York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 25th November 2026
Time: 9:30am – 12:30pm
Venue: PGME Discussion Room, Scarborough Hospital



York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:30
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 28 October 2026** To be agreed as an accurate record.	Chair	Report	6	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	21	
6.	**Patient's Story** To consider.	Rachael Barron and Shelley Cooper, Admiral Nurse Team	Verbal	-	9:35
7.	**True North Report** To review the report.	Chief Executive	Report	22	9:45
8.	**Chair's Report** To review the report.	Chair	Report	40	9:55

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	42	10:00
10.	**Quality Committee Report** To receive the November meeting summary reports.	Chair of the Quality Committee	Report	95	10:20
11.	**Resources Committee Report** To receive the November meeting summary reports.	Chair of the Resources Committee	Report	100	10:30
12.	**Trust Priorities Report (TPR)** November 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	103 110 155 174 185 193	10:40
Break 11:25					
13.	**Enhancing Patient and Public Engagement if Councils of Governors Cease** To consider the report.	Chair	Report	219	11:35
14.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	224	11:45

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Maternity and Neonatal Reports** 15.1 Maternity and Neonatal Safety Report 15.2 MNVP Engagement with Diverse Communities 15.3 Maternity Feedback Survey Update 15.4 Maternal Care Bundle Implementation Update 15.5 Saving Babies' Lives Care Bundle 15.6 Perinatal Culture Improvement Plan 15.7 Maternity Equity: Analysis by Deprivation and Ethnicity 15.8 Care Group Learning from Deaths and Perinatal Mortality Review Tool (PMRT) Report Quarter 2 2026/2027 15.9 Learning Themes Report Quarter One and Two 2026/2027 To consider the reports.	Chief Nurse - Executive Maternity Safety Champion	 Report Report Report Report Report Report Report Report Report	 231 260 265 273 279 287 296 305 311	11:50
16.	**Q2 Patient Experience and Complaints Report** To consider the report.	Chief Nurse	Report	319	12:00
17.	**Ethnicity and Gender Pay Gap Reports** To consider the reports.	Chief Culture and People Officer	Report	356	12:10
18.	**Education and Training NHSE Self-Assessment** To ratify the submission.	Medical Director	Report	366	12:20
19.	**Green Plan** To approve the plan.	YTHFM Managing Director	Report	394	12:25
Governance					

Item	Subject	Lead	Report/ Verbal	Page No	Time
20.	**Emergency Preparedness Resilience and Response (EPRR) Annual Report and Action Plan** To consider the report.	Chief Operating Officer	Report	**460**	12:35
21.	**Board Committee Terms of Reference Amendments:** - **Resources Committee** - **Group Audit Committee** To approve the terms of reference.	Associate Director of Corporate Governance	Report	**470**	12:40
22.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
23.	**Time and Date of next meeting** The next meeting held in public will be on 27 January 2027 at 9am at York Hospital.				
24.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
25.	**Close**				12:45

Minutes
Board of Directors Meeting (Public)
28 October 2026

Minutes of the Public Board of Directors meeting held on Wednesday 28 October 2026 in the Trust HQ Board Room, York Hospital. The meeting commenced at 9.00am 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 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
- Dr Sarah Dexter-Smith, Chief Culture and People Officer

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

In Attendance:
- Mr Muhammed Patel, Non-Executive Director (NExT placement)
- Ms Wendy Gough, Senior Organisation Development Practitioner (For Item 6)
- Dr Magnus Harrison, Clinical Strategy Implementation Lead (For Item 10)
- Ms Stefanie Greenwood, Freedom to Speak Up Guardian (For Item 17)
- Ms Sascha Wells-Munro, Director of Midwifery (For Items 18 and 19)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Linda Wild, Elected Governor – Public and Lead Governor
- Ms Jean Flanagan, Elected Governor – Public
- Mr James Cannon, Appointed Governor – Community and Social Care
- Mr Graham Lake, Elected Governor – Public

DRAFT

- Cllr Tim Norman, Appointed Governor, East Riding of Yorkshire
- Mr James Hayward, Elected Governor – Public
- Four members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting, with a particular welcome to Dr Dexter-Smith who was attending her first meeting as the newly appointed Chief Culture and People Officer.

2 Apologies for absence

Apologies for absence were received from:
Mr Matthew Taylor, Non-Executive Director

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 30 September 2026

The Board approved the minutes of the meeting held on 30 September 2026 as an accurate record of the meeting.

5 Matters arising/Action Log

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

BoD Pub 10 *Investigate why the number of zero-day length of stay non-elective admitted patients is high*.
Ms Hansen advised that the number had increased when the new Extended Emergency Medicine Ambulatory Care (EEMAC) and Emergency Assessment Unit (EAU) services were introduced into Urgent and Emergency Care pathways. The number had dropped when the new Nervecentre Electronic Patient Record (EPR) had been implemented due to a change in the way patients were coded. The Discharge Lounge was counted as a ward on Nervecentre which had also skewed the figures. Mr Barkley asked why patients were being admitted to wards if they had zero-day length of stay and Ms Hansen responded that this was under discussion as part of changes informed by the Acute Model of Care. The action was closed.

BoD Pub 17 *Discuss with Mr Taylor how the Well-Led action plan might be re-formatted to provide a clearer update on progress.*
The reformatted Well-Led action plan was included in the paper presented under Item 14. The action was closed.

BoD Pub 23 *Add data from previous quarters to the Freedom to Speak Up report as a comparison.*
The data had been added to the report. The action was closed.

BoD Pub 26 *Check if Care Groups have written escalation protocols in relation to Cancer Patient Tracking Lists.*

Ms Hansen explained that she was reviewing Standard Operating Procedures and escalation processes in terms of alignment with daily management and the Integrated Accountability Framework. She would provide an update in January.

BoD Pub 27 *Provide information on the Emergency Care Standard (ECS) position in relation to Type 2 and 3 patients*.
Mr Hawkins provided the figures for September: for Type 2 patients, the ECS was 92.5% and for Type 3, 100%.
The action was closed.

BoD Pub 28 *Send information to Mr Barkley regarding complaints about ED and the split between York and Scarborough.*
The due date was deferred.

BoD Pub 29 *Clarify for Mr Barkley the sentence in the TPR "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".*
Dr Dexter-Smith explained that the introduction of longer shifts had changed establishments due to the reduction in time needed for handovers as there were fewer. Mr Hague confirmed that roster templates were all based on funded establishments. The action was closed.

6 Colleague's Story

Ms Gough joined the meeting to present the item. She introduced herself and described her role in the Trust as Senior Organisation Development Practitioner, which included coaching, mentoring, mediating and mental health first-aid. She shared a graphic which set out the internal elements involved in organisational success and advised that she worked with teams to develop their capabilities and she supported colleagues on an individual basis.

Ms Gough observed that work pressures often led to colleagues becoming task focussed rather than focussed on leading by example. With her team, she supported leaders to understand what they could control, and how to find time for meaningful discussions and to build trust. Her team prioritised work by considering what the Trust would most thank them for in six to twelve months' time and by responding to Board priorities. Ms Gough confirmed that the Staff Survey results were used to identify teams requiring support, but teams were encouraged to develop their own action plans. She also confirmed that the team offered courses in the development of coaching and mentoring skills and had done so for some years.

Dr Dexter-Smith linked the work of the Organisational Development team to the People Strategy and the outcomes of the Big Conversation, the aim being to ensure that the people and culture function enabled leaders and teams to apply these skills directly in their own areas.

Directors thanked Ms Gough and she left the meeting.

7 True North Report

Miss Smith presented the report, noting that the True North and the Trust Priorities reports would change as a result of the work with KPMG and Catalysis on the Continuous Quality

Improvement (CQI) Programme. This would be discussed at the Board seminar in November.

Referring to the metrics linked to Urgent and Emergency Care and reducing the number of patients treated in non-designated areas, Miss Smith reported that there had been significant surges in demand in Emergency Departments (ED), particularly at York Hospital. The work to eliminate corridor care continued, as did the development of the Acute Model of Care. She was pleased to report however that as part of the Winter Plan, both EDs would have "Frailty at the Front Door" from November. Miss Smith advised that there had been a small reduction in the number of patients treated in non-designated areas, but this was not significant enough to impact on staff and patient experience.

In terms of the Cancer Faster Diagnosis Standard, Miss Smith reported that demand continued to be challenging, not least in the number of skin cancer referrals submitted without dermoscopy images. There was some positive news in that the Dermoscopy Local Enhanced Service agreement with GP practices had been extended.

Mr Hague reported that there had been a slight improvement in the timeliness of responses to complaints.

Miss Smith highlighted that the rate of staff sickness absence continued to be challenging and Dr Dexter-Smith was working with the team to review systems and processes.

Mr Hawkins reported that his team was working with Nervecentre to finalise the design milestone for Tranche 3 of the new EPR.

Mr Floyd highlighted the variations in performance which were a notable feature of the True North metrics and underlined the need for more consistency. Miss Smith agreed and observed that consistency was a key element of the CQI work in that this would address the root causes of performance in, for example, complaints responses. She noted also that the variations in the charts in the report indicated that many of the variations were not statistically significant as shown in the statistical process control charts (SPCs). Consideration should be given to providing training for the Board on the use and interpretation of SPCs.

8 Chair's Report

The Board received the report.

Mr Barkley reported that the Task and Finish Group referred to in Section 5 of his report had met and had reached a consensus to build on the annual constituency meetings which were already in place for patient and public engagement. The Group had proposed that there would be five constituencies, each with two meetings a year. Mr Barkley outlined how these might operate and advised that a paper would be brought to the next meeting with recommendations for approval. He noted that the legislation which planned to eliminate the powers of Councils of Governors, if passed, would take some time to come into effect and there would need to be a decision on whether the Council of Governors would be retained until any new arrangements were in place.

9 Chief Executive's Report

The Board received the report.

Miss Smith highlighted the significant increase in the number of patients presenting through EDs. The work to eradicate corridor care continued to be a priority as the Trust could not allow this to be normalised.

Miss Smith reported that, with Mr Hague, Ms Hansen and Mr Norman, she had attended a very valuable listening event at Malton Hospital following the fire in July.

Miss Smith advised that the CQI work now taking place in the Trust would be known as "Better Together". The outputs of the Big Conversation were being analysed: whilst it was clear that the Trust values still resonated with colleagues, there was feedback that these values were not always reflected in behaviours. The national Staff Survey for 2026 had been launched which colleagues were being encouraged to complete.

Miss Smith highlighted that the Trust's results from the National Cancer Patient Experience Survey were the best ever, with patients who received cancer treatment during 2025 rating their overall care at an average of 9.02 out of 10.

The Trust had received NHS England's guidance on single sex services and facilities, and the implications were being worked through.

Finally, Miss Smith welcomed Dr Dexter-Smith to the Trust.

In response to a question, Mr Hague advised that 26.2% of frontline staff had been vaccinated against flu to date.

Dr Reece highlighted the nomination of the Speech and Language Therapy Clinical Lead for a Star Award, noting that the new strategies being deployed by the paediatric Speech and Therapy team to reduce waiting time were bearing fruit.

10 Clinical Strategy

Dr Harrison joined the meeting to present the new Clinical Services Strategy 2026-31, a draft of which had already been presented to the Board and the Council of Governors. He sought approval from the Board for the Strategy as a framework for the future development of clinical services and referenced the use of tests for every proposed clinical pathway. The first priorities would be frailty, given the growth in the over-75 age group, and family health, particularly that of women and children.

Miss Smith recorded her thanks to Sarah Coltman-Lovell, who had commenced the work on the Strategy, and to Dr Harrison. She observed that the document was a starting point and would concentrate the Trust's focus on reducing inequity across its catchment areas.

Ms Hazelgrave noted that the Strategy was consistent with current commissioning arrangements and with the strategies of partner organisations.

Board members were appreciative of the format of the Strategy as a framework. There was further discussion on its implementation.

The Board of Directors approved the Clinical Services Strategy 2026-2031.

11 Half-Yearly Annual Operating Plan Update

The Board received the report.

Miss Smith noted that performance in Quarter 2 was variable. She explained that the priority “Coming off Corridors” was currently rated as amber as, whilst the actions were on track, they were not yet having an impact on patient and staff experience.

In response to Mr Barkley’s question in relation to the priority “Outpatient Transformation – Planned Care”, Ms Hansen explained that chronological booking was still an area for improvement and would be an element of a workstream to review patient administration structures. She advised that the Trust had secured support to undertake a deep dive into medical and dental staff job plans to ensure that they were being correctly fulfilled.

12 Quality Committee Report

Dr Reece summarised the key escalation points from the meeting of the Quality Committee on 20 October:

- the Committee had received a paper outlining business continuity plans to support patient safety in the event of a cyber-attack;
- the Committee had welcomed the improvement in the Trust’s Inpatient Survey results;
- Family Health Care Group leaders had presented to the Committee; the quality and clarity of the reporting was challenged; Dr Reece outlined the key issues which had been escalated;
- the lack of consistent updating of the corporate risks assigned to the Committee had been discussed.

Dr Reece highlighted the key risks discussed by the Committee. Overall, the Committee had received a moderate level of assurance, with some evidence of improvement.

13 Resources Committee Report

Ms Grantham highlighted the main discussion points from the meeting of the Resources Committee on 20 October:

- the meeting had focussed on the delivery of the Waste Reduction and Productivity (WRAP) programme and the financial plan; the Committee welcomed the news that the full WRAP target was now fully planned, albeit with some plans which were considered high risk; usage of bank staff and high costs drugs were other drivers of the deficit;
- the Committee had noted the high levels of staff sickness absence;
- there had been a focussed review on elective care and the Committee had noted plans in place to support NHS England’s focus on first appointments; the challenges to reducing the total waiting list were well-understood;
- the Committee had noted progress in the sustainability agenda although the Trust was not on track to achieve targets to reduce carbon emissions;
- the Committee had discussed the deterioration in Urgent and Emergency Care metrics, despite data demonstrating that attendances in EDs had decreased; further work was being undertaken to validate the figures;
- the Committee had welcomed the positive results from the National Cancer Patient Experience Survey, which Miss Smith had previously referenced, but had also noted challenges to performance against constitutional standards.

Ms Hansen advised that the Trust had engaged the support of its partners to reduce the total number of patients waiting for treatment, as a significant proportion could be treated by more appropriate services outside of secondary care.

14 Well-Led Action Plan Q2 Progress Report

Miss Smith reported that 62% of the Quarter 1 and Quarter 2 actions had been completed and noted that large programmes of work, such as the Big Conversation and the roll out of the Integrated Accountability Framework, would inform actions not yet completed.

Mr Barkley referenced action 9.5 *Develop and implement a structured stakeholder management plan for 26/27, including objectives, engagement cadence, escalation routes and feedback loops* which was described as complete, subject to approval. Mrs Brown explained that the plan had been completed and was awaiting approval through the appropriate governance channels and thus the action was not yet closed. Once closed, actions 29 and 30 could also be closed.

In response to Mr Barkley's question about the actions in relation to recommendation 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),* Ms Hansen advised that existing processes had been changed to ensure a "standard work" approach but the format of the Care Group level management meetings would be informed by the CQI work.

15 Trust Priorities Report (TPR)

The Board received the TPR.

Operational Activity and Performance

Ms Hansen highlighted the following.

Acute Flow

- UEC metrics were a cause for concern as the deterioration in performance was sustained; Ms Hansen advised that the work to eradicate corridor care would be align with ED plans for improvement, which included work on streaming, the use of Urgent Treatment capacity, Frailty at the Front Door, validation and more education in the use of Nervecentre;
- average ambulance handover time had been maintained at just under 22 mins; Ms Hansen had asked the team to consider if the approach to maintaining consistency in this area could be used for other UEC standards;
- 13.9% of Type 1 patients waited over 12 hours in ED,
- metrics relating to length of stay and discharge were behind trajectory;
- UEC metrics were impacted by senior medical cover constraints in ED;
- work was underway to maximise the potential of EEMAC and EAU.

Ms Hansen was pleased to report that Discharge Command Centres had opened in York and Scarborough Hospitals which was very positive.

Dr Boyd queried the percentage of attendances at Same Day Emergency Care (SDEC) transferred from a GP, which stood at 15.7% and referenced anecdotal evidence from GPs who found it difficult to use this treatment pathway. Ms Hansen responded that SDEC was experiencing capacity constraints at this time but in principle this pathway should be expanded as part of the Acute Model of Care.

Ms Charge referred to Emergency Care Standard performance as it related to children and young people and noted that it remained below 90% although false breaches had been

identified after scrutiny of the data. The report suggested that a 3% improvement could be made. Ms Hansen confirmed that this would not be through improved data accuracy alone but would need to included utilisation of the EEMAC pathway.

Elective Care

Ms Hansen reported that the RTT Total Waiting List stood at just under 59k against a trajectory of just under 53k. The Trust was behind trajectory in terms of the number of patients waiting more than 52 weeks and five patients had waited more than 65 weeks. Ms Hansen explained the reasons for the delays. She reported that demand for services was nearly 5% higher in the year to date than had been planned, although there was considerable variation between services, with several specialties experiencing significant increases. The Trust was working with primary care to review long waiting patients and those waiting under 18 weeks. Primary care colleagues would contact patients to determine if the referral to secondary care was appropriate and would use this exercise to identify opportunities to reduce the number of referrals to the Trust. This approach was being piloted in the Gynaecology Service and would be rolled out rapidly to other challenged specialties if it proved successful.

Ms Hansen reported that teams were undertaking a seven week focus on increasing the number of first appointments as required by NHS England. Whilst services were not likely to reach the target of scheduling all first appointments to be carried out by the end of November, the proportion of outpatient first appointments had already increased by 7% which was the equivalent of 900 extra appointments in one month. The work on “Focus on Firsts” had already been impactful, as the number of patients without a future appointment in the cohort waiting under 18 weeks had reduced by 1500 in a single week.

Ms Hansen advised that there had been a formal launch of the operational excellence programme which was a development programme for Band 5 service managers.

Ms Hansen reported that the level of referrals to the Dermatology and Pain Management services had been discussed with the ICB at Contract Management Board meetings and there had been positive progress towards pathway changes. A further meeting with the ICB on paediatric Speech and Language Therapy was planned.

Cancer

Ms Hansen was able to provide more assurance around the performance of Cancer services. The metric for 62-day first definitive treatment stood at 71.8% and for the Faster Diagnosis Standard (FDS) at 74%. Some specialties were ahead of trajectory with breast, lung and non-specific sites well above 80% for the FDS.

Diagnostics

Ms Hansen was cautious about the sustainability of the diagnostic position, due to the increasing unreliability of the Trust’s ageing equipment, and workforce constraints. A further bid had been submitted for central funding to support activity in Community Diagnostic Centres. Ms Hansen highlighted the initiatives at Bridlington Hospital which included paediatric surgery.

In response to Ms Charge’s query, Ms Hansen confirmed that the new Single Point of Access approach was being rolled out across more specialties than was currently required by NHS England. Ms Charge also asked about the aim to reduce consultant to consultant referrals by 10% in 2026/27 and whether this was a potential risk to patient safety. Ms Hansen and Mr Bertram explained the context to the actual reduction this year of 12%,

which was in relation to incidental referrals not related to the original referral from primary care.

Mr Barkley reflected that the metrics relating to average non-elective length of stay and the proportion of patients discharged on their “discharge ready date” were the root cause of the prevalence of corridor care and the long waits in EDs.

Mr Barkley queried the zero figures for the number of RAFA and SAU attendances which Mr Hawkins undertook to investigate.

Action: Mr Hawkins

Mr Barkley referred to page 188 of the report and asked about the external review of the cancer information team, which was one of the actions planned. Ms Hansen explained that the support of another Trust had been secured to undertake a review of cross-team working with a view to identifying improvements.

Mr Barkley commented on a very clear yet comprehensive narrative in the first few pages of the report and thanked Ms Hansen.

