

# Clinical Services Strategy 2026-2031

Towards Excellence in Community, City, Coast and Countryside

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| <b>Purpose</b>      | A clinically led, population-focused strategy to guide the Trust's future clinical service model, partnership working and investment decisions. |
| <b>Status</b>       | Final Draft for Board discussion – 28th October 2026.                                                                                           |
| <b>Time horizon</b> | 2026/27 to 2030/31, aligned to medium-term NHS planning and a longer-term direction of travel.                                                  |
| <b>Prepared</b>     | October 2026. To be refined through population-health analysis, staff and partner engagement, and clinical pathway design.                      |

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## 1. Foreword

York and Scarborough Teaching Hospitals NHS Foundation Trust has a unique opportunity to transform the way we think about health and care delivery for the populations we serve. The three shifts at the heart of the NHS 10 Year Health Plan – from hospital to neighbourhood, from treatment to prevention, from analogue to digital – give the mandate to make transformational changes.

A significant transformational shift will be the way in which we work with our partners in the health and care system. We must all focus on what is right for the population we all serve. The transactional nature of current relationships must change; we will be a helpful and supportive partner focusing on how we build meaningful relationships with all providers of health and care.

We start from an uncomfortable truth; where a patient lives within the geographical area we cover, shapes how quickly they are seen and how far they must travel. We have excellent colleagues doing exceptional things every day under extreme pressure and they have told us that they are not able to deliver the care they want to because of those pressures and how we use our resources.

As a Trust we are not financially sustainable and a large proportion of our workforce have told us unequivocally that they would not recommend the Trust as a place to receive care or to work. The patients we care for experience inconsistent access for healthcare and inconsistent quality of healthcare. This is not the service a population of over 800,000 people deserves, or that our people should work in. This simply cannot continue. This strategy exists to close that gap: to provide the right care, first time, as close to home as clinically appropriate, and to organise services around what patients need. It is effectively the rules by which we will make decisions moving forward – the who, how, where and when of clinical service delivery.

This ambition is inseparable from the Trust strategy, Towards Excellence. Towards Excellence describes a commitment to challenge the ways of today, through research, innovation, and transformation, to build a better tomorrow. The clinical services strategy is a strategic framework, not a final service configuration plan. Clinical pathway changes will be evidenced, co-designed with colleagues, people and partners, subject to appropriate clinical, equality assessment, financial assessment, and sustainability assessments, and taken through the Trust's governance and statutory engagement processes.

A financially sustainable clinical model is integral to good care. Transformational changes in clinical pathways, delivered with partners, in neighbourhood models, must create value for patients. Every interaction a patient has with the Trust must be beneficial for each patient. Clinical pathways will be redesigned with partners to improve patient experience and reduce the overall cost of care by reducing waste. With partners, in neighbourhoods, we must deliver the best value health and care whilst achieving financial balance for the Trust.

The immediate development priority is how we manage people who are frail, because it tests the whole model: urgent and emergency care, planned care, community services, primary care, mental health, diagnostics, discharge, rehabilitation, unpaid carers and the voluntary sector support. The same approach will then be applied to other high-impact pathways. Women's health clinical services and children and young people's clinical services will be redesigned guided by population need, inequalities, clinical evidence, and local capacity.

The learning, methods and principles developed through these priorities will then inform our approach to other high-impact clinical pathways, with future priorities determined through population need, inequalities, quality, workforce, demand, capacity, estates and financial sustainability, alongside engagement with system partners.

## **2. Purpose and Scope of the Clinical Services Strategy**

The Clinical Services Strategy is the Trust's clinical narrative and decision framework for closing the gap between the care we deliver and the care our population needs. It describes the future characteristics of services, the standards against which choices will be judged and the conditions required to deliver change. It does not pre-determine the outcome of any future consultation, business case, procurement or service reconfiguration process.

The strategy covers services delivered in the localities York, Scarborough, Bridlington, Malton and Selby, the Trust's community settings and patients' homes. This strategy covers the Trust's contribution to clinical pathways and clinical networks beyond the Trust's organisational boundaries. It recognises that high-quality care depends on close relationships with newly forming integrated neighbourhood teams, primary care, adult social care, mental health providers, Yorkshire Ambulance Service, hospices, local authorities, the voluntary sector, community and social enterprise sector, universities and other NHS providers.

