan
- Publish the annual report on the Trust's website by 31 October 2026

Date: August 2026

Workforce Disability Equality Standard (WDES) Data Analysis 2026

Changes from 2025 to 2026 | Disabled and non-disabled staff comparison

York and Scarborough Teaching Hospitals NHS Foundation Trust

Introduction

The WDES covers 10 Metrics regarding the career progression and work experiences of disabled colleagues. The data is collected for the period of 1 April 2025-31 March 2026 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey.

Metric 1

Workforce representation

Disabled staff increased from 5.08% in 2025 to 6.33% in 2026 (+1.25 percentage points). Growth is reported across all staff groups, including Medical and Dental staff.

Improved representation

Metric 2

Appointment from shortlisting

Relative likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff improved from 1.03 in 2025 to 0.92 in 2026.

Improved/parity

Metric 3

Formal capability process

Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff improved, from 2.05 in 2025 to 1.01 in 2026.

Improvement

Metric 4

Harassment, bullying or abuse

From patients: 27.93% to 28.18% (+0.25pp, deteriorated). From managers: 16.28% to 12.40% (-3.88pp). From colleagues: 25.87% to 24.56% (-1.31pp). Reporting: 48.90% to 49.76% (+0.86pp).

Mixed picture

Metric 5

Career progression or promotion

47.41% of disabled staff reported that the Trust provides equal opportunities. Direct comparison is unavailable because the Staff Survey question wording changed in 2025.

New baseline for 2026

Metric 6

Pressure to work when unwell

Disabled staff reporting pressure from their manager to attend work when not well enough improved from 25.14% in 2025 to 22.08% in 2026 (-3.06pp).

Significant improvement

Metric 7

Feeling valued at work

Satisfaction with the extent to which the organisation values staff's work reduced from 32.57% in 2025 to 31.72% in 2026 (-0.85pp).

Slight deterioration

Metric 8

Reasonable adjustments

Disabled staff saying adequate adjustments had been made reduced from 79.05% in 2025 to 76.81% in 2026 (-2.24pp).

Slight deterioration

Metric 9a

Staff engagement

Staff engagement score comparison improved from 5.97 in 2025 to 6.11 in 2026 (+0.14)

Slight Improvement

Metric 9b

Action to hear the voices off disabled staff

- Engagement with the Enable Staff Network
- EDI Workstream meetings
- Inclusion Forum
- Equality Delivery System engagement events

Metric 10

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce. -5% in 2025 to 0% in 2026

Improvement

Overall message: In 2026 WDES shows notable improvement across the majority of metrics, while continued focus is needed on harassment from patients, feeling valued at work and timely reasonable adjustments.

Source: Highlighted Summary of Findings from WDES Annual Report 2026.docx.

Workforce Disability Equality Standard Action Plan 2025-2027

APPENDIX 2

York and Scarborough Teaching Hospitals NHS Foundation Trust

Red	Not yet begun
Amber	Begun but not complete
Green	Complete
Blue	New

Objective	Analysis	WDES Action	Executive Lead	Operational Lead	Commence Date	High Impact Actions*	RAG Rating
Metric 1 Staff in AfC pay bands or medical and dental subgroups and very senior managers (Including Executive Board members) compared with the % of staff in the overall workforce							
Encourage colleagues to update their equality monitoring information to help determine who is in the workforce. Continue to increase declaration rates above the regional average of 5.9%.	The number of disabled colleagues in the Trust has increased from 4.86% in 2024 to 5.08% in 2025. Representation across the Trust is equitable, this action is to reduce the % of those 'not stated', which is 11.45%.	The Enable Staff Network will implement actions to encourage members and colleagues within the Trust to share their equality monitoring information.	Executive Sponsor of Enable Staff Network	Enable Staff Network	Q4 2025-2026		
Metric 3 Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure							
Ensure there is equity in the application of the Capability Procedure. Reduce to a likelihood of 1.	The likelihood has increased since 2024 and now shows inequality. 1.13 in 2024 to 2.05 in 2025.	Roll out Management Fundamentals training for all line managers. **(Training offer will be ongoing.)**	Director of Workforce and Organisational Development	Head of Employee Relations	Q3 2025-2026		
		Review number of colleagues who receive support through the Performance Improvement Policy to establish whether there is a higher number of colleagues with a disability. If a higher number is established review processes for consistency and equity.	Director of Workforce and Organisational Development	Head of Employee Relations	Q4 2025-2026		
Metric 4a Percentage of staff experiencing harassment, bullying or abuse from patient/service users, their relatives or other members of the public in the last 12 months							
Reduce the percentage of colleagues experiencing harassment, bullying and abuse (HRA) from patients, relatives and the public by 3%.	HBA has deteriorated for 2025, 27.93% up from 25.13% in 2024.	Develop a campaign promoting No Excuse for Abuse internally, within external organisation and communities. E.g. Sending campaign posters to G.P. surgeries etc, healthwatch, community groups to raise awareness.	Director of Communications	Communications Team	Q3 2025-2026	6	
		Raise awareness of the Managing Violence and Aggression policy including the Exclusion section.	Chief Nurse Director of Communications	Darren Miller Communications Team	Q4 2025-2026	6	
		Triangulate information captured through the Staff Survey with information on Datix to determine the level of reporting.	Chief Nurse Director of Patient Safety	Darren Miller Patient Safety Team	Q4 2025-2026	6	
Metric 4b Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months							

Reduce the percentage of colleagues experiencing Harassment, Bullying and Abuse from managers to be better than the benchmark average (currently 15.10%.)	This has deteriorated from 15.40% in 2024 to 16.28% in 2025.	Workforce Leads to work with those responsible for local Staff Survey Action plans in triangulating data from Freedom to Speak Up and Anonymous Reporting Tool reporting HBA and discrimination. To then target interventions at a local level, e.g. awareness training and support.	Director of Workforce and Organisational Development	Workforce Leads Care Group Director Associate Chief Operating Officers Head of Employee Relations Freedom to Speak Up Guardian	Q2 2026-2027	6	
Metric 4d Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months							
Increase the percentage of disabled colleagues and colleagues reporting Harassment, Bullying and Abuse to better than the benchmark average (currently 51.82%)	There has been a deterioration since 2024, 54.99% to 48.90% in 2025.	Continue promotion of the anonymous reporting tool through the No Excuse For Abuse Campaign, to increase awareness of the tool and appropriate reporting of incidents.	Director of Communications	Head of Employee Relations Communications Team	Q3 2025-2026	6	
		Civility and Respect policy to be reviewed.	Director of Workforce and Organisational Development	Head of Employee Relations Communications Team	Q4 2025-2026	6	
Metric 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion							
Promote disabled colleagues as role models within the organisation to inspire other colleagues.	This metric continues to see a year on year deterioration. In 2024 it was 50.15% compared to 2025, 48.10%.	Feature Disabled colleagues (along with other colleagues with protected characteristics) in the new EDI section of Staff Matters, raising awareness promoting good practice and role models, shadowing, acting up, what's it like being in a senior role.	Director of Communications	Communications Team	Q3 2025-2026	2	
		Promote development opportunities to support career progression.	Director of Workforce and Organisational Development	OD Team	Q3 2025-2026	2	