Quality and Safety

Mr Hague highlighted some reductions in the number of Health Care Acquired Infections in areas which had been experiencing challenges. A significant programme of work had been undertaken with the Infection Prevention and Control team and the impact of this was beginning to be evidenced although Mr Hague cautioned that operational challenges still remained.

Mr Hague reported a slight reduction in the number of Category 2 pressure ulcers and reiterated that operational challenges were hindering significant improvement. A round table session with the Tissue Viability team was planned to refresh priorities.

Mr Hague advised that the volume of formal complaints received by the Trust remained high and the priority was to focus on the root causes. The eradication of corridor care would impact on the number of complaints and Care Groups had reprioritised resource to address complaint response times. An overarching review of the complaints response process was planned.

Maternity

Questions and comments on this section were deferred until Ms Wells-Munro joined the meeting.

Workforce

Dr Dexter-Smith reported that sickness absence remained a key concern as, despite the slight reduction in August, it had risen again in September. The overall turnover rate and vacancy rates in most cohorts of staff were, however, reassuring. The vacancy rate in the Health Care Support Worker cohort was high, but Dr Dexter-Smith referenced the success of the Sector-Based Work Academy Programme (SWAP) undertaken in collaboration with Job Centres for which the retention rate was excellent.

Mr Barkley noted that the Trust’s substantive workforce was 77 Whole Time Equivalents off plan in terms of the required headcount reduction and asked which areas in particular were showing variances. Mr Bertram responded that there were some adverse variances in the Care Group headcount reduction plans and actions to address these were tracked through Financial Improvement Board and Care Group performance meetings.

Digital and Information Services

Mr Hawkins reported that the Trust had experienced another Nervecentre printing issue and had received assurance that this had been fixed. The design milestone for Tranche 3 of the new EPR had been agreed with Nervecentre.

Mr Hawkins advised that, as October was Cyber Awareness Month, his team had undertaken a number of campaigns to raise awareness, including an internal phishing exercise.

As previously notified to the Board, Mr Hawkins reported that the number of Subject Access Requests received by the Trust had increased significantly and the team responsible was struggling to comply with the required response time. Some mitigations had been put in place, and the position would continue to be monitored. Mr Hawkins reported, however, that compliance with response times to Freedom of Information Requests were being maintained at a high level.

Finance

Mr Bertram reported that the Trust was £9.2m adrift of plan as at Month 6, the variance driven mainly by a year-to-date shortfall in the delivery of the WRAP programme of £7m. Mr Bertram highlighted the significant year-to-date delivery of £35m and that there were now plans in place for the full delivery of the £66m target although £8m of these remained high risk. The positive trajectory was thanks to the work of the recovery specialists assigned to the Trust.

Mr Bertram advised that the estimated commissioner overtrade position had reduced to £5.8m. He reported that the Trust had been awarded Deficit Support Funding of £4.7m for Quarter 1 of £4.7m. There had not yet been a decision on whether the Trust would receive the funding for Quarter 2. Mr Bertram reported that the run rate position was stable.

Mr Floyd thanked Mr Bertram for the detailed financial report received at the Resources Committee meeting, noting that whilst there were a number of actions in place to recover the position, the Board needed to be aware of the risks of failing to meet the financial plan. Mr Floyd referred to the graph illustrating forecast outturn scenarios which was contained in the report. Mr Bertram assured the Board that every effort was being made to ensure that the worst-case scenario was not realised.

16 CQC Compliance Update

The Board received and noted the report.

17 Freedom to Speak Up (FTSU) Quarterly Report

Ms Greenwood joined the meeting to present the report and highlighted that speaking up activity had increased significantly from the last quarter, but the rise was not unprecedented. Her focus remained on the themes of the concerns rather than the raw numbers. More concerns had been raised around patient safety and quality of care, and the culture within teams. There had been a small decrease in the number of concerns raised about bullying and harassment, but the longer-term trend remained stable.

Ms Greenwood referred to the recently published Thirlwall report and its conclusions on the importance of professional curiosity, psychological safety and organisational response, and whether staff felt empowered, supported and confident to speak up and challenge

without fear. The role of the FTSU Guardian role was to listen, support and to take appropriate action in terms of escalation through the appropriate routes.

Dr Dexter-Smith commented that she was considering how the work of the FTSU Guardian would feed into the work of the new Culture and People Committee in terms of addressing the themes of concerns whilst retaining the independence and confidentiality of the FTSU process.

Miss Smith underlined the importance of the FTSU role and function and reflected that creating the conditions in which staff felt safe to speak up would strengthen the organisation. Dr Boyd agreed and noted that it was positive that staff were becoming more confident in the FTSU process. Ms Greenwood added that the positive change in the Trust's senior leadership had encouraged staff to express concerns.

Ms Greenwood was thanked for her report and she left the meeting.

18 Maternity and Neonatal Reports

Ms Wells-Munro presented the safety report. She highlighted the following points:

- there had been no neonatal deaths in August, no Maternity Outcomes Signal System (MOSS) safety signals had been received since January 2025 and there had been no new Maternity and Neonatal Safety Investigation referrals in August;
- workforce recruitment continued following the investment in April: six newly qualified midwives were due to begin in October and a further seven in February;
- the Service had met the 90% training compliance in September, as required under the Maternity Incentive Scheme (MIS) Year 8;
- work towards full compliance with the Maternal Safety Bundle and the Saving Babies' Lives Care Bundle continued but there were risks to the delivery of some elements relating to digital requirements which had been escalated both regionally and nationally;
- September had been a busy month for the Service, but Ms Wells-Munro assured the Board that there had been no poor outcomes from the diverts reported; she explained that the diverts had been necessary due to lack of capacity and were only actioned for short periods as a last resort;
- the Service had significant roster vacancies due to sickness absence, maternity leaves and supernumerary requirements; there had been agreement that substantive midwifery staff could be recruited to the bank to increase capacity;
- in terms of perinatal mortality review cases, two reports had been returned to the Trust; the first report outlined opportunities for strengthening processes although these would not have materially changed the outcome; the second report linked to improvement work with MBRRACE-UK and the Neonatal Operational Delivery Network;
- in the last 12 months, there had been 19 deaths, none were intrapartum stillbirths, 11 were pre-term and 8 were term.

Mr Barkley noted the relatively low number of Caesarean Section births in August. Ms Wells-Munro supplied context to the figures and added that the Service would support women whatever their choices.

18.1 Maternity & Neonatal Voices Partnership (MNVP) Workplan Update – January to July 2026

Ms Wells-Munro presented the paper which provided the Board with a summary of the work of the work of the MNVP and its future plans, formulated in response to service user

feedback and wider stakeholder engagement. She added that the Trust continued to work with ICB on longer term resourcing for the MNVP.

Mr Barkley queried the MNVP's finding in relation to ante-natal care that "feedback shows inconsistent quality and accessibility across geographic areas". Ms Wells-Munro explained that the Service should be delivering antenatal education and this was being progressed but there was a lack of clarity around the commissioning. There was an improved offer in Scarborough, which was delivered by community midwives.

In response to a question, Ms Wells-Munro explained that "Golden Hour partner access" referred to partners being able to stay with mothers and babies post-delivery which was not yet possible at either York or Scarborough due to the limitations of the estate. The ambition was included in the Single Improvement Plan.

In response to a question, Ms Wells-Munro explained that the MNVP was independent of the Trust and was until recently hosted and funded by the ICB. The Trust had maintained the MNVP by awarding the co-leads bank contracts whilst a long-term solution was discussed with the ICB.

18.2 Implementation of the National Maternity Early Warning Score across the Trust

Ms Wells-Munro advised that Sophie Keely, Labour Ward Matron, had led the work to implement the National Maternity Early Warning Score (MEWS). This had been launched within Maternity Services, and all maternity staff had been trained but the tool should be used in treating pregnant women across the Trust. Ms Wells-Munro noted that the approach met national standards. Mr Hague added that a training and rollout plan was now needed to implement MEWS across the Trust.

The Board of Directors approved the immediate 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

The Board noted the September checkpoint position, received assurance that Safety Action B requirements were achieved, and supported continued monthly oversight through to the end of the reporting period on 30 November 2026. The final position would be reported to the Board in January 2027.

19 Thirlwall Inquiry Report – Summary, Trust Response and Assurance Position

Mr Hague presented the paper which set out the immediate actions required by NHS England in the light of the Thirlwall report and the Trust's responses. The actions had been RAG rated in the report. Mr Hague observed that more work was required to be assured that senior leaders had the curiosity referred to in the report.

In terms of the immediate actions, Mr Hague highlighted the action around access to and storage of insulin in neonatal units which had been rated amber/red: this had now been addressed and would be rated green. Next steps were included in the paper and Mr Hague observed that these would encompass services across the Trust, not just Neonatal.

Ms Hazelgrave referred to the action around safeguarding and noted that the Board had received safeguarding training. Mr Hague responded that a refresher session was likely to be needed.

20 Patient Experience and Complaints Report Quarter 1

Mr Hague presented the report and highlighted notable improvements around volunteering, access arrangements and health inequalities. Complaints to the Trust had reduced by 8% compared to Quarter 4 but Mr Hague noted that this had not been sustained in Quarter 2. The main themes centred on communication and delays to treatment and the focus was on using education and training to address the root causes.

Mr Hague advised that the Trust would not be compliant with accessible information standards until Nervecentre Tranche 3 was implemented. However, a new appointment to the Trust was supporting work to address health inequalities through more person-centred care.

In response to a question, Mr Hague advised that the Patient Advice and Liaison team was fully established although there were still challenges to capacity caused by sickness absence. The establishment of the team would form part of a wider review of complaints processes which Mr Hague had alluded to earlier. Triangulating complaints and concerns with other patient experience information and other areas, such as staff sickness, would also be a priority.

21 Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Annual Reports

Dr Dexter-Smith presented the reports, noting that they covered the period from April 2025 to March 2026 and demonstrated a variation of between 0.8 and 1.25, with 1 being equity of opportunity.

Dr Dexter-Smith reminded the Board that the data was from different staff groups from year to year and was therefore not directly comparable. It also needed to be triangulated with other sources of feedback. Nevertheless, it was positive that the 2026 data showed improvement across most findings for both the WRES and WDES.

Miss Smith referenced the work of the Anti-Racism Steering Group which had discussed the need for a dashboard to track improvements and for one clear narrative in terms of the WRES actions.

Mr Barkley noted that the WRES report recorded Ms Abeysekera as a non-voting member of the Board; this error would be corrected.

There was some discussion on how the data in the WRES report compared with the experience of non-BME staff and with other Trusts, and Dr Dexter-Smith advised that she aimed to include benchmarking data in the next report.

Referring to section on the 2025-2027 WRES action plan, Mr Barkley queried which two actions were yet to be implemented.

Following the meeting, the report was amended to include the actions:

- *to implement a process for BME representation on recruitment panels at Band 7, expanding to band 8a and upwards in the future (Metric 2)*
- *to review Statutory and Mandatory training and Conflict Resolution training against the Enhanced Conflict Management training model to ensure colleagues receive the essential training they need in this field (Metric 5).*

DRAFT

Dr Dexter-Smith noted that the WDES data was also largely positive, apart from the metrics “Feeling Valued at Work” and “Reasonable Adjustments” in which there had been a slight deterioration.

22 Premises Assurance Model (PAM)

Mr Norman presented the paper, noting that 2025/26 NHS England Premises Assurance Model Self-Assessment contained a new set of questions from previous years. The self-assessment was a joint submission from the Trust and YTHFM. There were 12 areas reported as fully compliant and 36 with one or more gaps requiring action plans. Mr Norman assured the Board that the gaps in compliance did not necessarily indicate operational risk, and the next steps would be to validate the evidence and to assess the significance of the gaps. Any investment needed to be compliant would be subject to the normal approval processes.

Mr Norman underlined the need for more robust evidence to meet the standards and advised that he had instigated quarterly reviews, exception reporting and active monitoring of delivery against the action plans.

Ms Charge drew attention to the 0% compliance with the two questions relating to “Safety reporting and actioning safety alerts”. Mr Norman explained that there were processes in place which he assured the Board were fit for purpose, but the organisation was not fully compliant with the wording of the self-assessment question. He confirmed that a risk management system was in place.

Ms Hazelgrave asked what the next steps would be, and if there would be any consequences of non-compliance. Mr Norman explained that, as this was the first year of the new Premises Assurance Model questions, he would await more information about the national picture. The outcomes of the exercise were not unexpected given the more challenging question sets.

The Board of Directors ratified the submission of the 2025/26 Premises Assurance Model position and endorsed the proposed 2026/27 governance arrangements.

23 Q2 2026/27 Board Assurance Framework

Mr Taylor reported that the Board Assurance Framework (BAF) had been updated for Quarter 2: no risk ratings had changed. He highlighted the updates which were in red text and the inclusion of formal ratings. Directors recorded their thanks to Mr Taylor for the improved format of the BAF.

In response to Mr Barkley’s challenge to the scoring of Principal Risk 1, Miss Smith assured him that Executive Directors would continue to discuss and challenge the scoring of the BAF risks.

24 Board of Directors and Committee 2026/27 Revised Dates

The Board of Directors approved the revised schedule of meetings for the remainder of 2026/27 and into 2027/28.

25 Questions from the public received in advance of the meeting

There were no questions from members of the public.

26 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 25 November 2026 at 9.30am at Scarborough 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 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. Update 28.10.26: the due date was deferred to November	Nov 26 from Jul 26	Delayed
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	Update 28.10.26: Ms Hansen expained that she was reviewing Standard Operating Procedures and escalation processes in terms of alignment with daily management and the Integrated Accountability Framework. She would provide an update in January.	Jan-27	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		Nov 26 from Oct 26	Delayed
BoD Pub 30	28-Oct-26	15	Trust Priorities Report	Investigate the reasons for the zero number of RAFA and SAU attendances recorded in the TPR	Chief Digital & Information Officer		Nov-26	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

November 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’.

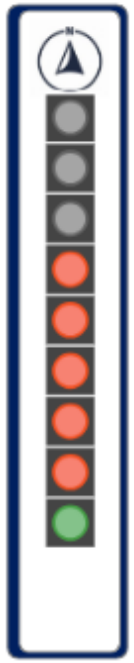
This is the single point of reference to measure our progress.

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)

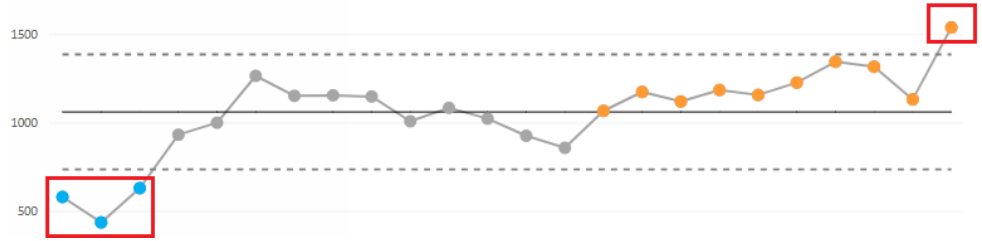
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

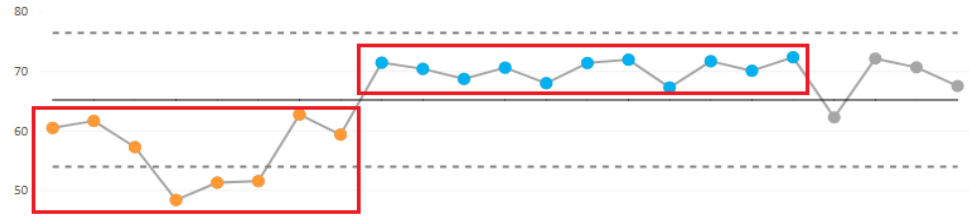
These lines (limits) help to understand the variability of the data and are set to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

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.



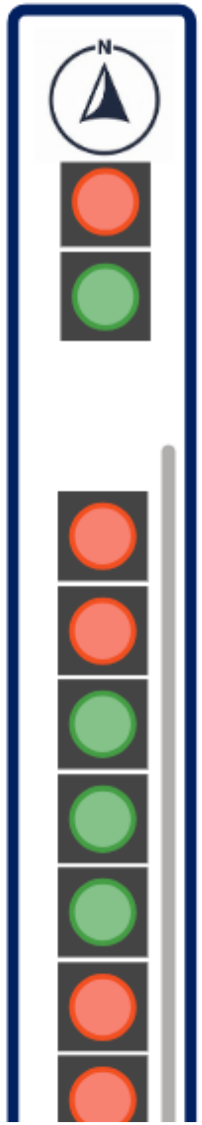
Trend: Counts the number of occasions there is a run of 7 consecutive points going in the same direction.



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

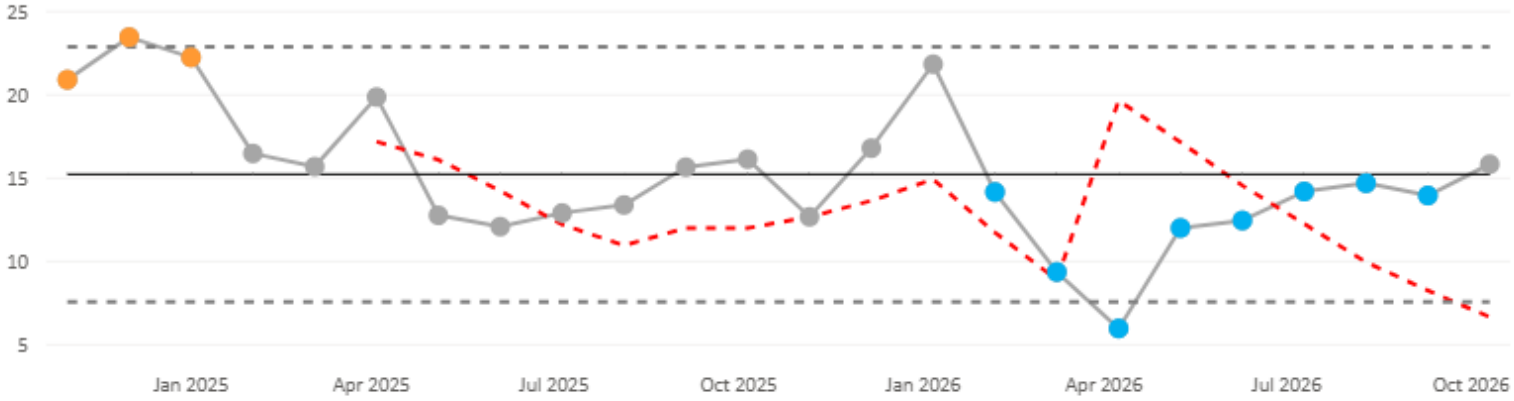
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target Mar 2027
Value	16.1%	12.6%	16.7%	21.8%	14.1%	9.3%	5.9%	12%	12.4%	14.1%	14.6%	13.9%	15.8%	5%
Trajectory	11.9%	12.6%	13.6%	14.9%	11.7%	8.9%	19.6%	17.1%	14.5%	12.2%	9.9%	8.2%	6.6%	

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 and surges.
- Workforce capacity, skill mix, absence rates.
- Financial constraints mean limited options for testing new ways of working.
- Poor flow out of hospital, linked to challenges in system partner organisations.

What are we doing about them?