Our approach is place sensitive. Communities across the Trust's geography have different patterns of need, deprivation, rurality, differing abilities to travel, differing workforce supply and differing access to health and care. The strategy will therefore combine consistent clinical standards with locally responsive delivery, using population-health intelligence, maximising multidisciplinary teams, listening to patient experience and clinical insight, to target improvement where it will make the greatest difference.

## **3. Why Change is Necessary**

Care in our Trust is not equitable, not affordable, and not always commissioned. This cannot continue.

Our population who are frail are the single biggest driver of unplanned care demand in nearly all clinical specialties, and this group will grow sharply as our population ages. Across York and Scarborough, the number of people aged 65–74 is projected to grow by around 16,000, and the number aged 75 and over by around 23,000, by 2035 compared with 2024. By 2043, our population aged 75 and over, is projected to be 43% larger than it was in 2024. This is not a future pressure to plan for eventually: it is the demand our services must be designed for now. We must plan equitably for the whole population we represent, irrespective of where they live.

Our ageing population is the biggest driver of demand, but it is not the whole picture. Children and young people in our coastal communities experience some of the greatest health inequalities. The Chief Medical Officer's 2021 report on health in coastal communities found that hospital admissions for self-harm among 10–24 year olds, and for alcohol and drug misuse among under-18s, are substantially higher in coastal areas than elsewhere. The care a child can access also depends on where they live: the Trust's community paediatric service covers York only.

Since the 2012 merger of York and Scarborough Trusts, activity has moved steadily; many patients and families are expected to travel to access care. Many outpatient episodes for Scarborough and Bridlington residents are delivered at York Hospital. This is far from ideal for a population with some of the highest levels of deprivation in the region. Moving the location of outpatient appointments is not a neutral administrative shift: it is a widening gap for those who need care, borne disproportionately by the communities who can least absorb it.

The Trust is currently spending money it does not have. In the financial year 2025-2026, the Trust reported a deficit position of £32 million. We must reduce the per capita cost of care, whilst improving the experience our patients have when receiving that care.

The buildings we use to care for our patients are not all suitable for 21st century healthcare.

There is a significant maintenance schedule that is almost £300 million in total. The risks associated with an incomplete and unaffordable maintenance schedule are significant; and therefore we must utilise our best estate efficiently and effectively. This can also be said for medical equipment, such as our radiology equipment, as well as IT infrastructure. We must consider how best to use existing assets and how we deploy future capital investment to benefit patients over seven days of the week.

We have a demographic issue to manage, an equity issue to manage for adults and children alike, a significant financial deficit, buildings that need significant repairs, and we are providing some clinical services that we are not commissioned to deliver.

We have a unique opportunity to transform the way we deliver care. With partners, utilising the newly forming neighbourhood model of care, we can reduce care inequalities, reduce the per capita cost of care, whilst improving the experience of our patients and improving the health of the population we represent.

This is a time for courageous decisions, a time to challenge the status quo, a time to deliver the best possible value healthcare for the populations we serve.

## 4. Our Strategic Clinical Ambition

By 2030/31, the Trust will be recognised for safe, compassionate and equitable care; for strong clinical and community partnerships; and for a sustainable service model that gives people timely, coordinated care in the setting that best meets their needs. In doing this we will meet all constitutional standards.

We will be a Trust where clinical teams use evidence, outcomes, lived experience and improvement science to redesign pathways; where people receive clear information and can participate in value-based decisions about their care; and where staff can contribute their ideas and are enabled to work across organisational boundaries.

Our campuses will continue to provide high-value generalist and when needed, specialist, urgent, diagnostic and planned care. Where services need scale or concentration to sustain quality, we will develop networked solutions that protect access, maintain clear transfer and escalation arrangements, and address the needs of rural and coastal communities. Where care can safely be delivered closer to home, we will support neighbourhood and community models that are clinically integrated with the Trust.

Robust neighbourhood and community services require effective acute services. York and Scarborough hospitals will remain at the heart of the Trust's clinical model, providing high-quality urgent, emergency, specialist, diagnostic and planned care for the populations we serve. This strategy will challenge historical models of care, including our own long-standing ways of working. Success will be judged by outcomes for the whole population we serve, not by activity retained in any one setting.

Not every service will be delivered in every setting. Where evidence demonstrates that concentration, networking or standardisation will improve quality, outcomes, resilience or workforce sustainability, the Trust will work with partners and stakeholders to develop the most appropriate model of care for the population served.

We will judge success through outcomes. We will redesign and deliver high quality, equitable clinical pathways that cross organisational boundaries, reduce the per capita cost of care, and improve patient experience. The environmental impact and use of resources will be assessed for all changes. Progress will be demonstrated through measurable improvement in these outcomes at Trust, place and pathway level and reported through annual planning and Board assurance processes.