*** High Impact Actions**

1, Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	3, Develop and implement an improvement plan to eliminate pay gaps	5, Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.
2, Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	4, Develop and implement an improvement plan to address health inequalities within the workforce.	6, Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Author: Head of Equality, Diversity and Inclusion
Senior Responsible Officer: Director of Workforce and Organisation Development
Publish and Submission Date: 30th November 2025
Note: BME staff were engaged with via a staff network meeting. These actions are designed to address the Workforce Race Equality Standard.
Where an action has been given a Green RAG rating to indicate complete, the action, where necessary, will be continuously implemented.

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	Premises Assurance Model – 2025/2026
Director Sponsor:	Chris Norman, Managing Director
Author:	Rob Barker, Head of Information and Governance Darren Neale, Compliance and Performance 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 2025/26 assessment covers 48 NHS Premises Assurance Model Self-Assessment Questions. Twelve SAQs (25%) were reported as fully compliant, while 36 (75%) identified one or more gaps requiring costed action plans. These proportions describe the number of SAQs in each category and do not represent an overall percentage compliance score. The assessment therefore provides a baseline position rather than complete assurance across all premises-related requirements.

The costed action plans total £3,393,552, comprising

- £1,675,000 capital
- £1,718,552 revenue.

The lowest reported SAQ compliance relates to safety reporting and actioning safety alerts at 0%, followed by estates and facilities vision and strategy at 8%. These results represent a material assurance concern but do not, in isolation, establish the level of operational or regulatory risk. The management team will validate the underlying responses and evidence, assess the significance of each gap, assign accountable leads and timescales, and escalate any immediate or significant risk through the Trust's established risk management and governance arrangements.

Recommendation:
The meeting is asked to note the 2025/26 Premises Assurance Model position and associated costed action plans; acknowledge that the submission provides a baseline rather than complete assurance across all areas; and endorse the proposed 2026/27 governance arrangements, including validation of low-scoring SAQs, named accountability, quarterly exception reporting and oversight of delivery against costed action plans. Endorsement of the action plans does not constitute approval of the associated capital or revenue expenditure, which remains subject to the Trust's established prioritisation and approval processes.

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
Executive Performance Assurance Meeting	6th October 2026	Noted

Premises Assurance Model 2025 – 2026

1. Introduction and Background

The Premises Assurance Model (PAM) is a mandatory self-assessment management tool developed by NHS England to provide a nationally consistent approach for assessing the performance and safety of healthcare premises.

The NHS PAM Self-Assessment Questions are organised across safety, estates competency, patient experience and finance, with additional sections covering helipads where applicable, the Facilities Management standard maturity framework and organisational contacts

- Safety (hard and soft)
- Helipads (where applicable)
- Estates competency
- Patient experience
- Finance
- FM standard maturity framework
- Contacts

Each SAQ is supported by a series of prompt questions. Responses to those prompts generate the reported percentage for the individual SAQ and contribute to the relevant domain-level position. The resulting percentages should be interpreted alongside the underlying evidence, the significance of any unmet requirement and the associated action plan, rather than treated as a standalone measure of premises safety.

2. Considerations

A new format which includes new sub questions forms part of this year's annual return. As part of the national review undertaken by the NHS PAM user group, changes were made in January 2026, with a new format and new SAQs being added this year. The national NHS PAM user group coordinates with NHS England and brings together estates, facilities and compliance experts from various NHS Trusts to share best practices, discuss data standards and review updates to the self-assessment framework. Direct comparison with prior-year scores must therefore be treated with caution where question wording, scope or scoring methodology has changed. Where no prior-year comparator exists, the reported result will be treated as a baseline and supported by an evidence review and improvement plan where required.

Year-on-year movements will be validated at SAQ level before they are used as evidence of improved or reduced compliance. Delivery of PAM compliance depends on coordinated input from YTHFM and relevant Trust services. Shared responsibilities will be documented for each applicable SAQ, with a named accountable lead, evidence owner and escalation route to prevent gaps arising between organisational boundaries.

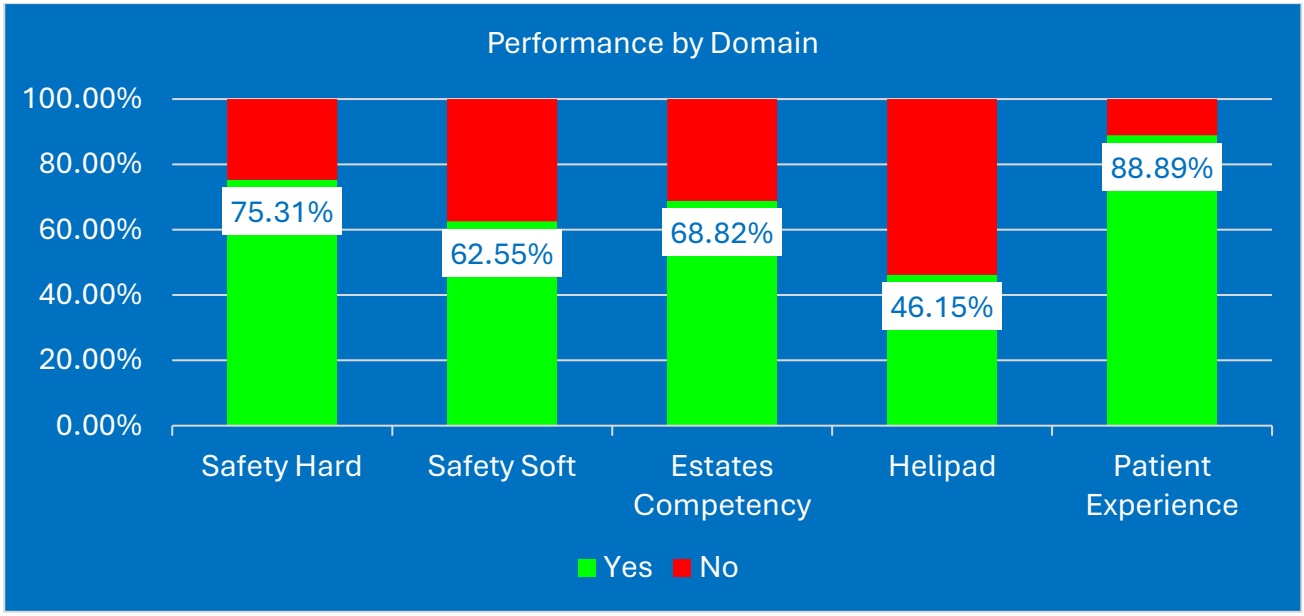
Relevant NHS England guidance and available regional partnership arrangements will be used to validate interpretation, support benchmarking and identify good practice. External comparison will supplement, but not replace, internal ownership and assurance of the submitted position.