- The EAU SOP is being reviewed by Clinical Leads and a 'user friendly' version is being created.
- 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

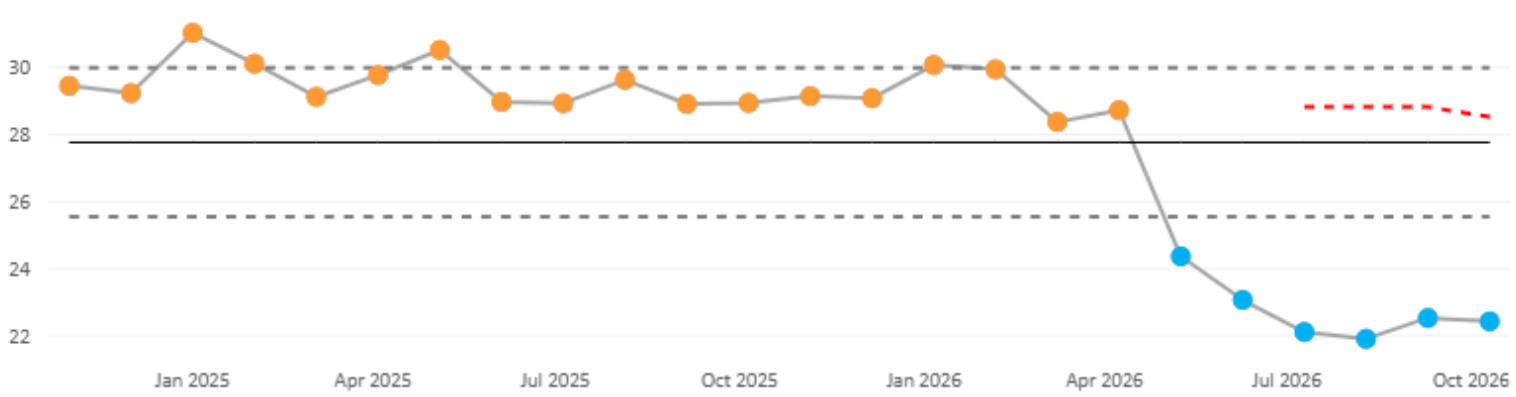
Urgent Emergency Care: Reduce the proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero

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)?

10 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

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target Mar 2027
Value	28.9%	29.1%	29.1%	30.1%	29.9%	28.4%	28.7%	24.3%	23%	22.1%	21.9%	22.5%	22.4%	28%
Trajectory										28.8%	28.8%	28.8%	28.5%	

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?

- Increasing frailty at front-door capacity in November 2026 at both sites.
- Trialling cardiology input in ED/EAU one morning per week from November 2026.
- 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

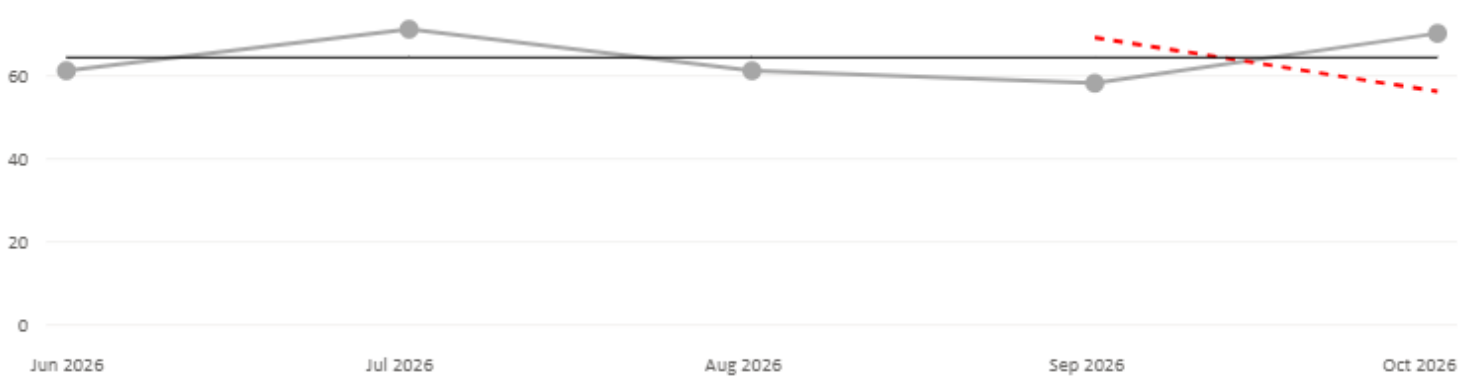
Urgent Emergency Care: Reduce the number of patients treated in non-designated areas

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	Oct-26	Target Mar 2027
Value	61	71	61	58	70	0
Trajectory				69	56	

* 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.

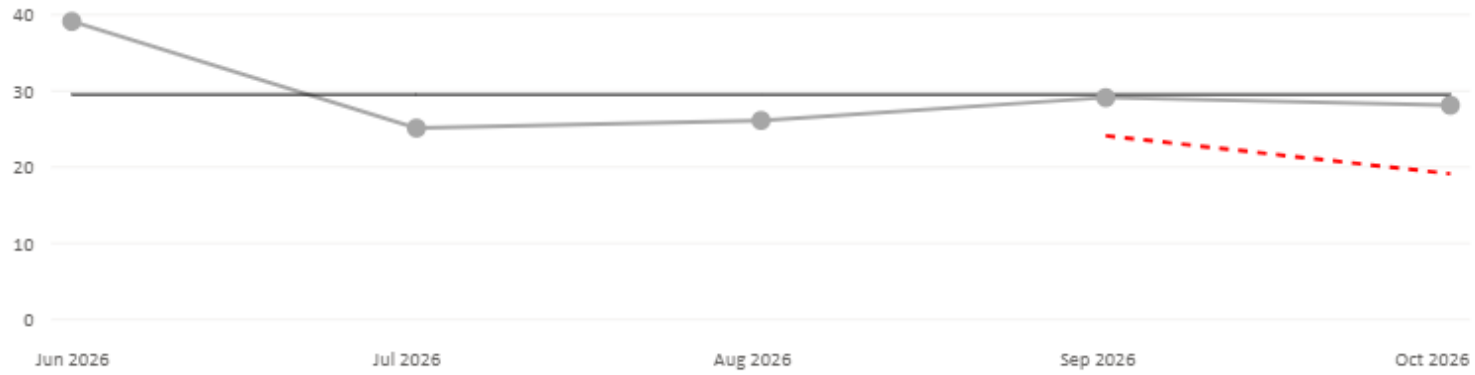
True North Report

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	Oct-26	Target Mar 2027
Value	39	25	26	29	28	0
Trajectory				24	19	

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

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

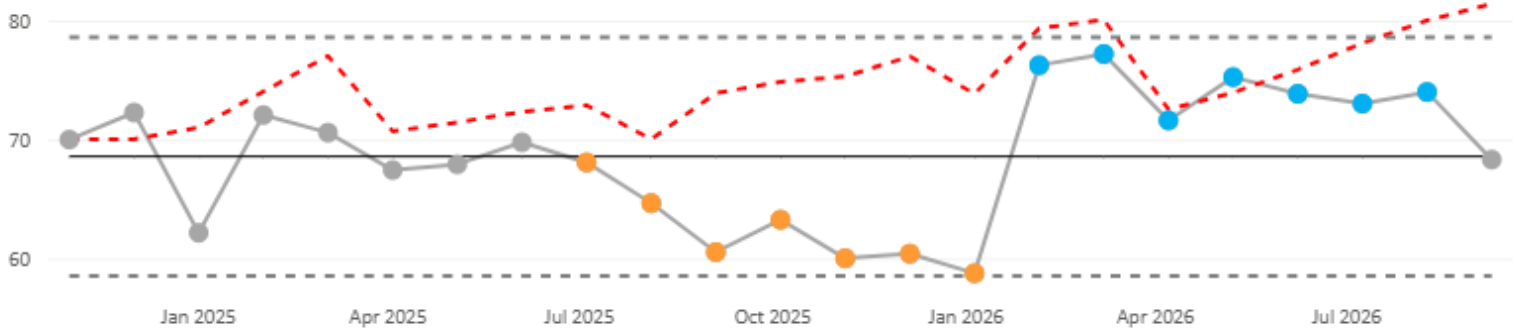
True North Report

Objective Status ⊗ Up Is Good

Elective: Cancer: Improve the Faster Diagnosis Standard

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

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



Is there special cause variation?

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

0 found

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

Occurs

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

Does Not Occur

	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	60.6%	63.3%	60%	60.4%	58.8%	76.2%	77.2%	71.6%	75.2%	73.8%	73%	74%	68.3%	84.3%
Trajectory	73.9%	74.8%	75.3%	77%	73.8%	79.3%	80.1%	72.5%	73.9%	75.9%	78.1%	80%	81.4%	

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.

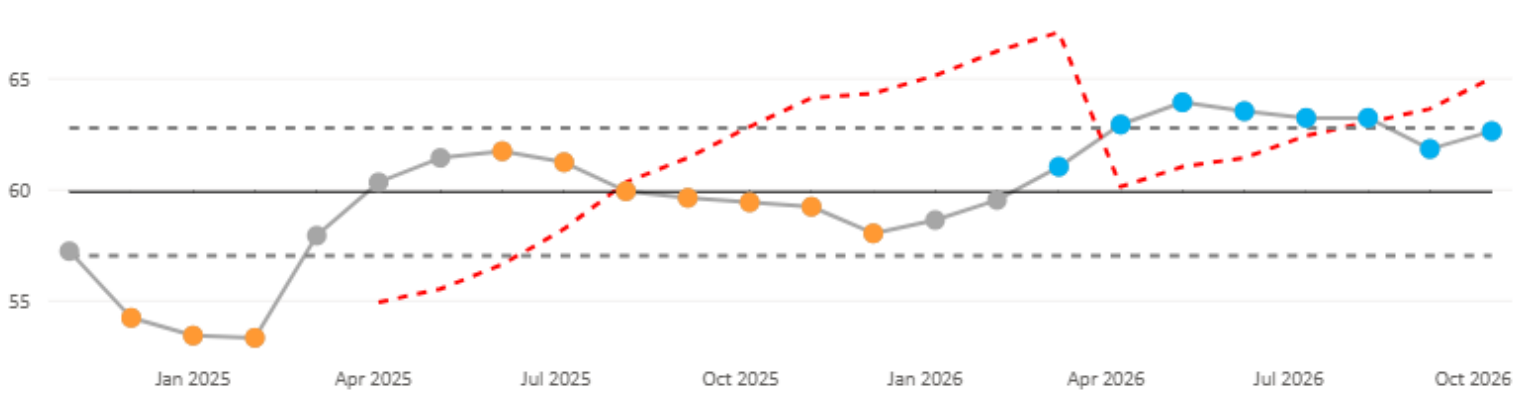
True North Report

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

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target Mar 2027
Value	59.4%	59.2%	58%	58.6%	59.5%	61%	62.9%	63.9%	63.5%	63.2%	63.2%	61.8%	62.6%	67.1%
Trajectory	62.8%	64.1%	64.3%	65.1%	66.2%	67.1%	60.1%	61%	61.4%	62.4%	63%	63.6%	65%	

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 elective 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
- 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 Q3
- Implement 2weeks of RTT clinics per specialty in
- Partnership working to identify opportunities to undertake primary / secondary care virtual reviews and clinics.,

True North Report

Objective Status Up Is Good

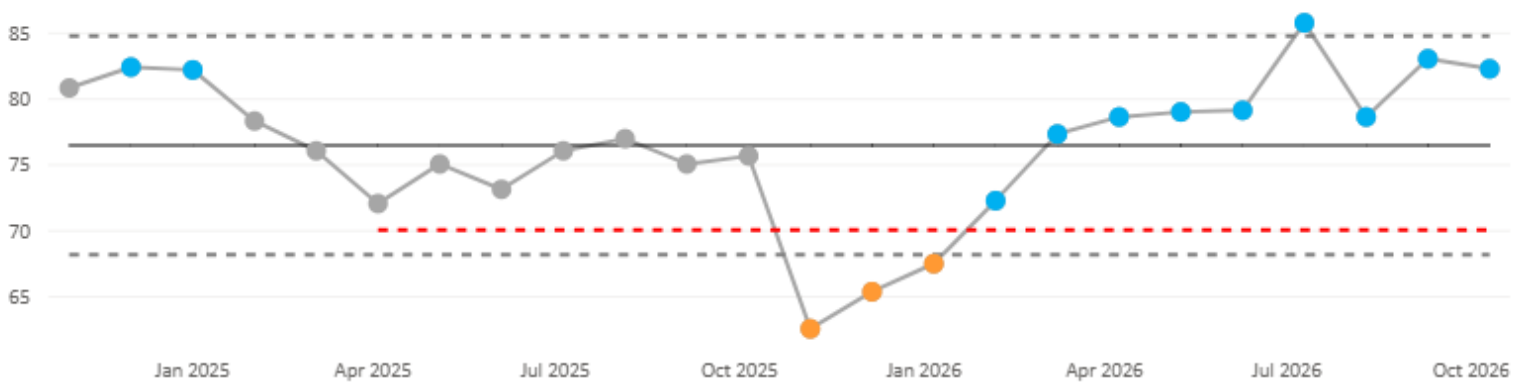
Community: Increase 2-hour Urgent Community Response Compliance

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)?

4 found

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

Occurs

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

Occurs

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target Mar 2027
Value	75.6%	62.5%	65.3%	67.4%	72.2%	77.3%	78.6%	79%	79.1%	85.7%	78.6%	83%	82.2%	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

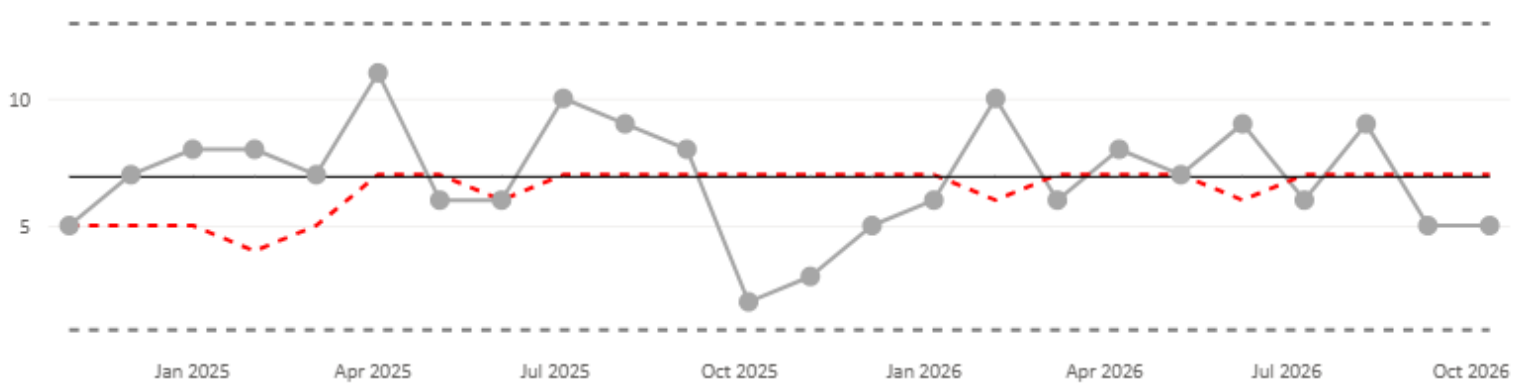
Q&S: Reduce the number of Trust Onset MSSA Bacteraemia

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

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target Mar 2027
Value	2	3	5	6	10	6	8	7	9	6	9	5	5	7
Trajectory	7	7	7	7	6	7	7	7	6	7	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
- 1 case over the threshold, year to date, this is an improvement of the position of 4 cases over in September

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

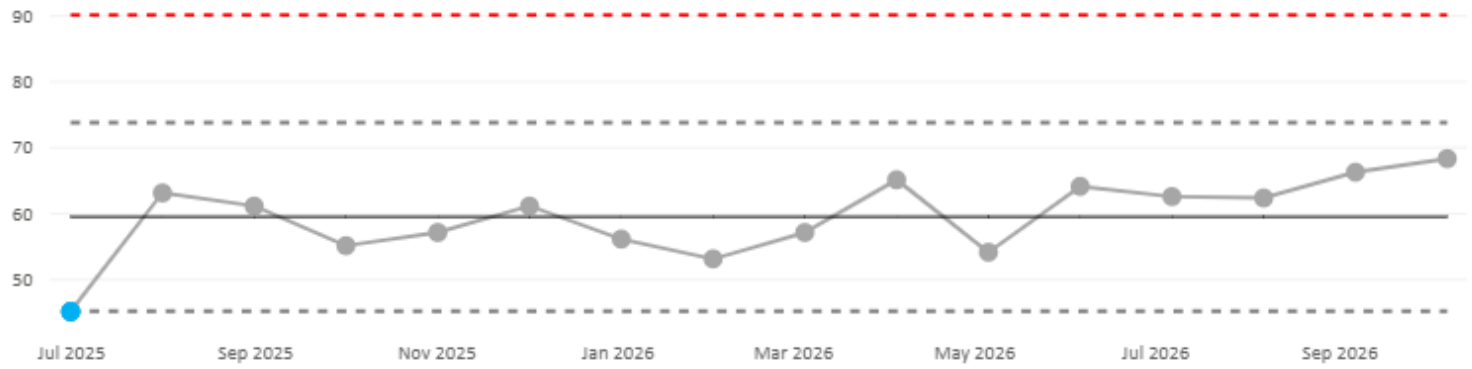
Objective Status Down Is Good

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)?

1 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

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Target Mar 2027
Value	55%	57%	61%	56%	53%	57%	65%	54%	64%	62.5%	62.2%	66.2%	68.2%	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

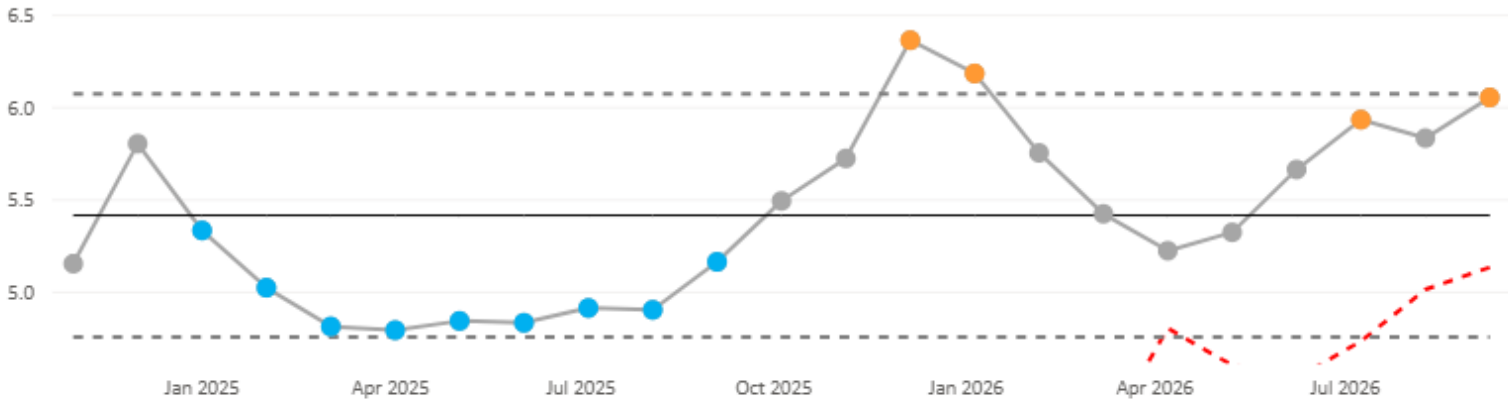
Workforce: Reduce the Monthly Sickness Absence rate

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

	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	5.2%	5.5%	5.7%	6.4%	6.2%	5.8%	5.4%	5.2%	5.3%	5.7%	5.9%	5.8%	6.1%	4.7%
Trajectory	4.2%	4.2%	4.2%	4.5%	4.5%	4.5%	4.2%	4.8%	4.6%	4.5%	4.7%	5%	5.1%	

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.