## 5. Our Strategic Shifts

The NHS 10 Year Health Plan sets three shifts for the whole health service. We adopt them as our own. The three principles described mirror what our patients and the population we represent need, and we hold ourselves to a specific, local commitment under each, not simply a change in emphasis.

**From hospital to community:** care will be delivered by default in people's homes and neighbourhoods, not in a hospital bed or outpatient clinic. We will decompress the York and Scarborough campuses and deliver outpatient appointments, diagnostics and rehabilitation as close to peoples' homes as possible. We will design out avoidable travel to York for coastal and rural communities. We will work with integrated neighbourhood teams to proactively manage patients with urgent care needs in their own homes when possible.

Care closer to home is our default, not an absolute. Where the evidence shows that specialist expertise, workforce sustainability or safety require care to be networked or concentrated, we will do so – and the test will be outcomes for patients, not organisational preference. Where we concentrate care, we take on responsibility for the access consequences: transport, outreach clinics, virtual follow-up and clear escalation, so that the cost of concentration does not fall disproportionately on coastal and rural families.

**From treatment to prevention:** we will not wait for people to reach crisis before we act. Working with multidisciplinary neighbourhood teams, using population-health data, we will identify people at risk and intervene before they deteriorate. For those who are at risk of ill-health, we will work in a boundaryless way, to prevent deteriorations. For children and young people, the return on prevention is the longest of any group we serve – and so is the cost of failing to act.

**From analogue to digital:** every pathway we redesign will default to digital access, virtual review and shared information, unless there is a clear clinical or inclusion reason not to. We will have an explicit plan for the people digital access does not reach, so going digital never means leaving someone behind.

These are not incremental adjustments to how we work. Clinical pathway redesign may require initial funding decisions, workforce decisions and estate decisions to follow the clinical pathway. Some clinical services currently based in one place will need to look different, or be delivered somewhere else, by 2030/31.

## 6. Our Decision Framework: Value to Patients

We are retiring a fixed set of design principles in favour of a single, harder test: what value does this pathway, investment or way of working create for the people using our services and the population we serve?

Value-based healthcare means being explicit about the outcomes that matter to patients – not only clinical outcomes, but experience, equity and the true cost of achieving them. We will use that evidence to have honest conversations, with patients and with each other, about value and trade-offs. Every significant pathway or investment decision will be able to answer: what outcome does this improve, for whom, at what cost, and what do we stop doing to afford it? For children and young people, and for prevention more broadly, value will be judged across the life course and across the whole system, not only within a single financial year or the Trust's own accounts.

This may be an uncomfortable discipline, but it will be used supportively. It gives clinical teams and leaders a shared, evidence-based way to challenge how care is delivered today. We must challenge our own long-standing ways of working. Decisions will be transparent about benefits, trade-offs and opportunity cost, tested against the three strategic shifts above, and open to challenge from anyone who can bring better evidence.

## 7. What this Means for Our Clinical Model

The clinical model translates our strategic ambition and revised design principles into how care will increasingly be organised and delivered, with our partners across York and Scarborough

Teaching Hospitals NHS Foundation Trust.

Guided by this test of value to patients, we will develop a clinical model that is person-centred, evidence-led and sustainable for the future. This model will not be applied uniformly across all services and locations. Instead, it will provide a framework for consistent decision-making whilst recognising the differing needs of our urban, rural and coastal communities.

### 7.1 Whole care pathways closer to home

The default will be to support people in their homes, communities and neighbourhoods. The Trust will maximise its status as an integrated acute and community Trust and work with primary care, other community health providers, mental health, social care and voluntary-sector partners to improve proactive case finding, anticipatory care, rapid response, rehabilitation and supported self-management. Hospital-based teams will provide timely advice, diagnostics and specialist input to these models.

For each redesigned clinical pathway, we will make explicit what should be standardised, what should be varied to suit local needs, what requires specialist concentration or network provision, and how people will move between settings. Clinical criteria, minimum quality

standards, equality and travel impacts, workforce viability and innovative workforce models, estate implications and financial sustainability will all be considered together.

## **7.2 Prevention, early diagnosis and proactive care**

The Trust will use its clinical reach to support prevention and earlier intervention. Our contribution will be aligned to ICB and place priorities, targeted using population-health management and evaluated for impact on inequalities. For children and young people, we will use the national Core20PLUS5 framework – asthma, diabetes, epilepsy, oral health and mental health – with partners to target our contribution where coastal and rural inequalities are greatest.