3. Current Position

3.1 Overall SAQ Compliance

Figure 1 presents the reported proportion of compliant responses within each applicable PAM domain. Patient experience records the highest reported domain result and helipads the lowest. Domain-level percentages should be read alongside the individual SAQ results and supporting evidence, as a higher aggregate result may still contain significant gaps. Appendix 1 (available on request) contains the full SAQ response (available on request).

Figure 1



3.2 Compliant Areas (=100%)

The fully compliant areas include premises design and use, document management, health and safety, medical gas, radon gas, transport services and performance management. It also lists capital procurement efficiencies, access to professional estates and facilities advice, service perceptions, travel access and Public Switchboard Telephone Network (PSTN).

3.3 Area's reporting <=50% compliance

Although it is recognised that 12 areas reported as being fully compliant with the SAQ, of the remaining 36, 8 SAQs reported as being equal to or less than 50% compliant, these are reflected in Table 1.

Table 1

SAQ & Descriptor	Reported compliance (SAQs)
SH18 – Safety reporting and actioning safety alerts	0.00% (2)
C6 – Estates and facilities vision and strategy	8.00% (9)
SH21 – Reducing harm associated with ligature risks	22.00% (6)
SS3 – Cleanliness and infection control	31.00% (32)
C11 – Estates and facilities leadership and culture	45.00% (7)
H1 – Helipads	46.15% (7)
SH19 – Safety and suitability of externally provided Hard FM services	50.00% (4)

P1 – Engagement with service users, the public and staff	50.00% (4)

3.4 Costed Action Plans

Costed Action Plans are required for all SAQs where any non-compliances are identified. Unlike the scoring, the overall costs can be reflected against previous submissions. They are comprised of two categories associated to the domains as demonstrated in Table 2.

Table 2

Domain	Capital	Revenue	Combined
Safety Hard	£1,080,000	£1,133,776	£2,213,776
Safety Soft	£20,000	£584,776	£604,776
Estates Competency	£575,000	£0	£575,000
Helipads	£0	£0	£0
Patient Experience	£0	£0	£0
Total	**£1,675,000**	**£1,718,552**	**£3,393,552**

The total value of costed action plans is £3,393,552, a net increase of £433,000 compared with the 2024/25 total. This comprises a £694,000 increase in estimated revenue requirements and a £261,000 reduction in estimated capital requirements. The comparison reflects changes in the recorded cost of addressing identified gaps and should not be interpreted as approved expenditure or a direct measure of deterioration in compliance. Appendix 2 (available on request) contains the detailed costed action plan.

4. Summary

The 2025/26 Premises Assurance Model was completed within the required timescales set by NHS England and provides a clear baseline for strengthening our assurance moving forward. The assessment identified twelve fully compliant SAQs, with the remaining thirty-six supported by costed action plans. It also highlighted established areas of compliance, alongside priority areas requiring further improvement and management oversight.

During 2026/27, the assurance process will be strengthened through clearer ownership and accountability, regular reviewing and reporting, improved evidence management, and closer monitoring of costed action plans. These arrangements will support earlier identification and escalation of issues, enable progress to be monitored throughout the year, and improve the quality and timeliness of the next PAM assessment and its approval through the relevant governance route.

5. Forward Plan and Assurance Arrangements

Whilst the 2025/26 NHS Premises Assurance Model submission was completed within required timescales, several opportunities have been identified to strengthen governance, ownership, evidence management and organisational oversight. The following actions will be implemented during 2026/27 to support a more proactive assurance process, improve the quality of submissions and facilitate formal Board approval ahead of future submissions.

Any SAQ gap indicating an immediate or significant risk to patient, staff, operational or regulatory safety will be assessed promptly through the Trust risk management framework. Where the relevant threshold is met, the risk will be entered or updated on the appropriate risk register, assigned to a named risk owner and escalated in

accordance with the Trust's established risk escalation arrangements. PAM action plans will reference the associated risk entry to maintain a clear audit trail between the assurance gap, mitigating action and residual risk.

5.1 Governance and reporting

- Establish a formal quarterly Premises Assurance Model review cycle
- Monitor costed action plans through YTHFM Risk, Health & Safety & Quality Group
- Introduce quarterly exception and escalation reporting through the appropriate governance structure, including YTHFM Management Group, Executive Performance Assurance Meeting (EPAM), Executive Committee, Resources Committee and Board of Directors as required.
- Develop an annual timetable to support Board review and approval prior to submission.
- Quarterly exception reporting will identify overdue actions, actions without an accountable owner or confirmed funding route, material changes in cost or delivery timescale, deterioration in compliance, insufficient or expired evidence, and any new or increasing risk requiring escalation. Reports will set out the issue, impact, mitigating action, accountable owner, revised completion date and decision required from the receiving group or committee.

5.2 Ownership and accountability

- Define and maintain a register of designated leads for each applicable question set, including both YTHFM and Trust colleagues where responsibilities are shared.
- Clearly identify accountable officers for improvement actions and evidence provision.
- Strengthen monitoring arrangements to ensure actions are reviewed and progressed throughout the year. Each action plan will record the relevant SAQ and prompt question, the identified gap, the required action, accountable owner, delivery lead, target date, funding source, dependencies, current status, evidence required for closure and the residual risk where delivery is delayed or incomplete. Actions will only be closed after the supporting evidence has been reviewed and the revised compliance position has been confirmed.