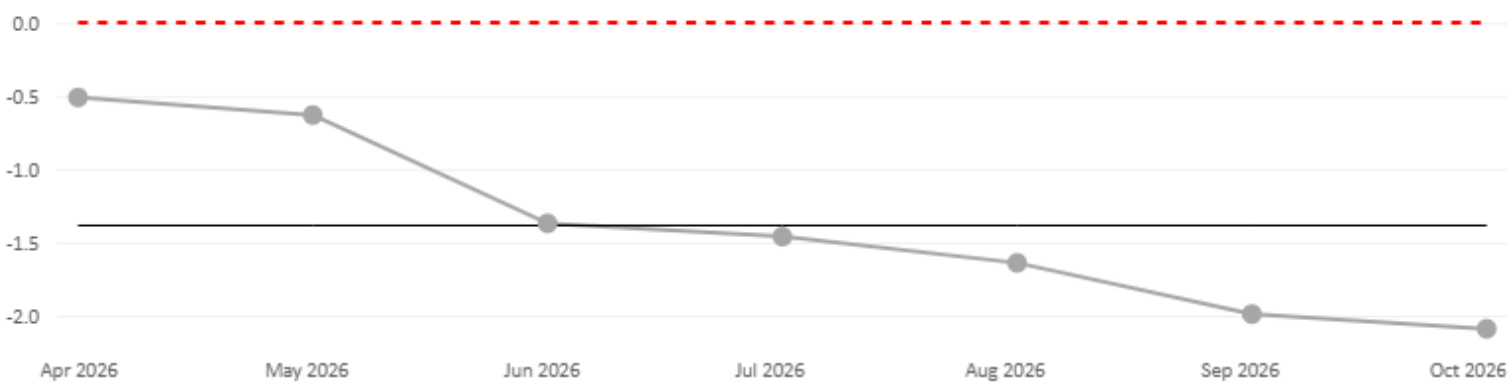
True North Report

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?

Occurs

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Value	-0.5%	-0.6%	-1.4%	-1.5%	-1.6%	-2%	-2.1%
Trajectory	0%	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 October, WRAP delivery falls £6.8m short of the YTD target, although this has improved from £7m shortfall in September.
- The WRAP programme is fully planned as at October.
- Of planned schemes still to be delivered, £4.5m WRAP plans are High-Risk (a reduction from £7.4m in September), £5.3m Medium Risk (a reduction from £6.9m) and £15.3m 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/Robert Black)

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 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 supplemented 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 | October 2026

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

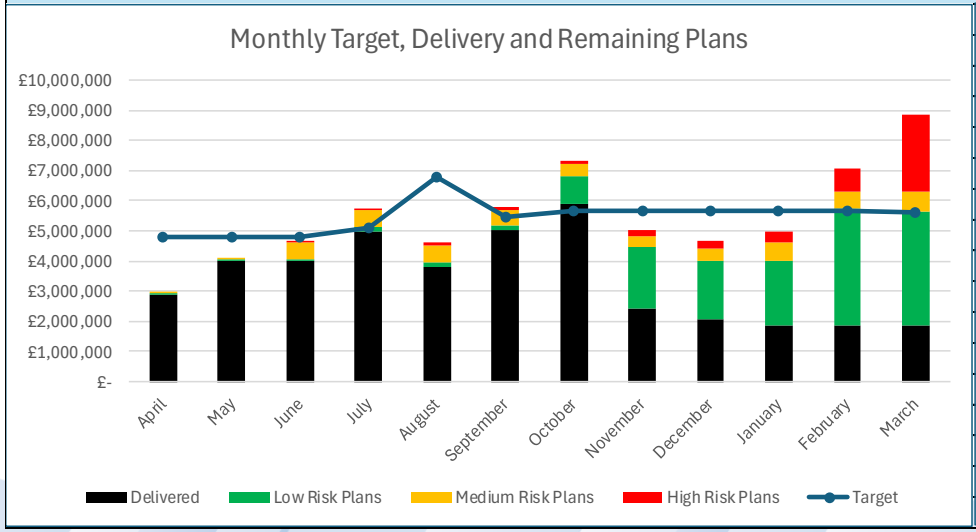
Executive Summary

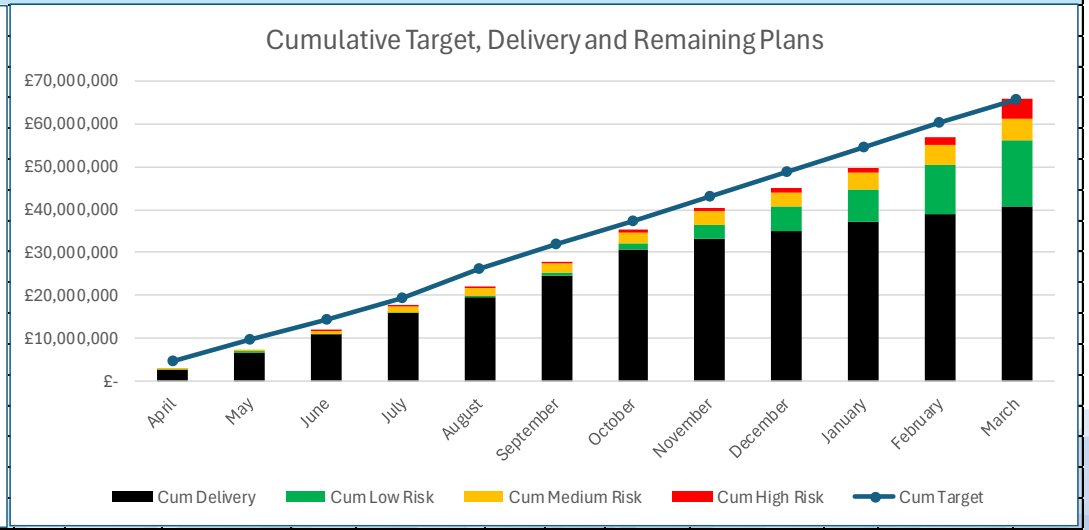
Programme Summary Position	Full Year	YTD Position
Target	£65,785,699	£37,472,082
Delivered	£40,719,237	£30,646,992
Variance	**-£25,066,462**	**-£6,825,090**
Addititional Plans to be delivered		
Planned Low Risk	£15,284,396	£1,478,259
Planned Medium Risk	£5,268,908	£2,659,844
Planned High Risk	£4,513,158	£396,334
Total Additional Plans	**£25,066,462**	**£4,534,437**
(Planning Gap)/Over delivery	**-£0**	**-£2,290,653**

WTE Plan	256.07	**WTE Delivered**	79.11

Scheme Governance									
Total Number of Live Schemes	**154**								
EQIA Outstanding	53	34%							
Pre-Pipeline	10	6%							
Opportunity	31	20%							
Plan in Progress	6	4%							
Fully Developed	107	69%							
	Plans	**%**	**Delivered**	**%**		**Plans**	**%**	**Delivered**	**%**
Recurrent	£37,754,355	57%	£23,846,573	36%	**Pay**	£28,604,952	43%	£17,821,947	27%
Non Recurrent	£28,031,344	43%	£16,872,664	26%	**Non Pay**	£36,961,384	56%	£22,677,927	34%
Total	**£65,785,699**	100%	**£40,719,237**	62%	**Income**	£219,363	0%	£219,363	0%
					Total	**£65,785,699**		**£40,719,237**	
YTD Period Name	October 2026								

In Year Plan Profile





Report to:	Board of Directors
Date of Meeting:	25 November 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 – November 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 chaired an appointment panel with four Governors to appoint a new NED to I fill the vacancy succeeding Noel Scanlon. A preferred candidate was agreed by the panel and subsequently the Council of Governors. The necessary fit and proper persons test due diligence checks have started. It is hoped that the person will be able to commence in December or January at the latest.

3. I chaired the first meeting of the Task & Finish Group the Trust with the Council of Governors established 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). The outcome of that meeting is contained in a paper on the Board’s agenda today, which describes a set of proposals for consideration by the Board and the Council of Governors next month.

4. I had the pleasure and privilege of attending the annual Celebration of Achievement Awards evening. It was a wonderful occasion learning of the citations that had led to the teams and individuals who had been shortlisted, and the happiness and pride displayed by everyone knowing their achievements had been recognised and celebrated. An inspiring and humbling evening.

Martin Barkley
Trust Chair
21.10.26

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Chief Executive's Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Clare Smith, Chief Executive

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

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

- Around the Trust
- Major milestone reached for Scarborough's new laboratory
- Building Better Healthcare Award
- National review of Band 5 nursing roles
- Sexual health EPR
- Veteran Aware

- Director of Midwifery
- Celebration of Achievement Awards
- Star Award nominations: October 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

Since my report last month I have had two weeks of annual leave, but prior to going on holiday we really started to see the signs of winter as our services continue to face high demand and our cases of flu and COVID-19 are increasing.

I am concerned about rising respiratory infections and their impact on vulnerable patients. We have introduced mask-wearing in higher-risk areas at York Hospital in response to these concerns about respiratory infections and their potential impact on vulnerable patients. We also continue to emphasise the importance of following local Infection Prevention and Control guidance, in particular in relation to hand hygiene.

Our flu vaccination programme is also critical to this, and we continue to monitor uptake and target support where participation is lower to help us achieve our target of vaccinating at least 65% of front-line colleagues.

I have continued to spend time with colleagues across the Trust, and my visits to teams in Scarborough, Selby and York this month provided valuable opportunities to hear how things are for our colleagues and patients.

Thank you to the team at Selby Hospital for talking to me about the minor surgery service, and to the team on Ward 14 at York Hospital for showing me around the Surgical Assessment Unit and ward.

I also visited York's Renal Unit, where I heard positive feedback about the team alongside concerns about the accommodation, and I particularly recognised the nursing team's efforts to maintain patient dignity and safety despite limitations in the space and infrastructure.

My Chat and a Brew sessions continue to provide valuable opportunities to hear colleagues' ideas and concerns, and I have also suggested team-based sessions from colleagues who cannot attend the wider events.

I was pleased to join the Black History Month 'Honouring Our Communities' Living Library, supported by our Race Equality Network. I thank colleagues who shared their lived experiences so openly; their contributions reinforced the importance of listening, challenging assumptions and understanding one another.

I also joined the Scarborough Leadership and Management (SLAM) course for medical colleagues approaching the end of training.

The course, which has been running for a number of years, is open to medical colleagues from across the country and is designed to develop leadership, operational management, and administrative skills for healthcare professionals. Our discussion explored values, psychological safety and teamwork as they prepare for consultant roles.

Whilst offering valuable training in its own right, it has also proved effective in helping to recruit a number of colleagues to our Trust in consultant roles, and is one of the innovative ways we have of making York and Scarborough attractive to future colleagues.

Alongside innovations such as SLAM it is important we continue to focus on the basics for our colleagues. I met with the Medical Education team who highlighted that we need to do more to improve some resident doctors' sense of belonging and support. As a teaching hospital trust, we must provide a more consistent experience that helps our resident doctors feel valued and supported. This will be a focus over the coming year.

2. Major milestone reached for Scarborough's new laboratory

I am pleased to report that construction of Scarborough Hospital's new £25 million acute service laboratory has reached the topping-out stage.

The three-storey, 2,600 square metre facility will provide a modern, purpose-built home for pathology services and an improved working environment for colleagues delivering diagnostic services to patients across Scarborough and the surrounding communities.

The new laboratory will replace ageing accommodation following the identification of reinforced autoclaved aerated concrete (RAAC) in the existing pathology department in 2023, which required colleagues to relocate to other areas of the hospital.

We are delivering the development with Integrated Health Projects (IHP), the joint venture between VINCI Building and Sir Robert McAlpine. This continues our partnership following the delivery of Scarborough Hospital's £47 million Urgent and Emergency Care Centre.

The building will accommodate a fully equipped, 24/7 acute laboratory service supporting clinical biochemistry, haematology, blood transfusion, point-of-care testing and molecular diagnostics. In the longer term, it will also provide additional space for ophthalmology and outpatient services.

Pathology is essential to timely diagnosis and treatment decisions. I welcome this investment in the facilities and infrastructure our colleagues need to support patient care and the future development of services on the East Coast.

Thank you to our pathology and estates colleagues, York Teaching Hospital Facilities Management, IHP, P+HS Architects and the wider project and supply chain teams for their contribution to reaching this stage.

We expect the new acute service laboratory to become operational towards the end of 2027.

3. Building Better Healthcare Award

More good news for Scarborough as the hospital's Urgent and Emergency Care Centre (UECC) has received further recognition for its design and delivery.

The centre won Gold in the Best Healthcare Development between £25 million and £75 million category at the 2026 Building Better Healthcare Awards.

The award recognises excellence in healthcare design, construction and delivery, including how developments meet the needs of patients, colleagues and visitors, their sustainability, partnership working and contribution to care.

This follows earlier recognition, including the Integration and Collaborative Working award at the 2024 Constructing Excellence Yorkshire and Humber Awards and a Highly Commended distinction for Building Project of the Year in 2026.

The development reflects a collaborative, one-team approach to a major project, bringing together the expertise and commitment of colleagues and partners, and provides a purpose-built environment to support colleagues in delivering care for people in Scarborough and the surrounding communities for many years to come.

I would like to congratulate everyone involved in this achievement, particularly as there was some tough competition in this category.

4. National review of Band 5 nursing roles

We have begun work to implement the national review of Band 5 nursing roles, following agreement between the Government, NHS Employers and trade unions and the publication of updated national nursing job profiles under Agenda for Change.

The review provides an opportunity to ensure that job descriptions accurately reflect contemporary nursing practice and the skills and responsibilities of our Band 5 registered nurses, with the national Agenda for Change Job Evaluation Framework applied fairly and consistently.

This will be a significant programme of work involving our Band 5 nursing workforce and will be undertaken in partnership with colleagues and our recognised trade unions. The national timeframe is for reviews to be completed by October 2028, although our ambition is to complete the work locally ahead of that deadline where possible.

Engagement with Band 5 nursing colleagues begins this month and will help inform our approach. Appropriate governance and oversight will be maintained throughout to ensure the process is fair, transparent and consistent.

5. Sexual health EPR - another digital milestone

I am pleased to report that our sexual health service has begun the phased introduction of its new electronic patient record (EPR) system, marking a further milestone in the Trust's digital development.

This follows substantial work by colleagues from sexual health, digital and pathology, alongside our delivery partners, to replace older systems and improve ways of working.

I recognise the planning, problem-solving and collaboration required to introduce this change alongside the day-to-day demands of delivering services, so thank you to all involved on what is is a further important step in our use of digital technology to support patient care.

6. Veteran Aware

I am delighted to share that we have been reaccredited as a Veteran Aware Trust.

As someone who has served in the Armed Forces, I place particular importance on recognising and supporting those who have served and their families.

We first achieved accreditation in 2022, followed by a review in 2023. This latest recognition reflects the work undertaken by colleagues to strengthen the support we provide to our Armed Forces community.

Being Veteran Aware means ensuring that the particular needs and experiences of veterans and their families are recognised and supported when they access our services. It also means translating our commitments under the Armed Forces Covenant into practice.

I would like to thank our Veterans' Network for its work in preparing the reaccreditation submission, and the wider Veteran Aware group for its continued contribution to this work.

7. Director of Midwifery

Sascha Wells-Munro, our Director of Midwifery, has been appointed Director of Midwifery at Leeds Teaching Hospitals and will be leaving us in the New Year.

During Sascha's time with the Trust, our maternity services have made significant improvements, including achieving Good CQC ratings at both York and Scarborough. Sascha's leadership has been absolutely vital to this, and her impact during her time with us has been hugely positive both for our colleagues in maternity services and for the local people we serve.

I would like to thank Sascha for her service to the Trust, congratulate her on her appointment and wish her every success in her new role.

We are currently advertising for a new Director of Midwifery, and I will keep the Board updated as that progresses.

8. Celebration of Achievement Awards

Last month, I hosted my first annual Celebration of Achievement Awards as Chief Executive, where we recognise the contributions of colleagues and teams across the Trust.

While we continue to face significant challenges, I remain proud of the care, compassion and determination colleagues bring to their work, and the awards offered an important opportunity to acknowledge that commitment.

For me, the celebration was about more than individual achievements. It recognised the collective contribution of colleagues to patient care and to making the Trust a supportive place to work.

Colleagues often regard their contribution as simply part of their role, but I believe it is important that we take time to acknowledge the kindness, skill and dedication behind this 'everyday work'.

I am grateful to our sponsors, including those who support us year after year, for making the celebration possible, and I look forward to seeing what the coming 12 months will bring for us to celebrate at next year's event.

9. 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. October's nominations are included at **Appendix 1.**

Date: 25 November 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

October 2026

Sue Tyce, Complaints Officer **York** **Nominated by a colleague**

I am absolutely terrified and distressed by moths. I came into work on Monday morning, as I went to check the landline phone, which is on the window sill, I froze as I almost put my hand on a big grey moth, typing this is making my stomach turn and I feel sick. I shot back uttering some profanity I have no doubt, to which Sue asked if I was ok. I could barely tell her what was wrong with me and she stood up, came around to my side of the desks and opened the window then spend five minutes or so putting said beast out of the window for me. This meant I could calm myself and get on with my work which if she hadn`t removed the beast, I could not have gone near my desk to get my laptop in order to go and work elsewhere and I would have been stressed and on edge all day.

Ziek Faulkner, Maintenance Assistant **Scarborough** **Nominated by a colleague**

Ziek came down to the ED to fix a door and showed care and compassion towards an elderly lady who had presented with new confusion and was very distressed. After Ziek spent some time with her, she settled and was in a much happier mood. Ziek went above and beyond his job role and reflected the Trust values.

Amie Mollon, Registered Nurse **York** **Nominated by a colleague**

During a recent night shift, I witnessed Amie being faced with the most difficult and challenging situation while working on a ward. Before she even started her shift, it was clear that it was going to be a tough night due to limited resources and staffing. I watched in awe as she was faced with a very complex bay of patients who tested her to her limits. She handled it like the professional that she is, remaining firm but fair when faced with unreasonable requests. She proved that she has integrity and drive and throughout it all remained cheerful and positive. I just wanted her to know that her amazing attitude towards her work is infectious and that what she did was seen, heard and respected by her colleagues.

Glenn Hawthorne, Cardiac Nurse Specialist **York** **Nominated a colleague**

I would like to nominate Glenn for his outstanding enthusiasm and positive approach to education. Throughout the years, he has made a significant contribution to staff development and has been a great support to the education team, always willing to help and share his knowledge. Glenn has a real talent for making learning interesting and enjoyable, helping staff build confidence and develop their skills. He consistently goes above and beyond, taking pride in his work, and always wants to make sure things are done properly. His enthusiasm, professionalism, and dedication make him thoroughly deserving recognition.

Ali Couttie and Julie Sharp, Paediatric Dieticians | **York** | **Nominated by a colleague**

Julie and Ali have been instrumental in progressing the Dietetics transformation work. Their support in reviewing acceptance criteria, waiting list communications, referral processes, and stakeholder engagement has been invaluable. They bring a positive and collaborative approach, encouraging contributions from across the team and helping drive forward a long-awaited piece of work that will improve outcomes for children and families while enhancing staff wellbeing.

Scarborough Outpatient Department | **Scarborough** | **Nominated by a colleague**

Today is my last day working with this amazing team and there are too many things to say regarding these amazing people but here are a few: I have never worked with such a supportive, kind, caring team. The friendships we have made will be for life.

From Magda the Operational Manager who is honest, straightforward, thoughtful and kind – she's new to town so we've all looked after her, helping in any way we can. Gemma the Service Manager whose smile lights up any room. She is a real Disney princess and her deputy Ross who is the only man in the department so takes some stick but can't do enough for us all. We have all shared the trials and tribulations of life for a lot of years, some sad some very challenging but some very happy times, especially this past year with the arrival of three new babies to team members. The Trust values could have been written by this team because every day the department is full of kindness, openness and excellence and I am lucky to have worked alongside them all.

Paediatric Speech and Language Therapy team | **Scarborough** | **Nominated by a colleague**

Rebecca Balf was faced with a complex safeguarding case during a clinic appointment. She and her team exemplified excellent safeguarding practice and professionalism throughout the episode and ensured that all the correct processes were followed, while simultaneously supporting the family with care and compassion.

Her actions and those of her colleagues enabled a child to feel safe enough to report to her the worries that he had about what was happening for him and this allowed Rebecca to escalate and report her concerns to wider agencies.

