York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 4

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.

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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)

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

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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.

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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.

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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.

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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

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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.

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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

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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.

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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.

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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.

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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

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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.

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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.

APPROVED