5.3 Evidence and Assurance Management

- Develop a supporting guidance framework document to improve consistency of scoring and evidence requirements.
- Review and strengthen evidence repositories, including the use of hyperlinks and direct links to source systems where appropriate, to ensure evidence remains current and auditable.
- Establish a consistent and coordinated approach to the management of assurance evidence.

5.4 Performance Improvement and Benchmarking

- Undertake benchmarking against comparable organisations, local peers and high-performing trusts to identify good practice and opportunities for improvement.
- Explore opportunities for regional collaboration groups to share best practice and process.

- Identify priority domains and questions where score improvements can be achieved through process, governance or operational changes.
- Develop targeted improvement plans for low-scoring areas.

5.5 Financial Planning and Investment

- Review and validate all costed action plans associated with areas of non-compliance.
- Differentiate actions that can be delivered through existing resources from those requiring revenue or capital investment.
- Use outputs to support future business cases and investment prioritisation.
- The inclusion of an action within the costed action plans identifies the estimated resource required to address the recorded gap; it does not constitute approval of expenditure or confirmation that funding is available. Actions requiring investment will be subject to validation, prioritisation and the Trust's established capital, revenue and business case approval processes. Where funding is not secured, the accountable owner will record the resulting delivery impact, interim controls and residual risk for escalation through the appropriate governance route.
- Costed actions will be prioritised according to safety and regulatory significance, risk, mandatory timescales, effectiveness of existing controls, deliverability and affordability, with the rationale for the assigned priority recorded.

5.6 Collaborative Delivery

- Establish a multidisciplinary working group to coordinate activity, monitor progress and provide oversight of improvement actions throughout the year.

6. Recommendation

The Resources Committee is asked to

1. Note the findings of the 2025/26 Premises Assurance Model assessment and associated costed action plans;
2. Note the areas of established compliance and the opportunities identified for further improvement;
3. Note the 2025/26 submission provides a baseline assessment of compliance and assurance on the evidence available at the time of the submission and should not be regarded as providing complete assurance across all areas if the estate and facilities compliance, and
4. Support the proposed assurance arrangements for 2026/27, including strengthened ownership, regular monitoring and reporting, improved evidence management, and oversight of progress against the costed action plans.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 23

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	2026/27 Q2 Board Assurance Framework
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

☒ 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 report provides the revised 2026/27 Q2 Board Assurance Framework (BAF) with all updates provided in red text. No risk ratings have changed since the previous report.

Following the Well-Led Developmental Review and the Trust's increased focus on strengthening the Board Assurance Framework (BAF), a revised BAF template has been developed which introduces a formal assurance opinion for each strategic risk. The Lead Assurance Committee will be responsible for scrutinising the available evidence,

challenging the Executive Director's assessment, agreeing an assurance rating, and escalating concerns where assurance is deteriorating.

The assurance ratings are:

- Substantial Assurance – Strong evidence that controls are effective and objectives are likely to be achieved.
- Moderate Assurance – Controls are largely effective, although some material gaps or uncertainties remain.
- Limited Assurance – Significant weaknesses or assurance gaps exist that may prevent achievement of the objective.
- No Assurance – Insufficient confidence in the effectiveness of controls or the availability of reliable assurance.

Further guidance is provided at Appendix 1. During 2026/27, strategic risks will be subject to periodic Committee review and deep-dive scrutiny as required, with an assurance opinion provided to support Board oversight of the Trust's principal risks.

The assurance opinion following discussion with respective Committee members has been provided as follows for Q1:

- PR1 - Clinical Pathways & Quality of Care *(moderate)*
- PR2 - People, Culture and Capability *(moderate)*
- PR3 - Partnerships and System Working *(limited)*
- PR4 - Transformation, Innovation and Service Redesign *(limited)*
- PR5 - Sustainability, Estate and Infrastructure Resilience *(limited)*
- PR6 - Financial Sustainability *(limited)*
- PR7 - Governance, Leadership and Assurance Effectiveness *(moderate)*

Mitigating actions are in place to improve both the risk ratings and assurance opinions over the remainder of 2026/27.

Recommendation:
The Board of Directors is asked to approve the 2026/27 Q2 Board Assurance Framework noting the Committee assurance opinions for Q1.

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

Meeting/Engagement	Date	Outcome/Recommendation
Executive Director Updates	Q2 2026/27	Risks reviewed and updated

Appendix 1
Committee Assurance Definitions

Assurance Rating	Definition	Typical Characteristics
Substantial Assurance	The Committee is satisfied that controls are appropriately designed, operating effectively and supported by sufficient, reliable evidence. Any identified gaps are minor and are unlikely to prevent achievement of the strategic objective.	• Controls embedded and operating consistently • Positive performance trajectory • Strong assurance evidence from multiple sources • Few or no significant gaps • Risk managed within or close to appetite
Moderate Assurance	The Committee is satisfied that key controls are generally operating effectively; however, there are some material gaps, weaknesses or uncertainties that require continued management attention. These do not currently indicate a failure of control but could do so if not addressed.	• Majority of controls effective • Some adverse trends or emerging concerns • Action plans in place to address gaps • Mixed assurance evidence • May remain outside appetite despite controls operating appropriately
Limited Assurance	The Committee has significant concerns regarding the adequacy of controls, the effectiveness of mitigating actions, or the availability of reliable assurance evidence. There is a material risk that the strategic objective may not be achieved without additional intervention.	• Significant control weaknesses • Repeated slippage of actions • Incomplete or weak assurance evidence • Deteriorating performance indicators • Risk materially outside appetite
No Assurance	The Committee is unable to obtain sufficient evidence that effective controls are in place or operating. There are fundamental weaknesses in control, governance or assurance arrangements, creating a serious risk to achievement of the strategic objective	• Major control failures • Absence of credible assurance evidence • Serious regulatory, quality, financial or governance concerns • Immediate Board oversight and intervention required

PR1 – Clinical Pathways and Quality of Care

Principal risk statement

Failure to deliver consistently safe, effective and timely clinical pathways, resulting in avoidable harm, poor patient outcomes and experience, regulatory intervention and failure to achieve the Trust strategy.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 1	Chief Nurse	Quality Committee, with Resources Committee for flow and capacity dependencies	Quality of Care / Operational Performance	Low (1-6)	25 (5x5)	16 (4x4)	12 (4x3)	Out of appetite