Rebecca worked with multiagency teams to ensure that the child and his siblings were safe at the point of leaving the clinic and that other professionals had all of the information required to support the family. During this period, Rebecca maintained a trusted relationship with the parent and was kind and non-judgmental in her approach. This work made a real difference to the welfare and safety of the children, and the team should be commended for their dedication and care during a very challenging situation.

Nicola Walker, Healthcare Support Worker **Scarborough** **Nominated by a colleague**

I would like to nominate Nichola Walker of Beech Ward for a Star Ward. I am impressed with her dedication and high-quality work ethic she brings to the ward. She consistently goes above and beyond. She provides exceptionally kind and generous caring support to the patient and the staff working along with her. She leaves patient with smile and laughter, an absolute credit to her profession who deserves recognition and reward.

Sarah Munetsi, Nursing Associate **York** **Nominated by a colleague**

Sarah took care of a patient who had been incredibly unwell who also found out they had HIV. She spoke a regional language that the patient also spoke, so they were able to build an excellent rapport together during an incredibly hard time for the patient. Due to her past experience of caring for HIV patients, she was able to support and educate the patient, whilst helping them come to terms with the diagnosis and making plans for the future. I was in awe of Sarah and incredibly proud of her and the way she cared for this patient.

Polly Newell, Child Protection Advisor **York** **Nominated by a colleague**

A child made a disclosure of physical abuse by a parent during a routine clinic appointment where the parent was also present. I telephoned the children's safeguarding duty number to seek advice. Polly answered. She was calm and reassuring and helped me to carry out relevant actions. She made sure I called her back at regular intervals to keep her informed of what was going on. I felt such relief knowing she was on the end of the phone when I needed her.

She was professional and efficient whilst demonstrating compassion towards all involved. Polly was a lifeline that day. As a result of our collaboration, we successfully kept a child safe. Polly even called me in the days following to check that I was okay. I got to meet Polly recently and we exchanged a hug which felt fitting, given what we experienced together that day. She absolutely deserves this award. Thank you Polly.

Gavin Lawrence, Workforce Lead **York** **Nominated by a colleague**

When a problem emerged in relation to a visa renewal application which would have meant a colleague having to cease working a few hours later, Gav took it upon himself to ensure the situation was resolved. With little time available, he brought a number of departments together and through sheer persistence and with the help of colleagues, was able to find a solution which meant that a very difficult situation, both for the colleague and the service they work in, was avoided. A great example of action from a colleague working in a corporate service literally maintaining frontline care. Thank you Gav.

Emily Calvert, Staff Nurse **York** **Nominated by a colleague**

Emily is a fantastic asset to Ward 34 and to the NHS as a whole.

I have had the pleasure of working with Emily when she escalates deteriorating patients in her care to the Critical Care Outreach Team (CCOT). Emily demonstrates an excellent understanding of the SBAR handover tool and always provides valuable assistance to the CCOT team when assessing and managing unwell patients. I have witnessed this myself, and her patients always comment on how attentive and caring she is, as well as how fantastic she is at her job.

Whilst always being modest when receiving this positive feedback, I wanted to nominate Emily for a STAR Award to reflect how accurately this feedback represents her compassion and dedication to her patients.

On the most recent occasion I worked with Emily, she escalated a patient before they became critically unwell, allowing the appropriate interventions and treatment to be implemented promptly. The patient in question was subsequently transferred to the Intensive Care Unit to receive further treatment and monitoring that could not be provided on the ward.

Emily's excellent clinical awareness and prompt escalation helped to save this patient's life. She embodies the Trust's values of kindness, openness and excellence and is a fantastic colleague and a pleasure to work with.

Jay Varner, Senior EUC Engineer **York** **Nominated by a colleague**

Jay is always on hand to help us with any IT issues we have, sometimes just popping in to see how we are doing and to see if we need any help with anything, nothing is too much trouble.

Jay consistently goes above and beyond to ensure systems run efficiently and that staff receive prompt, effective support. Their technical expertise, professionalism, and approachable manner have made a significant difference to the daily running of our IT systems.

Phlebotomy Service **Trust-wide** **Nominated by a colleague**

I would like to nominate the York and Scarborough Phlebotomy Services and the Clinical Support Workers at Scarborough for recognition of their dedication, resilience and commitment to patient care. The teams have faced a particularly challenging period, including high levels of staff absence, significant patient demand and the transition from Order Comms to Nervecentre. This change has required colleagues to adapt to new working practices and digital processes while continuing to maintain service delivery. Despite these pressures, colleagues have worked incredibly hard to support one another, ward teams and patients attending our outpatient and community phlebotomy services. Team members have willingly picked up additional shifts and provided support wherever possible, demonstrating flexibility and a consistently positive, can-do attitude.

Throughout this period, the teams have remained friendly, supportive and focused on providing the best possible experience for patients. Their professionalism, teamwork and willingness to adapt during significant operational change make them a real asset to the Trust, and it is a privilege to support them as their manager.

Paula Wilson, Staff Nurse **York** **Nominated by a colleague**

Paula has been my assessor in my first year of my nursing associate diploma. She helped me to adjust to working in a different area of the hospital. She was incredibly supportive and encouraging, going over and above what was needed. She came into hospital on her days off to attend my tripartite meetings. She has also been very informative due to her experience as an intensive care nurse.

Haematology Secretarial Team **York** **Nominated by a colleague**

The Haematology Department has been carrying a significant backlog of work for over six months, as a result of circumstances outside of the team's control. In recent months, the team have had to restructure their way of working and introduce mitigating procedures to minimise the risk generated by this backlog. The team have taken this in their stride, and have made significant inroads into the backlog in the last couple of months. They have reduced the turnaround time of routine letters from 12-13 weeks at its' worst, down to less than four weeks at the end of September, which is a huge achievement. This is a reflection of the whole team's dedication to the service. They have all demonstrated great resilience in the face of these strained circumstances. I am very proud to line manage this team.

Vanessa Cole, Generic Therapy Assistant **Scarborough** **Nominated by a colleague**

I would like to nominate Vanessa for a Star Award to recognise and show my appreciation for everything she does on a daily basis, not only for our patients but also for the wider therapy team.

Vanessa is a true team player and consistently works alongside all members of the MDT to provide support wherever she can, always with the aim of prioritising excellent patient care. She is incredibly dedicated to helping patients throughout their rehabilitation journey, and we regularly receive positive feedback from those she works with. Patients often highlight how helpful and supportive Vanessa has been in helping them regain their independence, build their confidence with day-to-day activities, and ultimately improve their quality of life.

Vanessa is also a wonderful colleague. She has such a great sense of humour and is always willing to lend a hand when someone needs support, regardless of how busy she is herself. She is an incredibly reliable member of the team and consistently goes the extra mile to make things easier for those around her. Her willingness to help and support others has such a positive impact on the whole therapy team.

Above all, Vanessa is genuinely one of the kindest people I know. We are incredibly lucky to have her as part of our therapy team. Vanessa truly demonstrates our Trust values of kindness, openness and excellence every day through the way she supports her patients, colleagues and the wider MDT.

Neave Aston, Occupational Therapist **Scarborough** **Nominated by a colleague**

I would like to nominate Noa (Neave) for a Star Award to recognise and show my appreciation for all the hard work and dedication she has demonstrated recently. Noa has now rotated however prior to this embraced working within cardiorespiratory so well and has consistently gone the extra mile to ensure that her patients are treated with kindness, patience and compassion.

Many of our patients experience significant breathlessness and fatigue, which can make it difficult for them to communicate their needs or keep pace with the demands of the ward environment. Noa always takes the time to listen to their concerns and understand their individual perspectives, rather than rushing them.

She has also demonstrated excellent advocacy for her patients, particularly when their needs have not always been fully understood by others. She is able to recognise when a patient needs additional time, support or a different approach and is not afraid to advocate for what is right for them. One particular case that stands out involved a patient who was partially sighted and had hearing difficulties alongside learning difficulties. Noa advocated exceptionally well for this patient, particularly at times when some ward staff were struggling to understand their needs and provide the appropriate support. Her involvement made a significant difference to the patient's experience and care. The patient and their family were extremely appreciative of Noa's support and felt strongly that her contribution should be acknowledged.

Noa is a brilliant Occupational Therapist - her compassion, patience, professionalism and commitment to advocating for her patients are a credit to her, and I feel she thoroughly deserves recognition for the positive difference she makes every day.

Rose Low (HFSN), Rebecca Quinn (HFSN), Vicky Watson (HFSN), Becky Wright (CCU Outreach) Dr Owen Bebb (Cardiologist) **York** **Nominated by a colleague**

I would like to nominate this group of colleagues who work across teams and services, within the Medicine care group and the Family care group, and who were involved in the care of a patient who attended the Heart Failure Rapid Access Service, based at Clementhorpe Health Centre, for assessment and treatment of fluid overload.

The service allows patients to receive hospital level care, without the need to be admitted. The patient was known to specialist cardiology services in Leeds and had previously experienced a traumatic admission to York, making the prospect of another local hospital admission particularly difficult for him.

During his Rapid Access assessment, he was found to be significantly bradycardic and symptomatic, with syncope and concerning pauses. The Heart Failure team immediately recognised that his condition required urgent escalation. The cardiology registrar was contacted, an ambulance requested and, due to the risk of further deterioration while awaiting transfer, the patient was closely monitored with a defibrillator immediately available, if required.

Initially, the patient's strong preference was to be transferred to Leeds because of his previous experience. However, following ambulance assessment, the clinical risk of travelling that distance was felt to be too high. What followed was an excellent example of teams working across traditional service boundaries to provide safe, compassionate and truly patient-centred care.

The Heart Failure team contacted our Admission Avoidance Nurse (Vicky Watson) and liaised directly with the cardiology registrar and cardiology consultant (Dr Bebb). Together, a coordinated plan was agreed to make the patient's admission to York as safe, efficient and reassuring as possible.

The ambulance was met at the ED front door by the relevant teams, including Cardiac Outreach (Becky Wright) and Dr Bebb. The patient was taken directly into Resus, rapidly assessed and transferred to CCU for telemetry, with a plan for permanent pacemaker insertion the following day.

Throughout this episode, teams communicated exceptionally well across community, emergency and inpatient settings. Everyone understood not only the patient's immediate clinical risk, but also the importance of his previous experience and anxiety about admission. Rather than allowing organisational boundaries to dictate his journey, staff worked together to create a safe and coordinated pathway around him.

Most importantly, the patient felt listened to, reassured and well cared for. Despite beginning the day understandably anxious about returning to York, he was extremely happy with the care he received and hopeful that, following his pacemaker, he would still be able to go on his planned holiday if not on Sunday, maybe later in the year!

This was multidisciplinary and cross-setting working at its best: early recognition of deterioration, appropriate escalation, excellent communication, compassionate care and seamless coordination from Rapid Access through ED and into specialist cardiology care. I believe everyone involved deserves recognition for demonstrating what can be achieved when teams work together around the needs of the patient rather than the boundaries of individual services.

Emily Christie, Consultant Anaesthetist **York** **Nominated by a colleague**

I would like to nominate Emily in recognition of her exceptional commitment to her patients, her colleagues, and the wider team.

Emily is someone who consistently goes above and beyond in everything she does. She is always willing to help, no matter how busy she is, and regularly stays beyond her working hours to ensure that patients receive the care and support they need. Her dedication goes far beyond what is expected of her role.

What particularly stands out about Emily is the genuine compassion and kindness she shows towards her patients. She takes the time to make people feel reassured and cared for, often going the extra mile to ensure their experience is as positive and comfortable as possible during what can be an extremely stressful time.

Emily is also incredibly supportive of her colleagues. She is approachable, dependable and always willing to step in and help wherever she can. Her willingness to give her time, share her expertise and support others makes a real difference to the whole team.

Emily's commitment, compassion and selflessness embody everything a STAR Award should recognise. She consistently puts patients first, supports those around her and gives far more of herself than is expected. She is a truly valued member of the team and thoroughly deserves this recognition.

Emily Maurice, Midwife **York** **Nominated by a colleague**

I would like to nominate Emily in recognition of the outstanding support and commitment she has shown today while acting as Manager of the Day.

Today has been an exceptionally busy and challenging day within the maternity unit, and Emily played a vital role in helping to coordinate the department and ensure that everything continued to run as safely and smoothly as possible.

Emily demonstrated excellent teamwork throughout the day. She was approachable, supportive and always willing to step in wherever she was needed. She worked tirelessly alongside the wider team, helping to manage the demands of an extremely busy unit while keeping patient safety and the needs of staff at the forefront.

What particularly stood out was Emily's commitment to seeing everything through. She did not leave until she was satisfied that everything was safe, appropriately coordinated and sorted for the team coming through. Her willingness to stay, support others and take responsibility made a real difference on what was a very demanding day.

Emily's dedication, teamwork and commitment to patient safety are a real credit to her. I feel she thoroughly deserves recognition through a STAR Award for the support she has provided today and for the positive impact she has had on both patients and colleagues. Thank you, Emily, for everything you have done today.

Phoebe Plant, Team Manager, Martin Whipp, Locality Manager, Jack Tansley, Retinal Eye Screener, and Emma Coleman, Retinal Eye Screener | **Community** | **Nominated by a colleague**

On Saturdays, our team runs multiple clinics at Selby Hospital to screen patients for diabetic eye disease.

Quite often, patients may not be suitable for a routine photography examination and will need to be referred to attend another appointment at a later date to be screened with more specialised equipment.

On this particular Saturday a 92-year-old patient had a routine screening completed by Emma and Phoebe who detected that the patient had signs of early cataracts. To save the patient having to be recalled within three months to attend a slit lamp appointment it was agreed that a slit lamp examination would be completed on the same day by Jack and Martin. Therefore, the patient was screened, the images graded, the patient moved pathways and then they had their slit lamp examination all completed on the same day. This was a team effort and even though this can be time consuming each member of the team completed this 'extra' screening with no impact on their full clinics and the rest of their patients.

I am nominating them for a Star Award as they all pulled together in the best interest of the patient whilst ensuring there was no impact on the other patients being seen on that day. I am proud to call them my work colleagues/friends.

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

We had learning difficulty patient requiring dental treatment under general anaesthetic in hospital. The security were involved providing guaranteed parking space for the patient and their carers.

On the day they were extremely flexible and adapted to the very fluid situation of getting the patient into the hospital and through to theatres. Their adaptability and professionalism was much appreciated on what could have been a fraught day.

Tracy Oxley, Cleaning and Catering Operative | **Scarborough** | **Nominated by colleagues**

Tracy is the backbone of our day surgery team in Scarborough- simply, patients being able to flow through the unit and into theatre's would not be as smooth without her.

From the minute she gets to work on a morning, to the minute she puts her trolley away- she is friendly and helpful to everyone she comes across.

Tracy regularly goes above and beyond to ensure that the unit is cleaned to an impeccable standard, which shows in both the audit reports for the ward and patient feedback. She embodies every trust value, without ever even having to try and we do not take for granted just how lucky we are to have her.

Peter Walsh, Consultant Anaesthetist **Site** **Nominated by a colleague**

Pete saved the life of a patient with Ludwig's angina. These are a very scary airway emergency. Pete's combined skill, approach, team management and demeanour with the patient were just unbelievable to watch.

I see a lot of extreme airway pathology, and I have never seen a more skilfully approached and executed intubation, start to finish. It is no exaggeration to say that he saved this patients life against the odds due to skill, professionalism and leadership. Whilst you might argue that this would be a Great-ix nomination, please accept from me that the above is understatement not hyperbole. I'm writing on behalf of the entire theatre team tonight.

Special Care Baby Unit **York** **Nominated by a colleague**

I would like to thank all the staff for the support they have given me over the past few months.

The temporary relocation of SCBU to Ward 12 has been stressful for everyone involved, yet despite this the staff have maintained an exceptional level of care for the families and each other. Their openness and kindness shines through adversity and their willingness to go above and beyond for families is what makes SCBU such an amazing team which I am proud to lead.

We are one fantastic team of cleaner, housekeeper, HCAs, NN, NA, RNs. You are all wonderful ...keep up the good work x

Jemma Cropley, Matron **York** **Nominated by a colleague**

On a recent shift as on call manager, I was overwhelmed by the commitment and dedication shown by Jemma and Donna. Faced with an extremely busy Emergency Department and numerous operational challenges they stayed with me on the York site until late at night. They were tireless in their efforts to care for patients and support their colleagues. They did not need to be there, it would have been perfectly reasonable for them to go home, and I did urge them to do so but they kept going, doing what they could, when they could.

It is such an honour to have colleagues like this, who do their day job to such a high level and then do so much more to fill gaps, who don't give up or lose their sense of what's right for patients and what's needed to support colleagues.

Donna Jack, Head of Nursing, and Jemma Cropley, Matron | **York** | **Nominated by a colleague**

On a recent shift as on call manager, I was overwhelmed by the commitment and dedication shown by Jemma and Donna.

Faced with an extremely busy Emergency Department and numerous operational challenges, they stayed with me on the York site until late at night. They were tireless in their efforts to care for patients and support their colleagues. They did not need to be there, it would have been perfectly reasonable for them to go home, and I did urge them to do so but they kept going, doing what they could, when they could.

It is such an honour to have colleagues like this, who do their day job to such a high level and then do so much more to fill gaps, who don't give up or lose their sense of what's right for patients and what's needed to support colleagues.

Imran Ul-Haq, Consultant | **York** | **Nominated by colleagues**

Nomination 1: Dr Imran supported me even my busy scheduled working hours. He is very friendly and professional.

Nomination 2: This doctor in particular stands out for me all the time. I remember our first encounter - it was me meeting him to do a pain relief prescription. I just went into his office and said hi please could you prescribe this med. He responded, "How are you" and I was having a hard day and said to myself I don't recall anyone ever asking me that at work. We get so busy in the department that we forget to check in on each other, and he does that all the time to staff. He has the best engagement with patients, and they always feel safe with him. We need more colleagues like him at work.

Sarah King, Patient Flow Lead | **Community** | **Nominated by a colleague**

Sarah has worked for York Community Response Team for as long as i have been with them pre 2019and has progressed from coordinator lead to said position. Sarah does her job with ease whilst at the same time looking after other coordinators, generic support workers and registered staff with any problems they may face.

On a personal note, I suffer from mental health and over the past six years she has been there for not just me but other colleagues with issues around health, family and work. I may also be wrong, but I do not think she has even had a day off sick in all this time.

Sarah is always professional face-to-face and on the telephone with patients' families, professionals and staff and lives the Trust values all the time. Sarah is our matriarch.

Physiotherapy and Occupational Therapy Team	**Nelsons Court**	**Nominated by a colleague**

We have been really short of nurses and health carers for the last few weeks due to various reasons, and the Occupational Therapy and Physio teams have really gone out of their way to help me. Two of them stayed after their finish time to help me with a couple of hoist patients that we were struggling to get back into bed. I could not have survived this week without them. They are a marvellous team all the time, but they have really helped this past week. Thank you to Marta Mirren Jeanette Diana and Marilyn.

Sascha Wells-Munro, Director of Midwifery	**Trust-wide**	**Nominated by a colleague**

I would like to nominate Sascha for a Star Award in recognition of her exceptional leadership, unwavering commitment to staff, and the transformational impact she has had on our maternity services. When Sascha joined the organisation, she was met with a service facing significant challenges. Through visible and compassionate leadership, she has led us on a journey of improvement that has recently resulted in our maternity services achieving a Good rating across all five CQC domains, a significant achievement that reflects the dedication of the whole team and the culture she has helped create. What makes Sascha truly deserving of recognition is not only the outcomes achieved, but the way she has achieved them by ensuring that listening is at the heart of her leadership.

Staff voices have been actively sought, valued and acted upon which has created an environment where they feel heard, respected and empowered to contribute to change. Her approachable nature and genuine commitment to understanding the experiences of frontline staff have helped rebuild trust and foster psychological safety across the service. Sascha has driven a positive cultural transformation, moving the service from a period of uncertainty and low morale to one where teamwork, openness and continuous improvement are embedded in everyday practice.