## **7.3 Digitally enabled and inclusive care**

Digital transformation will improve, not merely digitise, the patient and staff experience. We will develop interoperable information flows, digital triage where clinically appropriate, virtual review and monitoring where it benefits patients, and decision support that improves reliability and productivity. Every digital pathway will have a clear inclusion assessment, accessible alternatives and measures of impact on quality, outcomes and workload.

Combined with advances in genomics, pharmacogenomics and biomarker-led diagnosis, these tools will allow us to identify risk earlier and target treatment more precisely. We will implement these innovation to narrow, not widen, inequalities for our coastal, rural and deprived communities.

## **7.4 Generalist Capability across whole pathways of care**

Delivering the three shifts depends on a workforce equipped to deliver holistic care, not just organ specific care. Our populations, urban, rural, and coastal, increasingly present with multi-morbidity, frailty, and complex needs that no single specialty can address alone, and this is most acute in the coastal and rural communities where recruitment to narrower specialties is hardest. Moving care closer to home, intervening earlier and working across boundaries all rely on clinicians, and multi-professional teams, who are confident in generalist assessment and in coordinating complex care.

This is additive to specialist expertise, not a retreat from it. Our campuses will continue to provide, and where necessary concentrate, high-quality specialist care; specialists themselves will be supported to keep and use the generalist skills their patients with multiple conditions need. Just as strong neighbourhood services require strong acute services, strong specialist services require a strong generalist foundation beneath them.

We will therefore build generalist capability deliberately into how we design all clinical pathways. For each redesigned pathway we will be explicit about what requires specialist or networked provision and what is best delivered by generalist teams closer to home. We

will develop workforce models, including new and extended multi-professional roles, around the generalist and core skills that multi-morbidity and frailty demand. We will use our offer as a place to train, teach and develop and retain that workforce in the communities we find hardest to staff. Frailty, our first strategic pathway, will be the proving ground for this generalist-led, specialist-supported model.

## 8. Research, Innovation and Education

**Research:** Through the Scarborough Coastal Health and Care Research Collaborative (SHARC), working with Hull and York Medical School, the University of York and other coastal and rural health systems, we will evaluate the pathways this strategy prioritises, starting with frailty and Family Health. Every redesigned pathway will include an evaluation plan, so that the outcome measures help build a research evidence base. This includes testing digital, AI-enabled and precision-medicine approaches in our own populations before scaling them. Coastal and rural communities are under-represented in research, so we will widen access to research participation for patients in Scarborough, Bridlington and our rural communities. Research activity will grow across medical, nursing, AHP and operational teams, not only in a small number of specialties.

**Education:** Research-active, teaching-rich organisations recruit and retain staff more successfully. We will strengthen our offer as a place to train, teach and develop across all professions. We will design education around the generalist and multi-professional workforce this strategy depends on. That includes training opportunities that span our sites and communities, so that clinicians train where we most need them to stay.

This ambition is a direct extension of the Trust's own strategic commitment – through research, innovation and transformation, to challenge the ways of today and build a better tomorrow.

## 9. Immediate Clinical Priorities:

### 9.1 Our Patients Who Are Frail

Frailty has been identified as one of the Trust's first strategic pathway priorities because it spans almost all services provided by the Trust.

Frailty is common, consequential and highly sensitive to the quality of coordination across the whole health and care system. It affects people differently across their lives and is not always synonymous with age. The programme will use a strengths-based, personalised approach that supports independence, function and quality of life.

The Trust will work with integrated neighbourhood teams and partners to develop a

coherent frailty pathway that includes:

- proactive identification and care management of people at risk, with agreed escalation and anticipatory care arrangements
- rapid access to expert assessment, diagnostics and treatment when a person deteriorates
- evidence-based hospital care, including early comprehensive geriatric assessment, delirium prevention, medicines review and discharge planning from admission
- coordinated rehabilitation, reablement, community response and support for unpaid carers
- clear information and shared decision-making, including advance care planning where appropriate, and
- outcome measures that include functional recovery, experience, avoidable admission and length of stay, equity and carbon/resource impact.

Frailty will be the first pathway used to test our new management system. The clinical, data, governance and engagement methods established through this work - supported by daily huddles, standard work and structured problem-solving - will then be applied deliberately to other priority pathways, including cardiovascular disease, respiratory care, diabetes, cancer, mental health, urgent and emergency care, and the Family Health programme set out in Section 9.2, guided by local evidence and system priorities.