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Fragile clinical services and workforce constraints in key specialties. • Sustained urgent and emergency care pressure, poor patient flow and bed capacity constraints, care on corridors. • Inconsistent fundamentals of care, infection prevention and control, documentation and assessment standards. • Variation in response to deteriorating patients and delayed escalation. • Clinical estate and digital dependencies affecting pathway reliability. • Reduction in effective clinical leadership	• Patient harm, poor experience and deterioration in clinical outcomes. • CQC/NHSE regulatory attention and/or conditions. • Increased complaints, incidents and avoidable variation in standards. • Staff stress, moral injury and reduced confidence in safety systems. • Reduction in public confidence

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Trust Priorities Report with clinical quality, safety and access metrics. • PRIM process for Care Group performance review across quality, operations, finance and workforce. • Patient Safety Incident Response Framework and Quality & Safety Group daily and weekly oversight. • UEC, elective recovery, maternity, IPC and deteriorating patient improvement programmes. • Clinical governance sub-groups with escalation to Quality Committee and Board. • Clinical Leadership Development programme in place for new and senior clinical leaders • Quality Management and Continuous Quality Improvement program in early stages of roll out.	• Quality Committee escalation reports to Board. • CQC inspection intelligence and action plan monitoring. • Internal audit, clinical audit and patient safety learning reports. • TPR performance trajectories and improvement plan updates. • Patient and staff feedback, complaints, incidents and claims triangulation. • Embedding of Ward Accreditation programme – pilot Nov 2026 and rollout January 2027 across the organisation	• Sustained pressure in ED and patient flow remains a high-rated operational risk. • Further consistency required in ward-to-Board assurance and evidence of embedded improvement as part of the QMS/CQI approach. • Clinical strategy and clinical estate dependencies require continued progression. • Patients cared for on corridors in ED and across the inpatient adult wards (operational risk-ID530) • Revised Integrated Accountability Framework to be approved and rolled out.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Complete clinical strategy and align quality, estates, digital and workforce dependencies as part of our Quality Management System.	Chief Nurse / Medical Director	~~Q2-Q3 2026/27~~ Q3-Q4 2026/27	Completed clinical strategy in place and aligned strategies
Strengthen assurance on deteriorating patient, IPC and documentation through thematic deep dives.	Chief Nurse	~~Q2 2026/27~~ Quarterly	Expected evidence from deep dives, including identified learning and improvement actions reporting to Patient Safety and Clinical Effectiveness Subcommittee.
Continue focused programme to reduce corridor care and improve flow, with clear escalation thresholds.	Chief Operating Officer / Chief Nurse	~~Quarterly~~ Monthly	~~Quarterly~~ Monthly report as evidence to Executive Committee including performance data
Focus on eradication of corridor care across the Trust	Chief Nurse	~~Q2 2026/27~~ Completed	Delivery Board Terms of Reference approved by July Executive Committee. Implementation of Workstreams. Workstreams continue – 5 identified with Key Leads and highlight reports

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Quarter	**Q1 2026/27**		**Q2 2026/27**		**Q3 2026/27**		**Q4 2026/27**	
Current risk rating	**16 (4x4)**		**16 (4x4)**		To update		To update	
Assurance rating	**Moderate**		To update		To update		To update	

PR2 – People, Culture and Capability

Principal risk statement

Failure to recruit, retain, develop and support a skilled, engaged and healthy workforce, leading to reduced service resilience, poorer staff experience and compromised delivery of safe, effective care.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 2	Interim Director of Workforce and Organisational Development	Resources Committee	People	**High (10-12)**	**20 (4x5)**	**16 (4x4)**	**12 (4x3)**	**Above appetite / monitor against agreed tolerance**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Recruitment and retention pressures in clinical and specialist roles. • Sickness absence, wellbeing pressures and staff fatigue. • Inconsistent appraisal, mandatory training and leadership development. • Cultural issues resulting in inconsistent experience for colleagues. • Insufficient capacity for transformation and improvement alongside operational demands.	• Reduced service resilience and increased reliance on temporary staffing. • Reduced staff engagement, morale and retention. • Impact on quality, productivity, performance and financial sustainability. • Weaker leadership capability and governance follow-through.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• People Strategy 2025-2030 and workforce plans. • Workforce performance reporting through TPR and Resources Committee • Mandatory training, appraisal and leadership development programmes. • Cultural reform programmes e.g. Big Conversation and Continuous QI • Freedom to Speak Up, staff engagement and staff network arrangements. • Care Group PRIM reviews including workforce metrics.	• Resources Committee workforce reports and Board escalation. • Staff survey, pulse survey, FTSU and people metrics. • Medical staffing, appraisal and training compliance reports. • Internal audit, external review and Well-Led action reporting. • Sickness and Employee Relations metrics	• Leadership development and consistency of line management capability require sustained focus. • Consistent agreement of, and sign up to, organisational values require concentrated effort. • Prioritization of Employee Relations and sickness support processes.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Leadership appraisals including 360 feedback Big Conversation: values and behavioural framework	Interim Director of Workforce and OD	Q2 2026/27	Appraisal data, Values and behaviour framework – all now available
Refreshed values and behavioural framework	Interim Director of Workforce and OD	Q2-Q3 2026/27	Values and behaviour framework
Integrated Accountability Framework	Chief Executive	Q3-Q4 2026/27	Expected evidence to be added before closure
Revision of leadership programmes and training to complement work to embed CQI Model	Interim Director of Workforce and OD	Q3-Q4 2026/27	Expected evidence to be added before closure

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**16 (4x4)**	**16 (4x4)**	To update	To update
Assurance rating	**Moderate**	To update	To update	To update

PR3 – Partnerships and System Working

Principal risk statement
Failure to work effectively with partners across place, provider collaborative and system arrangements, resulting in poorer patient care, delayed pathways, fragmented experience and reduced system sustainability.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 3	Chief Operating Officer	Resources Committee, with Quality Committee for quality-related partnership risks	Operational Performance / Quality of Care	Low (1-6)	16 (4x4)	12 (4x3)	8 (4x2)	Out of appetite