Colleagues feel more confident to raise concerns, share ideas and celebrate successes, knowing that their contributions matter. Despite the significant pressures facing maternity services, Sascha has remained visible, supportive and relentlessly focused on improving care for women, babies and families. She inspires those around her through her kindness and determination, bringing people together through a shared vision and ensuring that improvements are achieved sustainably. Sascha's leadership has made a lasting difference to our staff, our service users and our organisation. She exemplifies the very best of NHS leadership and the Trust values and I just want to say a huge thank you.

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

I have received some excellent feedback from Leeds University about the support Drew has given to a student as below and wish to nominate her for a Star Award:

I hope you are well. I wanted to take the opportunity to provide some feedback regarding Drew Tordoff, following her attendance at a recent student review meeting in her role as Practice Assessor. I provided feedback directly to Drew at the time; however, I also felt it was important to share this with you and the Trust, as her approach truly exemplified the philosophy of student support and the standards outlined within the NMC Standards for Student Supervision and Assessment. I felt completely confident in Drew as a Practice Assessor who demonstrated outstanding understanding and execution of the role.

Drew showcased exceptional effectiveness, preparation, and thoroughness throughout the meeting, which greatly supported its smooth and productive running. Having undertaken comprehensive due diligence in reviewing the student's electronic Practice Assessment Document including Practice Episode Records, proficiencies, feedback, and workbook documentation beforehand, she was able to clearly identify the student's strengths whilst also supporting their ongoing development.

What particularly impressed me was how she drew upon both her previous feedback and the student's previously identified areas for development to shape and direct the discussion, ensuring continuity and meaningful progression. Drew took the time to actively listen to the student, creating a supportive and professional environment. She also sought clarification from me regarding the student's stage of training and the expected level of performance before making any assumptions, demonstrating a thoughtful, evidence-based approach to assessment. She was absolutely fabulous throughout the process and is a real asset to student learning and support.

Should there be any Trust or external awards, recognition programmes, or opportunities for nomination, I would strongly encourage that Drew be considered. I hope you could use this feedback as supporting evidence in recognition of the hard work, dedication, and commitment she demonstrated in supporting this student. Thank you for taking the time to read this feedback. I felt it was important to formally acknowledge the outstanding contribution Drew made and the positive impact she is having on the student experience. Equally, I wanted to recognise the support and resources you are providing to Practice Assessors, which are clearly helping to promote high-quality assessment and student support.

EUC Team **York** **Nominated by a colleague**

I would like to nominate the End User Computing (EUC) Team for a Star Award in recognition of their outstanding dedication, professionalism, and unwavering support across our Trust. The EUC team are the unsung heroes who help keep our Trust running day in, day out. Whether it is something as simple as replacing a keyboard, supporting a new starter, resolving an urgent technical issue, facilitating a ward move, or coordinating a large-scale office relocation, they consistently deliver a first-class service. Their commitment to supporting staff and services operates around the clock, 24 hours a day, 365 days a year, ensuring our clinical and non-clinical teams can continue providing excellent patient care. From a project perspective, I have worked with the EUC Team across numerous digital, capital, and transformation initiatives. No project comes without challenges, changing timelines, competing priorities, or unexpected obstacles.

Regardless of the circumstances, the team always approaches every situation with a positive attitude, adapting quickly and finding practical solutions to overcome hurdles. Their flexibility, resilience, and willingness to go above and beyond have been instrumental in the successful delivery of many projects throughout the Trust.

What truly sets the EUC Team apart is not only their extensive technical knowledge and expertise, but also their patience and commitment to helping others. They take the time to explain, advise, and support colleagues regardless of the complexity of the issue. Personally, they have taught me an enormous amount throughout my time working with them, and I have no doubt they will continue to share their expertise and support others across the organisation. Whether based in York or Scarborough, the team works as one. They consistently support each other, collaborate effectively, and put the needs of the Trust first. Their professionalism, teamwork, and dedication make a significant difference every single day, often behind the scenes and without recognition.

For their exceptional service, commitment to excellence, and the positive impact they have across the Trust, I believe the EUC Team are truly deserving of a Star Award. Thank you, EUC Team, for everything you do.

Tendai Kupara, Healthcare Assistant **York** **Nominated by a colleague**

Tendai consistently demonstrates a positive and compassionate attitude towards both patients and colleagues. He always has a smile on his face and goes above and beyond to ensure that patients feel supported and well cared for. Whether it is making an extra cup of tea or helping a patient with a specific need, Tendai is always willing to assist to the best of his ability. If he is unable to help directly, he will always take the initiative to find the appropriate person who can.

Tendai is also incredibly proactive around the ward and regularly takes the initiative to complete those small but important tasks that help the ward run smoothly, such as restocking oxygen masks and ensuring equipment is readily available. You rarely see Tendai sitting down; he is consistently busy, helping patients, supporting colleagues and contributing to the smooth running of the ward. His dedication, hard work and willingness to go the extra mile make him a real asset to the team. Tendai is highly valued and very much appreciated by both patients and staff.

Elisabeth Hall, Specialist Nurse **York** **Nominated by a colleague**

I would like to nominate Lissy for a Star Award because the care and compassion she showed to my family member, and to all of us as a family, will never be forgotten. During one of the most difficult and heartbreaking times of our lives, Lissy was a source of support, comfort and reassurance. She cared for my family member with such kindness, dignity and respect, always taking the time to make them feel valued and cared for. Just as importantly, she cared for us as a family, recognising that we were going through this journey too. What made Lissy so special was the way she combined professionalism with genuine warmth. She was there during some incredibly difficult conversations and handled each one with compassion, honesty and sensitivity. No question was ever too much trouble, and no concern was ever dismissed.

The little things she did, taking the time to listen, offering reassurance, and simply being present, made a huge difference to us. Her calm and caring approach brought comfort when we needed it most and helped us navigate an overwhelming and emotional time. As a family member, I cannot fully express how grateful I am for everything Lissy did. The care she provided went far beyond her role; it came from a place of genuine compassion and humanity. She made an incredibly difficult experience more bearable, and the impact she had on my family will stay with us forever. Lissy is an exceptional nurse. She embodies everything that outstanding palliative and end of life care should be, and she is thoroughly deserving of this recognition.

Nicky Richards, Sister **Scarborough** **Nominated by a colleague**

The Ward Sister, Nicky Richards, was exceptional throughout the visit. It was immediately clear that Nicky is a nurse who is genuinely passionate about providing the highest standard of care to patients. Her compassion, professionalism and commitment to both patients and staff were evident in everything she did.

Nicky was the absolute epitome of what an NHS nurse should represent. She demonstrated a genuine pride in her role, a strong commitment to patient centred care and an obvious desire to ensure that every patient received the best possible experience. Her enthusiasm and caring approach were infectious, and she created a positive and welcoming atmosphere on the ward. It was particularly encouraging to see how engaged she was with the PLACE Team and how openly she shared her knowledge, experiences and understanding of the ward.

Her leadership was evident, but equally important was the genuine warmth and humanity she demonstrated towards patients and colleagues. The PLACE Team would strongly recommend that Nicky receives formal recognition for her infectious personality, enthusiasm and outstanding commitment to patient care and highly commended for the outstanding example she sets. She represents the very best of NHS nursing and is a credit to her profession, her ward and the Trust.

Steve Page, Discharge Liaison Officer | **Scarborough** | **Nominated by colleagues**

Steve goes above and beyond to help out on Juniper Ward for both staff and patients to ensure all discharges are done quickly and safely. He also will answer the phone if staff are busy to help out, run to pharmacy for medications for discharge. Steve will also assist in taking patients down to discharge lounge or front entrance for transport. Steve always has a smile on his face and is always kind.

Nathan Brasier, Healthcare Support Worker | **Scarborough** | **Nominated by a colleague**

Nathan is a fantastic example of excellence, a fantastic role model to his colleagues always willing to help and support others. Nathan is always positive and always goes the extra mile to ensure he delivers high-quality care to his patients. Nathan is inspiring to talk to and his passion for his job reflects in his persona and the care he provides to our patients. Well done Nathan!

Claire Adams, Cleaning and Catering Operative | **Scarborough** | **Nominated by a colleague**

Claire deserves recognition for her commitment to her job and attention to detail whilst performing her duties.

The environment is spotless and Claire never stops from the minute she comes into work to the minute she leaves. Claire takes great pride in the work she does and this is reflected in her standards of cleaning on the ward and attitude towards colleagues and patients.

Although Claire does a lot of her duties on Chestnut Ward, she has worked a lot of shifts recently on Cherry Ward and her professionalism and pride in her work hasn't gone unnoticed. Claire is always happy to help, polite with patients and staff. Thank you, Claire, for the work you have done to support cherry recently, this is appreciated by our team and patients.

Benjamin Adu-Agyei, Staff Nurse | **Scarborough** | **Nominated by a colleague**

Ben is a fantastic example of excellence and a great advocate for his patients. Ben has excelled in his role and developed so much since joining the Cherry Team. Ben demonstrates great leadership and role modelling when leading the ward and always goes the extra mile to support his colleagues and patients to the very best of his ability. Ben is an excellent team player and always wants the best for patients, relatives and staff. I would like to thank Ben for the tremendous amount of support he has provided to myself and the Cherry Team over the past few months, providing motivation and leadership on the ward when needed. Ben is an asset to Cherry Ward! Well done, Ben and thank you!

Steve Edwards, Porter **York** **Nominated by a colleague**

I was struggling on crutches leaving A&E after I had been told I had a fracture to my tibia. Steve saw me and got me a wheelchair and kindly wheeled me all the way to the car park and to our car. Then on Friday 21st August, I came back to the hospital for a CT scan and again was struggling on the crutches and my husband could not find a wheelchair. Steve, again saw me and got me a wheelchair with a support for my leg. I am a member of staff, Steve did not know that, and he went out of his way for me, and it was so appreciated.

Linen Team **York** **Nominated by a colleague**

The team have all come together amazingly with major some essential equipment being down and unusable these last few months and awaiting repairs, and with staff shortages. They have all stepped up to make sure the whole hospital still receives a full waste and linen service without other staff even realising there has been major issues going on. The whole department has worked tirelessly to ensure this was done so as not to make any impact upon the patients' experiences while in the hospital.

Maisie Luckhurst, Outpatient services senior administrator **York** **Nominated by a colleague**

Maisie has recently become our senior administrator here in Outpatients, and she has taken to the role incredibly. Maisie is currently working solo and is not only absolutely thriving and completing all her tasks, but she is also taking on the responsibility of trainer in the department. She is always cheery, smiley, helpful, approachable and an absolute joy to work with.

Her kindness and caring attitude make her a wonderful trainer as well as a senior administrator.

The whole team values and respects her and as her line manager I couldn't do the job I do without Maisie's help every day. She is an asset to our work. Thank you, Maisie!

Megan York, Service Manager in Haematology **York** **Nominated by a colleague**

Megan has tirelessly supported both Oncology and Haematology admin teams and services, including training me as the new service manager for Oncology, while continuing to ensure that our deadlines and targets across both services are being met.

Megan has supported the Oncology Outpatients Team and Oncology Secretarial Team in the interim and has been fantastic in keeping the teams on track, improving our turnaround times for appointments and provided myself with comprehensive and in-detail training.

This in addition to continuing to ensure our patients are seen in a timely manner; letters are turned around swiftly and there is effective 'firefighting' urgent queries across both specialties. I would like Megan to know how valued she is, not only as a service manager, but also as a colleague.

She always goes above and beyond to support patients and staff and embodies the Trust values of kindness, openness and excellence continuously.

Leigh Heseltine, Platform Analyst **Scarborough** **Nominated by a colleague**

Leigh was coming home and found a man collapsed in his street. Leigh found him to be unresponsive and immediately started resuscitation whilst waiting for the emergency services to arrive. He co-ordinated with another member of the public to fetch the nearest defibrillator and continued to apply resus. Paramedics then arrived and the man survived and was transferred to hospital.

The paramedics commented that Leighs immediate action had saved the man's life. Leigh exemplifies everything that is good about the NHS both through the excellent resuscitation training received and the calmness, caring and professionalism demonstrated by NHS employees, in this case Leigh.

He is an absolute star as a person and should feel very proud that his actions have given this man his greatest gift.

Oncology Secretarial Team **York** **Nominated by a colleague**

Our Oncology Secretarial Team have demonstrated extraordinary teamwork and initiative by addressing the high-volume typing backlog in Oncology across both York and Scarborough.

By sharing workloads and thus optimising their turnaround processes, plus maintaining exceptional attention to detail, the team have achieved a dramatic reduction in backlog, seeing reductions by up to five weeks in some cases in backlog over only three weeks.

Their efforts have directly ensured targets are being met, patients are receiving their clinical letters and associated treatment in a timely manner, in addition to collaborating with clinicians to prioritise appropriately.

This accomplishment highlights their deep commitment to patient care, expressing Trust values in kindness and openness and is a clear example of operational excellence. This has been no mean feat and we as the operational team are immensely proud of their achievements and commitment to the Oncology service and its patients.

Katie Coxon, Theatre Support Worker **York** **Nominated by a colleague**

Katie always takes a proactive approach to patient care, going above and beyond to ensure the patient journey within theatre is a pleasant one. She has recently supported several new staff members within the team and takes time and care whilst explaining and diligently showing them the ways of working whilst providing a friendly, warm presence. Katie's hard work is constant and unwavering and shouldn't be overlooked.

Thank you for being amazing, Katie!

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

My father is currently a patient on Ward 28. Michelle came along, whilst I was visiting my father, to take some bloods from him. It was lunch time and the HCA was trying to assist my father with eating soup, but he didn't appear interested in eating. The HCA gave up and put the soup down.

Michelle felt the soup and commented that it was cold and that's probably adding to his reluctance to eat. She took the soup into the ward kitchen, told staff it was cold, and came back with a strawberry mousse. She then fed that to my father herself (explaining she used to be an HCA).

On preparing to take his bloods she felt how cold he was, and as a result she couldn't find a vein. She then went to bring him 2 extra blankets and covered him over to warm him up. Although she was unable to carry out her task of taking bloods, she tended to other needs of my father that are not within her job description. She went above and beyond for him, where some other staff would probably have just walked away. She is a credit to the Phlebotomy Dept and the Trust as a whole.

The Trust would benefit from a lot more staff being as genuinely caring as she is and more willing to go that extra mile, especially for vulnerable patients.

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

In October, members of the Security Team were made aware of a major incident on Ward 26 at York Hospital and Main Street. I had tasked all available security officers, including myself, to attend and assist where needed. The team consisted of four members from the day shift and three members from night shift, and all attended either the ward or the location of where the incident was.

I co-ordinated the team to make sure that equipment was brought quickly, areas closed off from the public whilst staff medical staff dealt with the incident itself. The team worked amazingly well together from point of call through to the end when the patient was taken to Resus.

We all made sure that other patients and visitors were safe and also made sure that the corridors were kept clear for the medical team to transfer the patient to Resus with minimal obstructions. I am extremely proud with how all the security officers handled themselves in a highly stressful situation and managed to make sure things got done when it was needed.

The team worked together to make sure everyone was safe and I de-briefed afterwards to make sure the security officers and some medical staff were OK while also protecting the patient's dignity. Three security officers who wasn't due to start shift at that time showed dedication by attending before their shift were due to start and four security officers showed their dedication by finishing later than normal.

I believe that the Trust values were shown through excellence, helpfulness, professionalism and teamwork.

Lucy Ward, Deputy Ward Manager **York** **Nominated by a colleague**

During a very traumatic event on the ward involving external professionals as well as Trust staff, Lucy led the shift with exceptional leadership skills, kindness and compassion. The incident called for prompt action and effective leadership which Lucy gave in abundance.

She coordinated different staff groups to assist the patient in the initial emergency response to ensure the patient received the correct care.

Whilst remaining on the ward following the event, Lucy ensured all staff members were debriefed appropriately and checking on them throughout the remainder of the shift. She also ensured all patients on the ward were cared for and reassured.
Following the event Lucy, helped ensure staff had access to post trauma care if needed.

Well done Lucy and thank you. You are a true star!

Medical Deployment Team **Scarborough** **Nominated by a colleague**

The whole team has worked together over a difficult year but especially in the last few months and shown real teamwork and resilience. They have supported one another as not only colleagues but friends too. Their hard work and tenacity have kept the wards going and morale and spirits lifted when faced with challenges. They are a lovely team to work with, and their help is much appreciated.

Vicci Anderson, Deputy Chief Nursing Information Officer (CNIO) **York** **Nominated by a colleague**

We identified an issue with potential of causing harm. The whole digital team but in particular Vicci stepped up in terms of response, suggesting improvements, implementing short term fixes to reduce the chance of harm coming to patients and more importantly coming up with solutions to the problem and starting the work to address this. Has shown dedication to the job and clearly embodying excellence.

Jo Boyt, Quality and Governance Manager **York** **Nominated by a colleague**

I would like to nominate Jo Boyt in recognition of the outstanding support, dedication and kindness she consistently demonstrates to colleagues across the Family Health Care Group.

Jo plays a pivotal role in helping teams navigate the often-complex world of incidents, risks and complaints. No matter how busy she is, she always makes herself accessible and is never too busy to offer advice, guidance or reassurance. Her support helps keep us on the right track, ensuring that we approach issues with the right balance of governance, professionalism and compassion.

What makes Jo particularly special is the way she works with people. She brings warmth, patience and understanding to every interaction, making what can often be difficult conversations feel manageable. She has an exceptional ability to explain complex processes clearly and calmly, helping colleagues to feel supported rather than overwhelmed.

Jo's approachable and personable nature means that people actively seek her advice, knowing they will be met with kindness, respect and practical support. She never makes anyone feel like a burden and always takes the time to listen, even when under significant pressure herself. Behind the scenes, Jo's contribution is enormous.

Her commitment to ensuring incidents, risks and complaints are managed effectively helps strengthen patient safety, organisational learning and service improvement across the Trust. She is a trusted colleague whose expertise, professionalism and unwavering support make a genuine difference every day.

Most importantly, Jo embodies the values we aspire to as an organisation. She is knowledgeable, dependable, compassionate and generous with her time. Many of us are better at what we do because of her guidance and support, and it is difficult to overstate the positive impact she has on both colleagues and the wider organisation. Thank you, Jo, for everything you do. Your dedication, kindness and willingness to help others do not go unnoticed and are greatly appreciated.

Petya Spasova, Physician Associate **York** **Nominated by a colleague**

Petya has been instrumental in liaising with multiple specialties co-ordinating the care of a patient with learning disabilities to facilitate ongoing investigation. The patient needed an investigation to facilitate another investigation. Petya has demonstrated kindness towards the patient in terms of co-ordinating the care, liaising with family to keep them updated She has gone above and beyond in terms trying to ensure the patient gets the care they need in a timely manner.

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

I would like to nominate the York Hospital Security Team for a Star Award in recognition of their exceptional professionalism, teamwork, and commitment to keeping patients, colleagues and visitors safe during two particularly challenging incidents over the past week.

The team responded to a serious incident involving a mental health patient who had seriously hurt themselves.

On receiving the call, security officers on the day shift immediately responded, with several members of the night shift also running to the incident as they had arrived for shift 20 minutes early but did not hesitate to support their colleagues. Their priority was simply to get to the scene as quickly as possible and provide whatever assistance was required, supporting the Police and clinical colleagues by securing both scenes and giving access to the immediate enclosed location where the patient was injured, managed access and diverted staff and members of the public away from the scene.

They also ensured that overlooking areas were appropriately managed, maintaining communication between different locations, and when the patient was ready to be transferred, coordinated a clear and safe route through the hospital to Resus.

What particularly impressed me was the calm and coordinated way in which the whole team responded. Individual officers instinctively took on different responsibilities while continuing to work collectively towards the same objective: protecting the patient, supporting clinical colleagues, and maintaining the safety and dignity of everyone involved.