For each of these pathways, implementation planning will include:

- agreeing priority pathways and areas of focus with system partners
- co-designing future pathway models and outcome measures
- identifying workforce, digital, estate, operational and diagnostic dependencies
- developing business cases and engagement approaches for any significant service changes, and
- establishing governance, reporting arrangements and benefit realisation measures to monitor delivery.

This implementation planning process will determine how the strategy is delivered, the pace of change, and the sequencing of priorities over time.

## **9.2 Children's and Young People's Services and Maternity Services**

Family Health – women's health, maternity services, neonatal services, and children's and young people's services will run in parallel to frailty as a strategic priority for the Trust.

These services carry some of the biggest variations in health inequalities. This strategy must address the health inequalities: between local access and specialist sustainability,

between the coastal communities and York city population, and between short-term affordability and outcomes that are realised over a lifetime.

Care closer to home remains our default, but for Family Health it will be tested rigorously against safety, workforce sustainability and national clinical standards. Some care will move into neighbourhoods and homes; some will be strengthened through networked or concentrated specialist services.

The programme will be co-designed from the outset with Family Health clinical and operational leaders; with children, young people, parents and carers; and with partners including primary care, local authorities, education, mental health providers and the relevant Operational Delivery Networks. Clinical leaders will shape future-state models.

## 10. Making Change Happen: conditions, delivery and accountability

Strategies don't fail because the ambition was lacking. They fail because nobody does the unglamorous work of getting people ready for change, building a system that makes the change routine rather than dependent on a few individuals, and then checking honestly whether change is actually happening.

### 10.1 Getting ready: the conditions for change

The Clinical Services Strategy will only succeed if we create the conditions that allow colleagues, patients and partners to design, deliver and sustain change. These are not optional extras – they are the foundations on which delivery depends.

**Clinical leadership with real authority.** Medical, nursing, AHP and operational teams need the authority, information, time and support to lead change themselves. Decision rights and accountability will be clear at every level.

**A culture where people can speak up and improve.** Colleagues must feel safe to test new approaches, flag problems and learn from what goes wrong; improvement is everyday work.

**Data people can trust.** Everyone from ward to Board needs timely, understandable information on quality, outcomes, experience, equity, workforce, demand and finance. All decisions will be made using evidence rather than assumption.

**Removing the friction that gets in the way.** Simpler processes and governance, better access to the tools and data people need and protected time for improvement work.

**One clinical model, not several separate plans.** Workforce, digital, estates, diagnostics and capital investment decisions will be driven by the clinical model and patient pathways.

**Genuine partnership, inside and outside the Trust.** Patients, carers, communities, primary care, local authorities and system partners need to be involved early, with clear shared responsibility for outcomes, not consulted once the decision is made.

## 10.2 How we'll manage this day to day

A strategy is only as strong as the daily habits used to deliver it. 'Better Together' is our single continuous improvement management system across the Trust: short daily team meetings ('huddles') that connect problems on the ward or in clinic to decisions at Board level, standard ways of working, and a structured method for solving problems. Improvement will be part of everyone's daily work, rather than a separate programme. This replaces today's fragmented picture, in which transformation and improvement effort sits across separate teams.

## 10.3 How every pathway will be built

After frailty and Family Health, further clinical priorities will be informed by engagement with system partners and opportunities for alignment, alongside a disciplined assessment of population health need, inequalities, quality outcomes, workforce, demand, capacity, estates, financial sustainability and environmental impact.

For every priority pathway, the Trust will build the same five things, in the same order:

- a clinical case for change
- a future-state model of care
- a delivery plan
- outcome measures that tell us whether it is working
- a plan for realising the benefits

This gives every pathway the same disciplined route from strategy to something a patient experiences differently.

## 10.4 Checks and balances: how we'll know it's working

Agreeing the strategy is the easy part. Once it is approved, we move into implementation planning: setting baseline measures across population health, demand, quality, workforce, equality, finance and sustainability; agreeing priorities with partners; identifying what has to change in workforce, digital, estates and diagnostics; and building the business cases and governance needed to make it happen.

## 11. Annual review and adaptation

The Clinical Services Strategy is intended to provide a long-term direction rather than a fixed plan. This strategy will be reviewed annually to ensure the strategy remains aligned to population need, national policy changes, clinical evidence, workforce challenges and changing patterns of demand. This will allow the Trust to maintain a clear strategic direction whilst adapting to emerging opportunities and challenges.