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Unclear accountabilities across partnership forums and joint programmes. • Variable effectiveness of joint decision-making and escalation arrangements. • Data-sharing and digital interoperability limitations. • Conflicting organisational priorities and constrained system capacity. • Insufficient leadership capacity to support partnership development and delivery.	• Reduced ability to deliver system productivity, transformation and population health objectives. • Inconsistent patient experience across organisational boundaries. • Financial and operational pressure on the Trust and wider system.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Executive attendance at ICB, place-based and provider collaborative forums. • Collaboration of Acute Providers and joint delivery arrangements. • Information sharing frameworks and partnership agreements where established. • System oversight for UEC, diagnostics, cancer, finance, workforce and place-based priorities. • Clinical Strategy Implementation Lead capacity supporting partnership development.	• ICB, place-based, CAP and Committee in Common meeting outputs. • Resources Committee and Board partnership updates. • Programme reporting on EPR convergence, population health and pathway redesign. • TPR and operational performance data reflecting system-flow impact.	• Need to test effectiveness of partnership forums in delivering agreed outcomes. • Further assurance needed on whether system programmes are improving patient outcomes and sustainability. • Partnership risk ownership and escalation routes require clearer mapping.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Complete review of key partnership forums and map outputs to Trust strategic objectives.	Director of Communications	Q2 2026/27	Executive-approved map of key partnership forums, including purpose, Trust representation, decision rights, strategic objective link, output expectations and escalation route. Evidence of first effectiveness review and agreed priority forums for ongoing oversight. The mapping of key partnership forums has been completed, with the required information captured. The remaining evidence is the first effectiveness review, which will follow in Q4 once the arrangements have been operating for sufficient time to assess their effectiveness.
Develop and implement a documented framework for escalating system risks from partnership forums to Executive Committee, the relevant Board Committee, BAF and CRR.	Chief Operating Officer / Associate Director of Corporate Governance / Clinical Lead for Strategy Implementation / Assoc Director of Quality Improvement	Q3 2026/27	Approved escalation framework; documented route from partnership forums into Executive Committee, Board Committees, CRR and BAF; evidence of at least one system risk escalated and tracked through the route; quarterly Resources Committee report.

Provide annual Board seminar on system partnership priorities, risks, deliverables and unresolved dependencies requiring Board-level visibility or escalation.	Chief Executive / Clinical Strategy Implementation Lead	Q3-Q4 2026/27	Board seminar completed; agreed system priorities and dependencies documented; Board-confirmed areas for further assurance; actions incorporated into BAF, CRR or annual plan governance as appropriate

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**12 (4x3)**	**12 (4x3)**	To update	To update
Assurance rating	**Limited**	To update	To update	To update

PR4 – Transformation, Innovation and Service Design

Principal risk statement
Failure to redesign clinical services, pathways, digital transformation and workforce models at sufficient pace and scale, may prevent the Trust achieving its operational plan, elective recovery trajectories, service standards and productivity assumptions, resulting in reduced patient access, deteriorating performance, reduced financial sustainability and inability to deliver long-term strategic objectives.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 4	Chief Operating Officer	Resources Committee and Quality Committee	Operational Performance / Financial / Quality of Care	**Low to Moderate depending on scheme**	**20 (4x5)**	**16 (4x4)**	**12 (4x3)**	**Above appetite / requires sustained Board focus**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Operational capacity limits capacity to transform resulting insufficient pace of pathway redesign and service transformation •Limited alignment between annual planning, BAF risks and transformation portfolios. • Weak programme governance resulting in delayed decision making and escalation. • Benefits from transformation programmes are not consistently quantified, owned or tracked. • Delays in EPR optimisation, interoperability, and digital workforce implementation resulting in delays to fully utilise patient portals, digital communication and automation opportunities • Dependency on system partners, capital, digital and workforce resources.	• Longer waits for diagnosis and treatments for patients, failure to improve patient experience and access and increased risk of harm associated with delayed care. • Failure to delivery elective recovery across RTT, UEC, diagnostic, community and cancer standards and failure to achieve operational plan trajectories. • Lost income opportunities resulting in increased recurrent cost pressures. • Workforce experiences programme fatigue and disengagement. • Reduced ability to deliver commitments within the Trust strategy. • Reputational impact with Regulators and system partners, reduced confidence in organisational change capability.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Trust Strategy and associated delivery framework approved by Board. • Board-approved Operational Plan and annual planning cycle. • PMO oversight of major transformation schemes (UEC, Maternity, Culture and leadership, productivity and corridor care) • Quality Impact Assessment for productivity and efficiency schemes. • Continuous Quality Improvement programme for 2026/27. • Elective Recovery Programme with specialty-level trajectories with monthly delivery groups. •Procurement of external programme to support to deliver pathway and productivity schemes. • Implemented strengthened annual planning approach supported by IMAS demand and capacity. • Implemented GIRFT pathways and protocols review with self-assessment and peer review process.	• Programme highlight reports and exception reports • TPR, annual plan, operational planning delivery rep. • Resources Committee and Quality Committee focused reviews and Board escalation. • Internal audit, NHSE planning and performance reviews and external benchmarking (GIRFT, model hospital) • Patient, staff and stakeholder feedback on redesigned pathways.	• Benefits realisation arrangements are inconsistent across programmes. • Limited visibility of interdependencies between operational planning, elective recovery and digital programmes. • Transformation reporting focuses on milestones rather than achieved outcomes and benefits. • Assurance regarding delivery of productivity assumptions underpinning the Operational Plan requires strengthening. • Programme capacity and capability risks have not been fully assessed against delivery req

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Implement integrated Transformation Portfolio Dashboard showing schemes, benefits, risks, dependencies and trajectory delivery.	Chief Operating Officer / Clinical Strat Imp Lead	Q3 2026/27	Operational dashboard. Committee Reports
Establish formal benefits realisation framework with agreed baselines and measurable outcomes.	Clinical Strategy Imp Lead/ Finance Director	Q2 2026/27	Approved framework . Quarterly benefits tracking reports

Undertake programme capacity and capability assessment to ensure sufficient delivery resource.	Executive Committee	Q3 2026/27	Workforce assessment completed. Resource gaps addressed
Complete elective recovery transformation review linking pathway redesign programmes to RTT, UEC, Cancer and Diagnostic trajectories.	Chief Operating Officer	Q2 2026/27	Approved recovery plans. Demonstrable improvement in performance

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**16 (4x4)**	**16 (4x4)**	To update	To update
Assurance rating	**Limited**	To update	To update	To update