The team then remained with the patient in ICU on a security bed watch to ensure the safety of the patient, giving staff assurance when dealing with this complex case to enable them to provide the best possible care to the patient, with the ICU team and nurse Gemma sending via email a lovely gesture of thanks to the team, stating “you have been the most amazing, caring, and compassionate support on ICU for the past two days!”

Whilst still caring for the patient on ICU, only a few days later, the team faced another highly challenging situation when a member of the public accessed the roof of the hospital car park. Prior to the arrival of the emergency services and nursing support, Security Officers engaged with her calmly and sensitively while simultaneously implementing the appropriate safety arrangements. The team restricted vehicle and pedestrian access maintained a safe environment, and worked collaboratively with nursing, Police and Fire Brigade until the young woman was brought down safely.

These incidents demonstrate the difficult and often unpredictable circumstances in which our Security Team operates. Their role extends far beyond maintaining the physical security of the hospital, as they are often the first response to all significant incidents within the Trust, and regularly find themselves supporting people at their most vulnerable, responding to emergencies and working alongside clinical and emergency service colleagues, with their actions making a real difference to our patients and visitors.

I am incredibly proud of the way the team responded. Their professionalism, compassion, teamwork, courage, and commitment to patient safety were evident throughout both incidents. Despite the pressure and seriousness of the situations, they remained focused on protecting patients, colleagues, visitors and the wider hospital community.

Mo Kajouj, SAS Tutor and Donna Perrin, SAS Medicine Education Administrator | **Site** | **Nominated by a colleague**

I would like to nominate Mo and Donna for a Star Award in recognition of the fantastic work they put into organising SAS Week and the SAS Conference during October. They invested lots of time and energy in developing a varied and engaging programme, bringing together a range of activities and opportunities to celebrate and support SAS doctors in the Trust. They made a real effort to engage colleagues and encourage participation.

The organisation behind the conference and the wider week involved a significant amount of work, much of it behind the scenes. Their enthusiasm and commitment helped raise the profile of SAS doctors, recognise the important contribution they make to the Trust and gave opportunity for SAS doctors to learn about lots of things relevant to their careers.

Lesley Jordan, Senior Healthcare Support Woker | **Scarborough** | **Nominated by a colleague**

My co-worker goes out of their own way. Using initiative and supporting other co-workers on ward. If this co-worker sees other workers struggling, she will lend a hand no problem. Her skills are amazing and she's fantastic to work with. She goes above and beyond for her patients as well as co-workers.

Aston Smith, Security Officer | **York** | **Nominated by a colleague**

While all officers dealing with the major incident on the 10 October 2026, Aston had remained in the control room on his own dealing with all calls and radio communications. Being put under such pressure to deal with the major incident, as well as all other control room duties, Aston had shown dedication to his role and handled the high pressure professionally. Aston showed he can work to the Trust value of Excellence. I am extremely proud of how Aston had overcome such a stressful situation, while remaining calm and professional.

Elaine Dixon, Acting Domestic Services Manager, and Heather Rafferty, Operational Support Manager | **Scarborough** | **Nominated by colleagues**

I would like to nominate Elaine and Heather for a Star Award. Sometime ago, our supervisor from the ward clerk department went off on sick leave and as a result of this we were left with no manager or any support, and the team were going through some worrying times with our job roles.

After a few emails and phone calls, Elaine and Heather stepped in to manage and support us. They both stepped up for us with no complaints and were very helpful and very supportive and they never complained once. They are doing a fantastic job as well as doing their own roles.

I cannot thank them enough, so I would like to nominate them both and hope they know what a great job they have done, and I really appreciate all their hard work and support.

Estates Electrical Team **York** **Nominated by a colleague**

During the creation of the Discharge Command Centre (DCC), an unexpected wiring fault developed which affected both the power outlets and the access control system to the room. This occurred at a critical point, as several teams were in the process of moving into the new DCC.

The Estates Electrical Team, led by Michael Andrews, Electrical Supervisor, responded immediately. Michael, together with Paul and Jamie (Electricians), worked tirelessly to fault-find, identify and rectify the problem, enabling the move to continue with minimal disruption.

While resolving an electrical fault may appear to be a routine task, the timing made their intervention particularly important. Getting the teams operational within the new DCC was critical to maintaining continuity of service and supporting the smooth transition of multiple teams.

Throughout the issue, the team worked quietly, effectively and extremely professionally. Their determination to resolve the problem, without fuss and while working around the wider move, demonstrated an excellent commitment to supporting their colleagues and the Trust.

I would like to recognise the Estates Electrical Team for going the extra mile and demonstrating the Trust values of kindness, openness and excellence through their actions.

Dimitrios Pissas, Consultant **York** **Nominated by a patient**

I've been under the care of Mr Pissas for almost seven years with bowel cancer, who since surgery has given me astonishing care. I believe that his care for me has certainly extended my life and quality of life, nothing is too much trouble to him.

Martha Hodge **York** **Nominated by a patient and a relative**

I was admitted to the ED in September 2026 with a fractured pelvis after a fall, and after assessment was put under the care of Martha. She was most helpful, explained everything very clearly and took a personal interest in my ongoing care after discharge. Nothing was too much trouble for her, and she took great care in helping my wife and I with the trauma of it all.

Ward 26 **York** **Nominated by a patient**

Every single member of the team on Ward 26 in York Hospital deserves recognition for their genuine care of patients. I was recently in due to an abscess post-wisdom tooth removal and, aside from having my daughter, I've never stayed in hospital before. From the doctors, nurses, health care assistants and cleaners, every person I saw was so friendly, warm and kind to everybody. They were always attentive to our needs. They didn't need to be called to come and check if we had water or if we needed anything. They were regularly passing by and checking in with us, so it didn't feel like you were causing a fuss asking for pain meds or help. They're all angels and I am so grateful for the genuine care you all show to everyone who comes in. Thank you, Ceri.

Michelle Wright, Midwife Scarborough Nominated by a patient

It has taken me four months after giving birth to finally write this, but I still remember so clearly how deeply cared for I felt by Michelle, one of the midwives on the night shift during my stay.

I had pre-eclampsia and spent at least four days on Hawthorn Ward. Those days were incredibly difficult for me emotionally. I felt very low, tearful and sad, and I desperately wanted to be discharged and go home to my family. Being in hospital for several days felt like an eternity, and every night I felt particularly lonely and overwhelmed.

Michelle went above and beyond in caring for me. During her night shifts, she took the time to talk to me, listen to me and reassure me whenever I was feeling particularly low. She didn't just attend to my medical needs; she noticed how I was feeling and took the time to comfort me. I had hardly slept at all during my time in hospital, and I was still recovering while trying to care for my newborn baby. Michelle did everything she could to help me get some much-needed rest and sleep. She even offered me a hug when I was feeling down. These may seem like small gestures, but to me, they meant so much.

Sometimes, all I needed was someone to talk to and comfort me. The nights felt especially long and lonely, but Michelle made me feel that I wasn't alone. She was always there to support me, reassure me and remind me that I was being cared for. Her kindness and compassion felt almost like having a mum there to comfort me during one of the most vulnerable times of my life.
Even now, four months later, thinking about how she cared for me brings tears of joy to my eyes. I will always remember how she made such a difficult experience feel a little easier. I was very well cared for by everyone at Hawthorne Ward, and I am truly grateful to the whole team for the care and support they gave me. However, Michelle was particularly special to me, and I wanted to take the time to acknowledge her.

I hope Michelle knows that the kindness, compassion and dedication she shows in her work as a midwife do not go unnoticed. The care she gave me went far beyond simply looking after me medically, she cared for me as a person, at a time when I really needed it and I will always be grateful for her kindness.

Greg Heath, Consultant **York** **Nominated by a patient**

I have been under the care of Dr Greg Heath at York Hospital for almost nine years for severe chronic uveitis, and I genuinely cannot speak highly enough of him. Before developing problems with my eyes, I had never even heard of uveitis. It has since become a huge part of my life, and having a specialist I know I can trust has made such a difference over the years.

My case is complex and can be difficult to manage, but Greg has always taken my condition seriously. When I have a flare, he is incredibly responsive and does everything he can to make sure I am seen quickly. He listens, understands what works for me and what hasn't worked in the past, and always puts a clear treatment and care plan in place. I have never felt like I am simply another patient or another set of notes to him.

After almost nine years, we have naturally built up a really good doctor-patient relationship. One of the little things that means a lot to me is that he remembers the name I prefer to be called and always uses it. It might seem like a small detail, but when you have spent years dealing with a chronic condition and countless hospital appointments, those things really do matter. It shows the level of care and attention he gives to his patients as people, not just their condition.

Greg is knowledgeable, understanding, approachable and, most importantly, he listens. I have complete confidence in him when it comes to my eyes. Throughout some very difficult periods with my uveitis, I have always felt that he genuinely cares about getting my condition under control and protecting my sight. I think people working within the NHS can sometimes hear far more about the things that have gone wrong than the things they are doing exceptionally well, which is why I wanted to take the time to write this.

Dr Greg Heath is an absolute credit to the Ophthalmology Department and to York Hospital. His hard work, dedication and the standard of care he has given me consistently for almost nine years deserve to be recognised. Living with severe chronic uveitis isn't easy but knowing that I have Greg looking after my eye care has made that journey much easier. I am incredibly grateful for everything he has done, and continues to do, for me. York Hospital is very lucky to have him.

Beth Guthrie, Deputy Sister/Charge Nurse | **York** | **Nominated by a patient**

From the very beginning, Beth was warm, reassuring and incredibly approachable. She has a wonderfully down-to-earth manner that immediately put me at ease during what was a difficult time. She was compassionate and empathetic, but also funny and personable, and she took the time to talk and converse with me as a person rather than simply as a patient. What stood out to me most was how genuinely caring she was, despite how incredibly busy she was. There were clearly many demands on her time, and yet she never once made me feel rushed, overlooked or as though I was inconveniencing her.

Whenever I needed her, she made me feel that she was available and that my concerns mattered - from something as simple as replacing a cannula dressing to giving pain meds or sorting out my IV. That level of reassurance meant a great deal to me during my admission. I also noticed the care and attention Beth showed to the other patients in the bay. She treated everyone with the same patience, warmth and dignity, even while managing what was clearly a very busy workload.

Her kindness didn't feel forced or simply part of the job, but it felt genuine. Being in hospital can be an incredibly vulnerable experience, and the way a nurse treats you can make a lasting difference. I've unfortunately had many hospital admissions over the last few years, but Beth made my experience considerably easier and more reassuring than I've ever experienced before. Her professionalism, compassion, humour and genuine human warmth are qualities that I believe deserve to be recognised and celebrated. She is a real credit to the nursing profession and to York Hospital, and I feel very fortunate to have been cared for by her.

Robert Reynolds, Advanced Clinical Practitioner | **Scarborough** | **Nominated by a patient**

In August, Rob set my broken ankle ready for a back slab cast. He was kind, professional and, as I have subsequently understood, exercised amazing skill. During my follow up appointments with the Fracture Clinic, I was told by the orthopaedic consultant that 99.9% of my type of break would require an operation to pin and stabilise the joint. However, due to Rob's skill. I would not need an operation because it was set with pinpoint accuracy (doctor's words). The doctor was very impressed and wanted to know who had performed such a quality procedure. Not only has Rob spared me the risks associated with the operation and weeks of post-operative recuperation, but he has also saved, what I would imagine to be, a significant sum of NHS money and staff resource. I want to say an enormous thank you and also to express my gratitude. Star.

Ailsa Atkinson, Specialist Nurse Practitioner | **York** | **Nominated by a patient**

I would like to express my deepest gratitude to Ailsa Atkinson for the wonderful care I received. Ailsa went above and beyond in every way possible. She took the time to answer all my questions, explained every step with incredible knowledge and thoroughness, and approached my anxiety with true empathy and gentleness. She recognised my concerns and provided me with the right pain relief option, her kindness turned what could have been a scary experience into one where I felt completely safe and cared for. Thank you so much.

Grace Richardson, Staff Nurse **York** **Nominated by a patient**

I came to the Gastro Ward due to an overdose causing internal bleeding and complications. I was very depressed, very anxious, and was upset I had survived my suicide attempt. Once, when feeling very low early on in my admission, I confided in Grace how desperate I was. She listened and had such a sense of understanding, calmness and a genuinely caring approach. She not only listened, but she would also then check how I was and most importantly acted on what I had told her.

Grace recognised the need to address my mental health and the issues that had led to my overdose and the need to get me help. I am typing this from my residential mental health care home. I feel safe here am being assessed for many things and I am finally getting the help I have been crying out for all of my adult life. Grace is amazing with all patients, works extremely hard, and does it all with a smile on her face for those she is caring for. In my opinion, someone like Grace should be leading by example and setting the standards for others to aspire to.

Lynda Robson, Play Specialist **York** **Nominated by a patient**

Lynda was amazing throughout my daughter's journey. My daughter came to the Play Team due to needing a blood test and feeling petrified. She had already had three failed attempts in the GP clinic, which left her feeling fairly traumatised. Lynda had her work cut out to support my daughter but from the start she showed so much warmth and empathy that my daughter was soon feeling more relaxed.

We had four play sessions before the planned blood test and throughout that, Lynda's attention to detail was really impressive. Lynda had all of my daughter's favourite toys and crafty bits to hand every week and spoke to my daughter in age-appropriate ways to widen her knowledge and understanding of what a blood test would look and feel like. She really empowered my daughter throughout and she regained a sense of control which was paramount.

A couple of highlights were a Taylor Swift picture hunt around the hospital on the walk from the children's centre to the ward, as well as a Taylor Swift themed Velcro plan which revealed pictures of Taylor Swift after achieving each step when having her blood test. Lynda was beyond anything we could have expected, and I can't thank her enough for making this whole process much less stressful and upsetting. An absolute asset to the hospital - thank you Lynda!

Ward 16 **York** **Nominated by a patient**

All staff have been so professional and kind, and lead with compassion in the daily care. All have been friendly to me as a patient and when my family were attending.

Maternity Team **York** **Nominated by a patient**

I had Millie as my midwife through the whole thing. I couldn't have asked for a better midwife to take me through the labour. Caring and calm, she made me feel comfortable and helped me get through it. Millie stayed with me the whole time and I just generally think she is amazing. But overall, the whole team are great! Everyone who I met just came across like they actually care! And just deserve the world.

Martin Almanis-McBain, Sonographer **Scarborough** **Nominated by a patient**

I went in for a growth scan and Martin was so kind and reassuring. We didn't want to know the sex which he was happy to comply with but still allowed us to look when possible and talked us through everything he was doing and what he was measuring/looking at. I wasn't feeling great after a past experience, and this was my fourth scan. He completely put me at ease and answered all my questions with no judgement.

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

I'd like to thank Drew on G2, who has actually been our constant support throughout.

She started as my community midwife, was always really approachable, informative, friendly and professional. She answered any questions I had in a way I could understand and nothing was too much trouble.

I was sad when she left the community but was so happy to find she was there on G2 when my twins were born and we needed a nine-day hospital stay. She went above and beyond, doing her absolute best to ensure we got the care we needed. I had a lot of down times due to anxiety, being a first-time mum, and I found it hard with the added stress of high blood pressure. Drew was always there for not only support medically but also emotionally. She really is magic, I/we genuinely cannot thank her enough.

Whenever Drew was on shift, I felt more relaxed, knowing she was there. She made us feel safe and supported in a way I can't begin to explain. She was always happy to help with feeds and cuddles for the girls if I needed rest or was busy with one and the other needed attention. Drew deserves to know what a difference she has made to mine and my girls lives, we will never forget her.

I feel so very lucky to have had Drew's support. You're amazing, and the best midwife I could have asked for.

Stephanie Coles, Senior Healthcare Support Works **Scarborough** **Nominated by a patient**

I've been on Beech Ward quite a few times, and even though the whole team are great, for me Steph and I have hit it off between us: great banter, fantastic person, outstanding health care work. This time of me coming to Beech Ward, Steph has absolutely fantastic. She has gone out of her way to support me with the outcome I was given, turning my frown upside-down! It's a shame there isn't more Steph's on every ward!

Holly (Aoi) Deguchi, Staff Nurse **York** **Nominated by a patient**

I have experienced a number of hospital admissions over the years, and I can genuinely say that Holly was one of the most exceptional nurses I have ever had the pleasure of being cared for by.

From the moment she cared for me, Holly was incredibly warm, personable and approachable. Despite being visibly extremely busy and having many patients to look after, she never made me feel rushed, overlooked or as though I was asking too much.

She consistently took the time to listen, check in on me and make sure I was comfortable and had what I needed. Holly cared for me through some particularly rubbish moments, including helping me with my pain, my cannula and my IVs, but it was her compassion and the way she treated me as a person that I will remember most.

She took the time to get to know me, and her kindness felt completely genuine. Even during what I appreciate was an incredibly demanding couple of shifts, she made me feel seen, heard and cared for.

What also stood out to me was the way Holly interacted with the other patients around her. Her warmth, patience and empathy were evident in everything she did. She brought a sense of reassurance and humanity to an environment that can otherwise feel overwhelming when you are unwell.

Holly went far beyond simply providing excellent clinical care. She was caring, empathetic, reassuring and genuinely invested in the wellbeing of her patients. Her approach made a significant difference to my experience in hospital at a time when I was vulnerable and unwell. I feel very strongly that people like Holly deserve to know when their work has made a real difference.

She is an absolute credit to York Hospital, to the nursing profession and, most importantly, to the patients she cares for.

Rohit Sahai, Resident Doctor **York** **Nominated by a patient**

I was admitted on 4 September with a kidney infection, and Dr Rohit Sahai was the registrar looking after me on 7 and 8 September. I felt that his care and bedside manner were exceptional, and I would very much like this recognition to be passed on to him and his colleagues.

From the outset, Dr Sahai made me feel listened to and taken seriously. He took the time to hear what I was experiencing, validated my pain and concerns, and never made me feel rushed, despite the ward being extremely busy and knowing that he undoubtedly had many other patients to attend to.

On Monday, he and the consultant doctor took the time to listen carefully to my case. On Tuesday, Dr Sahai came to see me on several occasions after the morning ward rounds to personally update me on my progress. He explained that my infection markers had come down and kept me informed while we waited for further blood results and confirmation from the haematology team that it was safe for me to be discharged, as my platelet count was low.

Something that particularly stood out to me was the care he showed even with the smaller details. My cannula had become uncomfortable and was irritating my skin, and Dr Sahai personally came to redress it and subsequently remove it. He also adjusted my final antibiotic so that I could take it orally rather than requiring a replacement cannula. This meant that, once the medication was ready from the pharmacy, I could go home rather than having another cannula inserted unnecessarily.

Throughout all of this, he kept me informed and reassured me while we waited for the medication and the final arrangements for discharge. What impressed me most, however, was his genuine compassion. His bedside manner was warm, kind, personable and empathetic. I never felt that I was simply another patient on a busy ward. He listened to me, acknowledged my concerns and treated me with patience and dignity. That made a significant difference to my experience during this time. I appreciate that these qualities may not always be captured by clinical measures, but they matter enormously to patients.

Dr Sahai demonstrated not only excellent clinical care, but also the compassion and humanity that I believe make an exceptional doctor. He is genuinely a credit to York Hospital and the NHS, and I would be very grateful if you could formally recognise the level of care he provided. I hope this feedback can be shared with him directly, as I would like him to know how much his kindness, time and care meant to me.

AMU **York** **Nominated by a patient**

I am nominating the Acute Medical Unit (AMU) team at York Hospital because the care I received during my admission from 4 September to 08 September /09/26 was truly exceptional. I was admitted with a complex UTI/kidney infection, and, at times, I was in a great deal of pain, extremely tired and overwhelmed by what I was experiencing.

During what was a very difficult time for me, the AMU team made an enormous difference to how I felt. What stood out to me was that, despite AMU being an incredibly busy and demanding environment, I never felt like I was simply another patient. I was treated as a person. The doctors, nurses and wider team consistently showed me kindness, compassion, empathy, patience and dignity, while also providing an exceptionally high standard of clinical care.