PR5 – Sustainability, Estates and Infrastructure Resilience

Principal risk statement

Failure to maintain safe, resilient and sustainable estate and infrastructure, and to deliver the Green Plan, resulting in patient safety risk, service disruption, regulatory concern and failure to meet environmental obligations.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 5	YTHFM Managing Director	Resources Committee	Sustainability / Operational Performance / Quality of Care	**High for sustainability innovation; Low where patient safety or service continuity is affected**	**20 (4x5)**	**16 (4x4)**	**12 (4x3)**	**Above appetite for safety-critical estate elements**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Backlog maintenance, ageing infrastructure and constrained capital investment. • RAAC and roof-condition risks at Scarborough Hospital and other estate vulnerabilities. • Inadequate estate provision affecting service delivery in some areas. • Climate change, severe weather and environmental sustainability pressures. • Limited clinical estate strategy maturity and competing investment priorities.	• Patient safety and experience impact from estate failures or service disruption. • Increased cost, inefficiency and operational disruption. • Regulatory, environmental and reputational risk. • Failure to deliver NHS net zero and Green Plan requirements.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Estates risk register, capital planning and emergency preparedness arrangements. • Green Plan and climate change risk assessment processes. • Resources Committee oversight of estates, facilities, finance and sustainability. • EPRR standards, business continuity and incident response arrangements. • Clinical and estates strategy development.	• Estates and facilities reports to Resources Committee. • Capital planning, backlog maintenance and risk updates. • Green Plan works progress through quarterly and annual sustainability reporting and NHSE reporting. • EPRR assurance, climate adaptation and business continuity exercises. • Internal audit, external reviews and statutory compliance reports.	• Backlog maintenance and lifecycle funding remain significant constraints. • Further assurance required on clinical estate strategy, clinical strategy and prioritisation. • Green Plan compliance and Board ownership of sustainability require continued strengthening. • Agreement of clinical sustainability lead

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Develop Board-level estates and infrastructure risk prioritisation plan aligned to clinical strategy.	Finance Director / Director of Estates	Q3 2026/27	Expected evidence to be added before closure
Refresh Green Plan assurance against current NHS expectations and report to Board.	Executive sustainability lead	Q2 2026/27	Green plan updated and reported to October Resources Committee ahead of November Board reporting.
Provide quarterly updates on safety-critical estate risks, including RAAC and backlog maintenance.	Director of Estates	Quarterly	Expected evidence to be added before closure

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**16 (4x4)**	**16 (4x4)**	To update	To update
Assurance rating	**Limited**	To update	To update	To update

PR6 – Financial Sustainability

Principal risk statement

Failure to deliver the agreed financial plan and restore long-term financial sustainability, resulting in regulatory intervention, reduced investment capacity and compromised delivery of strategic objectives.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 6	Finance Director / Deputy Chief Executive	Resources Committee	Financial	**Moderate (8-9)**	**25 (5x5)**	**16 (4x4)**	**12 (4x3)**	**Out of appetite / above financial appetite**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Underlying deficit, demand growth, pay and non-pay inflation, and productivity challenge. • High waste reduction and productivity requirement and risk to recurrent delivery. • Operational pressures affecting productivity and elective recovery. • Reliance on system financial arrangements and challenged provider support. • Temporary staffing and workforce deployment pressures.	• Failure to meet annual plan and system control total expectations. • Reduced cash resilience, capital investment and strategic flexibility. • Increased NHSE oversight and reputational risk. • Potential quality, workforce and operational performance trade-offs if savings are not appropriately quality-assessed.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Financial governance, budgetary control and financial improvement arrangements. • Waste reduction and productivity programme with Quality Impact Assessment. • Executive Committee, Financial Improvement Boards and Resources Committee oversight. • System financial planning and engagement with ICB/NHSE. • Board and Committee reporting through TPR and finance reports. • Deployment of Financial Recovery specialists to aid delivery	• Monthly finance reports to Resources Committee and Board. • WRAP reporting and QIA approval process. • Internal and external audit reports. • NHSE and system financial review outputs. • Cash, capital and financial recovery plan monitoring.	• Scale of 2026/27 WRAP requirement creates delivery and quality risk. • Need stronger recurrent benefits tracking and triangulation with quality/workforce impact. • Financial recovery remains dependent on operational productivity and system support.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Maintain Board-level financial recovery dashboard showing grip, productivity, cash, CIP and QIA status.	Finance Director	Monthly	Single WRAP tracker in place with full dashboard capability
Report recurrent/non-recurrent split and quality impacts of major schemes to Resources and Quality Committees.	Finance Director / Chief Nurse / Medical Director	Monthly	Single WRAP tracker in place with full dashboard capability including recurrent/non-recurrent split
NHSE challenged provider support continuing deployment of additional WRAP delivery capacity.	Chief Executive / Finance Director	Q1-Q4 2026/27	Weekly flash reports. Adrian Roberts' feedback.

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**16 (4x4)**	**16 (4x4)**	To update	To update
Assurance rating	**Limited**	To update	To update	To update

PR7 – Governance, Leadership and Assurance Effectiveness

Principal risk statement

Failure to maintain effective governance, leadership, assurance and internal control arrangements, resulting in weak oversight, inability to evidence control of strategic risks and failure to meet statutory, regulatory and licence requirements.

Strategic objective	Executive owner	Lead assurance committee	Risk category	Risk appetite	Inherent	Current	Target	Status
Objective 6	Chief Executive / Associate Director of Corporate Governance	Group Audit Committee, with Board Committees for aligned risks	Governance / All risk categories	**Low where statutory compliance or internal control is affected**	**16 (4x4)**	**12 (4x3)**	**8 (4x2)**	**Above appetite / improving**

Causes – what must happen for the risk to occur?	Consequences – if the risk occurs, what is the impact?
• Complex governance architecture and variable quality of escalation. • Insufficient clarity between controls, assurances and meetings/forums. • Limited assurance grading and evidence of positive/negative assurance. • Action tracking without consistent ownership, milestones and evidence of closure. • Need to embed Well-Led developmental review improvements.	• Board unable to evidence effective oversight of strategic risks. • Weaknesses in Annual Governance Statement evidence base. • Duplicative or inefficient governance meetings and reduced accountability. • Regulatory concern, reputational risk and loss of confidence in governance systems.

Key controls currently in place	Sources of assurance / evidence	Gaps in control or assurance
• Risk Management Strategy and Policy approved by Board. • BAF, CRR and committee work programme cycle. • Board and committee escalation reports and effectiveness reviews. • Well-Led developmental review action plan - progress reported to Board quarterly. • Standing Orders, SFIs, Scheme of Delegation and corporate governance framework.	• Group Audit Committee oversight of governance, risk management and internal control. • Board BAF/CRR reporting and committee escalation reports. • Internal audit overall opinion and audit plan delivery. • External audit, CQC and Well-Led review findings. • Annual Governance Statement and effectiveness review evidence.	• BAF format should more clearly map cause-control-assurance-action. • Need explicit assurance rating and clear distinction between controls and assurance sources. • Further work required to rationalise meetings and improve action evidence.

Mitigating action to close gap	Action owner	Target date	Evidence required before closure
Implement refreshed BAF template with assurance ratings and cause-control mapping.	Associate Director of Corporate Governance	~~Q1-Q2 2026/27~~ Complete	Revised BAF template approved by the July Board of Directors and cause-control mapping completed.
Align BAF, CRR, committee work programmes and internal audit plan through a single assurance map.	Associate Director of Corporate Governance / Group Audit Committee	Q2-Q3 2026/27	Expected evidence to be added before closure
Report quarterly progress on Well-Led action plan to Board.	Chief Executive / Associate Director of Corporate Governance	Quarterly	Quarterly updates on the implementation plan throughout 2026/27

Quarter	Q1 2026/27	Q2 2026/27	Q3 2026/27	Q4 2026/27
Current risk rating	**4x3 (12)**	**4x3 (12)**	To update	To update
Assurance rating	**Moderate**	To update	To update	To update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 24

Report to:	Board of Directors
Date of Meeting:	28 October 2026
Subject:	Board of Directors and Committees Revised Dates
Director Sponsor:	Martin Barkley, Trust Chair
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

Equality Impact Assessment Concluded
(please document in report)

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The Board's revised schedule of meetings for the remainder of 2026/27 and into 2027/28 with revised venues are provided.

The new Culture and People Committee and Digital and Transformation Committee dates are provided with all meetings to commence at 2pm in the York Hospital Boardroom. In addition, for completeness the Resources, Quality and Group Audit Committees dates are provided with times unchanged.

Recommendation:
The Board is asked to note:

- the revised venues for the existing Board meeting dates; and
- the new dates for the Culture & People Committee and Digital & Transformation Committee.
- the existing Resources, Quality and Group Audit Committees dates.

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

Meeting/Engagement	Date	Outcome/Recommendation
N/a		

Board of Directors and Committees Dates and Venues

1. Introduction and Background

This paper provides a consolidated update to the Board meeting schedule. It records the revised venues for the existing Board dates and adds the meeting dates for the two new committees. The schedule is presented for information and diary planning.

2. Board of Directors: existing dates and revised venues

Day	Date	Meeting format	Revised venue
Wednesday	27 January 2027	Public & Private	York
Wednesday	24 February 2027	Private only	York
Wednesday	31 March 2027	Public & Private	Scarborough
Wednesday	28 April 2027	Private only	Selby
Wednesday	26 May 2027	Public & Private	York
Wednesday	30 June 2027	Private only	Bridlington
Wednesday	28 July 2027	Public & Private	Scarborough
Wednesday	29 September 2027	Public & Private	York
Wednesday	27 October 2027	Private only	Malton
Wednesday	24 November 2027	Public & Private	Scarborough
Wednesday	26 January 2028	Public & Private	York
Wednesday	23 February 2028	Private only	York
Wednesday	29 March 2028	Public & Private	Scarborough

3. New Committee meeting dates

Day	Date	Committee
Friday	18 December 2026	Culture & People Committee
Friday	22 January 2027	Digital & Transformation Committee
Friday	19 February 2027	Culture & People Committee
Friday	19 March 2027	Digital & Transformation Committee
Friday	23 April 2027	Culture & People Committee
Friday	21 May 2027	Digital & Transformation Committee
Friday	25 June 2027	Culture & People Committee

Day	Date	Committee
Friday	23 July 2027	Digital & Transformation Committee
Friday	20 August 2027	Culture & People Committee
Friday	24 September 2027	Digital & Transformation Committee
Friday	22 October 2027	Culture & People Committee
Friday	19 November 2027	Digital & Transformation Committee
Friday	17 December 2027	Culture & People Committee
Friday	21 January 2028	Digital & Transformation Committee
Friday	18 February 2028	Culture & People Committee
Friday	24 March 2028	Digital & Transformation Committee

Scheduling notes:

- All Committee meetings to take place in the York Boardroom commencing 2pm.
- The March Digital & Transformation Committee is scheduled for Friday 19 March 2027 because Friday 26 March 2027 is Good Friday.

4. Resources, Quality and Audit Committees Dates

Day	Date	Committee
Tuesday	15 December 2026	Resources Committee Quality Committee
Tuesday	19 January 2027	Resources Committee Quality Committee
Tuesday	16 February 2027	Resources Committee Quality Committee
Tuesday	23 March 2027	Resources Committee Quality Committee
Tuesday	20 April 2027	Resources Committee Quality Committee
Tuesday	18 May 2027	Resources Committee Quality Committee
Tuesday	22 June 2027	Resources Committee Quality Committee
Tuesday	20 July 2027	Resources Committee Quality Committee
Tuesday	17 August 2027	Resources Committee Quality Committee
Tuesday	21 September 2027	Resources Committee Quality Committee
Tuesday	19 October 2027	Resources Committee

		Quality Committee
Tuesday	16 November 2027	Resources Committee Quality Committee
Tuesday	14 December 2027	Resources Committee Quality Committee
Tuesday	18 January 2028	Resources Committee Quality Committee
Tuesday	15 February 2028	Resources Committee Quality Committee
Tuesday	21 March 2028	Resources Committee Quality Committee

Scheduling notes:

- All Committee meetings to take place in the York Boardroom with Resources Committee meetings commencing at 9am and Quality Committee meetings commencing at 2pm.

Day	Date	Committee
Tuesday	8 December 2026	Group Audit Committee
Tuesday	9 March 2027	Group Audit Committee
Tuesday	11 May 2027	Group Audit Committee
Monday	14 June 2027	Group Audit Committee (Year-End)
Tuesday	14 September 2027	Group Audit Committee
Tuesday	7 December 2027	Group Audit Committee

Scheduling notes:

- All Committee meetings to take place in the York Boardroom commencing at 930am with the exception of the Year-End meeting commencing at 9am.

5. Recommendation

The Board is asked to note:

- the revised venues for the existing Board meeting dates; and
- the new dates for the Culture & People Committee and Digital & Transformation Committee.
- the existing Resources, Quality and Group Audit Committees dates.