I would particularly like to recognise Dr Rohit Sahai, whose professionalism, knowledge and reassuring manner made me feel that I was in safe hands. His approach and the care he provided gave me confidence and reassurance at a time when I was feeling particularly vulnerable.

I would also like to recognise nurses Queen, Lena, Kelechi, Ditty, Holly, Beth and Rodi. Each of these nurses went above and beyond in the care they provided. They were attentive, compassionate and incredibly kind. They took the time to listen to me, check on me, make sure I was comfortable, explain what was happening and reassure me when I was struggling. It was the genuine human kindness they showed that made such a lasting impression on me. When you are in pain and feeling tired and overwhelmed, something as simple as someone taking the time to listen, offering reassurance or checking that you are okay can mean so much.

The AMU team repeatedly did those things for me. I also want to recognise the wider team - the doctors, nurses, healthcare staff, support staff, patient services staff and everyone else involved in my care. The compassion and professionalism I experienced was consistently exceptional throughout my admission. I understand how incredibly busy and pressured an acute medical unit can be, which makes the care I received even more deserving of recognition. The team managed to provide excellent clinical care while never losing sight of the person behind the illness.

I am nominating AMU because they made a very painful and difficult experience considerably easier for me to get through. I felt cared for, listened to, respected and reassured. Their dedication, compassion and professionalism made a genuine difference to me, and I feel they deserve to know how much that meant. I sincerely hope this nomination allows the whole AMU team, and particularly Dr Rohit Sahai, Queen, Lena, Kelechi, Ditty, Holly, Beth and Rodi, to receive the recognition they deserve. I feel incredibly fortunate to have been cared for by such a compassionate, dedicated and exceptional team.

Steve Smith, Volunteer **York** **Nominated by a patient**

Steve is truly worth his weight in gold. His job is to ensure that we are kept all fed and watered during our chemotherapy sessions, but he provides so much more than that. He remembers our names and our preferences (perhaps he keeps a notebook, but so what - it makes each of us feel special) and always has time to chat with each of us, never prying into our personal situations, always kind, always positive, finding something to compliment us on, invariably amusing. The nurses obviously love him too. He has tested all the food items himself, and his recommendations are always spot-on!

He'll even offer to assist with opening awkward packaging when we're trying not to dislodge our cannulas or put a kink the drip tube. My appointment was a little later than usual today, but Steve had already spotted me in the waiting room and, worried that I would miss the first of his rounds, offered to bring some coffee and snacks out to me. His joy is infectious, and for a few hours every Tuesday our little band of often anxious and frightened patients, are invited to join the party by a man who clearly loves what he does and expects nothing but our happiness in return.

Cecilia Aboyeji, Midwife **Scarborough** **Nominated by a patient**

I would like to take the opportunity to share my heartfelt appreciation for Cecilia Aboyeji, who cared for me during my stay on Hawthorne Ward from 12 to 16 May 2026. Although it has been four months since I gave birth, I have not forgotten the care and kindness Cecilia showed me during those difficult days.

I had pre-eclampsia and needed to remain in hospital for several days, which was a very emotional and overwhelming experience for me. I know how busy midwives are and how much responsibility and work they have, but despite this, Cecilia always took the time to check on me, talk to me and comfort me whenever I was feeling low. Her kindness never felt rushed or simply part of her routine. She made me feel genuinely cared for and reassured during a time when I was feeling vulnerable and lonely.

One particular moment that I will always be grateful for was when Cecilia noticed very quickly that my newborn baby was showing signs of hypothermia. She acted promptly and placed my baby in a baby warmer until she is well thermoregulated. I am incredibly grateful that she noticed this so quickly and took the appropriate action before the situation could become more serious.

As a new mother, seeing my baby being cared for so attentively gave me so much reassurance. Knowing that Cecilia was observant and attentive to even the smallest changes in my baby’s condition meant a great deal to me. Beyond the clinical care she provided, Cecilia was also incredibly compassionate. During the days when I felt lonely and overwhelmed on the ward, she would comfort and reassure me. Her care and kindness made such a difference to my experience in hospital. By the time I went home, I felt so comfortable with Cecilia that I genuinely felt as though I had made a friend.

That is how genuine and personal her care felt to me. I know she was simply doing her job, but the way she cared for me made me feel seen, heard and supported as a person, not just as a patient. I am very grateful to Cecilia and would really like to acknowledge the dedication, compassion and care she gives to the women and babies she looks after. I hope she knows that her hard work does not go unnoticed. The kindness she showed me and the care she gave to my baby will always be remembered and appreciated by our family.

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

I would like to nominate Nicole for a STAR Award for the incredible care and support she gave me and my partner throughout the birth of our baby girl.

Nicole supported us both physically and mentally during what was such a huge and emotional experience. She made us feel safe, listened to and reassured throughout, and her calm, kind and compassionate nature made everything feel so much easier. She supported me through the difficult moments of labour while also making sure my partner felt involved and supported.

We never felt like just another patient - Nicole genuinely cared about us and our experience. Bringing our daughter into the world is something we will remember forever, and we are so grateful that Nicole was there to support us. She made such a positive difference to our birth experience, and we will never forget her kindness and care. Thank you, Nicole, for everything you did for our little family. You truly deserve to be recognised.

Heidi Fry, Staff Nurse **Scarborough** **Nominated by a patient**

Heidi helped me after having surgery on my gallbladder. She was absolutely fantastic from start to finish. If I needed anything she was there in seconds. Nothing was too much to ask of her. She was kind gentle and incredibly sweet. She went above and beyond in my care and I'm incredibly grateful for her kindness. She made what is quite a traumatic experience much easier. Thank you for everything!

Acute Oncology Team **York** **Nominated by a patient**

On 22 September, I had to go to the Acute Oncology Department as health concerns had arisen overnight.

On arriving, Chrissie met me and instantly put me at ease all the time during questions and blood tests. Chrissie's calm and kind manner put me so much at ease. Lucy (Smith) then helped me further when going for a scan and having injections, and again I noted the calm and reassuring manner that Lucy had. Morgan (Garnett), who had dealt with me on the previous Friday, came to see me as she had helped me through an emotional episode.

I met Dr Arshad and was given updates and news. Sadly, the news was not particularly good, but he told me with such compassion I could cope. The compassion and kindness given to me by these good people makes me able to carry on as I know I am in safe hands.

Lynsey Duck, Emergency Nurse Practitioner **York** **Nominated by a patient**

Fantastic lady!! Spoke to my son after his accident and told him the importance of wearing a helmet after her experiences with her son. Kept my son calm and talked him through every step of the process from his examination right through to potting his hand. What a fantastic experience we had with her. Yes, we waited over two hours to be seen but was a very quick turnaround from her calling his name to walking out the door with his hand in a cast. Definitely need more of Lynsey's friendly attitude around.

Ward 21 and Ultrasound Department **York** **Nominated by a patient**

I had a knee replacement two weeks ago. Following a doctor's appointment, I was sent to Ward 21 with a suspected DVT.

The service I received from all the team, from when I got there to when I went home, was just brilliant. All the staff I engaged with were kindness itself - to the point it made me cry they were so lovely and I was in so much pain. They made me feel like a priority and that my wellness really mattered to them. I had missed my lunch, and they went out of their way to get me some food and drink - even making me a lovely cup of coffee.

I had to return the following day for an Ultrasound scan. The whole experience was efficient and well run. Colette (the sonographer) was so lovely, taking time to ensure I was comfortable and at ease. She explained what she was doing, what she could see and put my mind at ease. I can honestly say I have never had such excellent service, and both teams are a credit to the hospital. The whole treatment I have received for my knee has been outstanding. Well done York Hospital - you have a team of stars!

Alexandra Mayhew, Specialist Community Occupational Therapist **York** **Nominated by patient**

I just wanted to say that a simple thank you doesn't feel enough. I wanted to express my sincere gratitude for the kindness, respect and compassion you showed me throughout your involvement in my care. From our very first meeting, I felt genuinely heard and listened to.

You took the time to understand how my condition affects every aspect of my daily life and treated me with dignity, empathy and professionalism. That meant far more to me than I can adequately express. Your warmth, kindness and wonderful sense of humour helped put me at ease during what has been an incredibly difficult period of my life. You are an exceptional occupational therapist, but above all, a truly decent human being. Those qualities are not forgotten.

Thank you also for preparing such a thoughtful and comprehensive housing support letter. It accurately reflects the challenges I face and will, I hope, help others understand why suitable housing is so important for my health and independence. Although I am sorry to be discharged from the Community Therapy Team, I completely understand. I feel very fortunate that our paths crossed, and I am deeply grateful for everything you have done. Alexandra, you are a credit and asset to the Community Therapy Team and to the NHS. With my heartfelt thanks and very best wishes for the future.

Judith Seagrave, CBT Therapist **York** **Nominated by a patient**

Jude has been absolutely brilliant talking through my feelings and showing me how to be positive into the future, she has made a massive difference to how I feel. Many thanks.

Georgia Young, Community Staff Nurse | **Community** | **Nominated by a patient**

I have had some serious issues after a kidney removal and have been left with an open wound which the community nurses have been dressing. Georgia recognised that this issue wasn't usual and made every effort to assist in getting me re-admitted to hospital, contacting several departments by telephone and speaking with other staff until I was eventually moved back on a ward. Georgia was extremely knowledgeable, calm and professional at all times, giving me some much-needed reassurance. Thanks to her, the further medica assistance has stopped the bleeding, and I am on the way to recovery. I can't thank Georgia enough for all her kindness and thoughtfulness.

Emma Scott, Senior Healthcare Assistant | **Community** | **Nominated by a patient**

Emma has been to dress my open wound several times and is always very caring and efficient in her job. She recently had to contact a SHO to question my excessive bleeding. Although she never received a reply, she kept trying beyond the end of her shift and even phoned back to check on progress the following day. Emma is a very valuable addition to the team who is hard working, conscientious and professional.

Soumya Abraham, Rheumatologist | **York** | **Nominated by a patient**

Soumya Abraham was smiley and very helpful on arrival when I realised I had my bike with me but no lock. I was early, she saw me before my scheduled time and went over and above today. She was lovely, kind, friendly, reassuring and thorough. A refreshing change to many practitioners I’ve seen recently. Thank you! She deserves a special mention as today could’ve turned out so different.

Kennedy Hudson, Staff Nurse | **York** | **Nominated by a patient**

I was admitted to the Day Unit for my ReActiv8 implant, and from start to finish, Kennedy was absolutely fabulous.

During the day, I unfortunately took a turn, but Kennedy could not have done more to make me feel at ease. She remained calm and reassuring throughout, talked me through what was happening, and made me feel safe and cared for at a time when I was understandably anxious and upset.

Kennedy is a truly wonderful nurse and a real asset to the Day Unit. Her kindness, compassion and professionalism really stood out to me, and I cannot thank her enough for the care and support she gave me throughout my stay. Thank you, Kennedy, for making a frightening experience feel so much more manageable. You are a credit to the team.

Vanessa Kew, Healthcare Support Worker **York** **Nominated by a patient**

I was admitted to the day unit for my ReActiv8 implant, and throughout my stay, Vanessa was absolutely wonderful. Vanessa was constantly checking on me and making sure I was comfortable and okay. When I took a turn, she was incredibly caring and reassuring, and it was so comforting knowing she was there and keeping an eye on me.

Her kindness, compassion and genuine care really stood out. She went above and beyond to make sure I felt safe, supported and looked after throughout what was a very important and emotional day for me.

Vanessa is a real credit to the day unit and a fantastic healthcare assistant. I am so grateful for everything she did for me and for the reassurance and care she gave me when I needed it most. Thank you, Vanessa, for being so kind, caring and attentive. You made a difficult day that little bit easier.

Dr Jacqueline Wing Yin Tang, Consultant in Obstetrics and Gynaecology **York** **Nominated by a patient**

Words cannot describe what Miss Tang did for us and our family. She scanned our twin girls from 14 weeks and went all the way through and delivered them both. Unfortunately, at 20 weeks and five days, we lost one of our girls. It was heartbreaking, and during that time she was our absolute rock. She really was the only person we trusted implicitly. She kept us going when we had lost all hope. Everything she predicted that would happen did happen. Without her support, expert knowledge, and empathy, there is not a chance we could've got through the pregnancy. She went above and beyond on every single scan and made sure we knew what was going on and explained it so perfectly. She really feels like a part of our family now and we will be forever grateful for everything she has done.

This award isn't even a fraction of the praise she deserves! We owe her everything! York Hospital is very lucky to have such an amazing person on their staff!

Eleanor Oakes, Midwife **York** **Nominated by a patient**

Elle was an absolute hero from the moment we walked in the hospital to the second we left. After the loss of one of our twins, we stayed in the Butterfly Suite and not only did she help keep us going through such an awful time, but she also had excellent knowledge on what was going on with our little girl and handled the whole situation so unbelievably well. It really helped us get through such a tough time. She did all this while teaching a student midwife at the same time. She is an absolute superstar and deserves all the praise she can get! She is an asset to the hospital and anyone who is lucky enough to be under her care will say the same thing! Thank you so much Elle we are forever in your debt!

Gifty Otoo, Midwife **York** **Nominated by a patient**

After having my baby, Gifty went above and beyond to make sure I was as comfortable as can be. Upon staying on G2 a couple of nights, you could really see Gifty really cares about each individual in her care. Me and my partner cannot thank her enough for making us feel comfortable, safe and welcomed during our stay. Keep up the hard work Gifty, you're appreciated more than you know!

Robin Hughes, Gynaecology Consultant **York** **Nominated by a patient**

I was recently in hospital and suffered a miscarriage but originally, we didn't know if it was an ectopic pregnancy. Dr Robin was so caring and made me feel reassured each step of the way. In such a heart-breaking and scary situation, I really felt that Dr Robin took care of me and actually cared on a human level. He really took time to explain everything to me on a human level. What a lovely man and a real asset to York Hospital. Thank you.

Shirley Ross, Community Midwife **Community** **Nominated by a patient**

We would like to nominate Shirley for a Star Award in recognition of the truly exceptional care, compassion and support she has shown both my wife and me throughout our pregnancy journey and the transition to being parents to our beautiful baby boy.

Following an incredibly traumatic birth, Shirley went above and beyond anything we could ever have expected from a midwife. When we felt unable to attend the hospital, she took the time to travel to our home and visit us outside of her normal working hours. This honestly meant more to us than words can express, and we will always be forever grateful for the genuine care she showed to us. Throughout everything we experienced, Shirley made us feel heard, understood and supported. She listened to our anxieties without judgement, however big or small, validated our feelings and reassured us during moments when everything felt overwhelming. She encouraged and supported every decision we made regarding interventions to ensure we were able to make informed decisions about our care.

What made Shirley so special was that she became far more than just our midwife and colleague. She became a familiar, trusted face during a time when we needed comfort and reassurance more than ever. Her kindness, empathy and genuine dedication helped us feel safe and at ease during one of the most vulnerable periods of our lives.

The impact Shirley has had on us as a family is something we will never forget. She showed us what truly compassionate care looks like. She never made us feel like we were asking too much, and her willingness to go above and beyond made us feel that we genuinely mattered. During a time that was incredibly difficult for us - knowing we had Shirley in our corner made such a difference. We genuinely could not have asked for anyone better.

Shirley is truly one of a kind and is a credit to her profession. She is the perfect example of what an outstanding midwife should be. She deserves to be recognised for not only the care she provides but also the person she is and the compassion she shows to the families she supports.

Keep being fabulous!

Robert Driver, Consultant Hepatologist	**York**	**Nominated by a relative**

My sister has been a long-term patient of Dr Robert Driver. He always goes the extra mile to ensure that she feels valued seen and is informed on both her health and the next steps of her treatment, all whilst making her quality of life a priority. He is respectful and understanding without judgement and I know that her progress is a testament to his dedication. We as a family just want to say thank you for all he has done and all he continues to do to support her: he is a fantastic doctor!

Naimh Peckston	**York**	**Nominated by a patient**

I wanted to say a huge thank you to Niamh. She was so incredibly patient and was amazing at providing advice. She wasn't our designated midwife for one of the evenings, yet she still came and helped me get up and about out of bed and was so gentle about everything.

She massively helped me with providing confidence and expertise around feeding which put me and my partner at so much ease. She is incredible and we are so grateful to have had her help!

Early Pregnancy Assessment Unit	**Scarborough**	**Nominated by a patient**

I became pregnant after two years of trying and a chemical pregnancy the year prior. From day one, all of the staff there made me feel welcome and cared for. Sadly, at my 12-week scan I found out my baby had no heartbeat and had stopped growing. What has been one of the worst times in my life, was made somewhat easier due to the care and attention I received from each member of staff at Scarborough EPAU.

I was always given the full scope of info in responsible, digestible but an ultimately caring way. It's their job to do what they do, and they see many women I'm sure, but it didn't feel like I was just another job to them. I cannot thank them enough for all of the support they provided to me and have continued to give me.

Giuliana Saudella, Trainee Midwife	**York**	**Nominated by a patient**

Giuliana was absolutely amazing in delivering my son. She made me so happy and at ease, she made the experience so lovely and relaxed after I came into hospital very upset and stressed after being moved from Hull.

Leighton Walker, Consultant in Obstetrics and Gynaecology **Scarborough** **Nominated by a patient**

I would like to nominate Mr Walker for a Star Award for the incredible care and support he has given me and my family over the last few years.

After some very difficult experiences with RPOC, ectopic pregnancies, salpingectomy and then difficulty falling pregnant again, I was left feeling incredibly anxious about what the future would hold.

Mr Walker was there for us professionally during one of the hardest points of our lives, and the care, compassion and reassurance he showed us is something we will never forget.

Not only was his care second to none during all this, but he continued to support us throughout our journey, arranging further blood tests and treatment, and going above and beyond to help us get to where we wanted to be when others wouldn't.

When I finally became pregnant, seeing him again at my 20-week appointment meant so much to me. Having someone who understood everything we had been through made such a difference. Then, on the morning of my planned C-section, I discovered that Mr Walker would be the consultant delivering our baby girl, Phoebe.

After everything we had been through, having him there felt incredibly special. I was nervous, but knowing I was in his care gave me a level of reassurance that is difficult to put into words. He has been there through the hardest parts of our journey, helped us navigate the medical challenges, supported us in achieving our dream of having another baby, and ultimately delivered our beautiful daughter.

I genuinely don't believe we would be where we are today, with our family of four, without his care and dedication. Mr Walker shows incredible medical expertise with genuine kindness, empathy and compassion. He remembers you as a person, takes the time to listen and explain, and makes you feel that you truly matter.

We will always be grateful for everything he has done for us. He has helped turn what was an incredibly difficult and frightening journey into one with the happiest possible ending, and I cannot think of anyone more deserving of recognition.

I nominated Mr Walker for a Star Award back in 2025, and here I am nominating him again! I think that says everything about the impact he has had on our lives. I really do think it's his turn to win one now, if anyone deserves it, he does!

Jennifer Platts, Staff Nurse **York** **Nominated by a patient**

Jenny helped me with my anxiety on one particular session of dialysis. She is always very polite and nice to talk to. She is calm and very professional. Without Jenny on the team, I think my anxiety and time there wouldn't be as comfortable. She's so gentle when applying the needles into my arm.
Jenny makes me and my mental health more stable whilst I am in hospital. She always goes an extra mile just to make sure I am OK. Honestly, please consider her getting an award she really does deserve one. And it's not just me she makes comfortable she's like it with everyone. But I think she's the best nurse there by a mile.

Becky Hawksby, Midwife Sonographer **York** **Nominated by a patient**

I came in for a scan to check my baby's growth, and Becky was fantastic. She was an incredible communicator -really good at setting anxiety at ease and really good at providing the perfect amount of information for us to understand each step of the scan. Thanks so much for your excellent patient-centered care! The department are very lucky to have you.

Lisa Thomas, Vascular Waiting List Coordinator **Scarborough** **Nominated by a colleague**

I would like to nominate Lisa because she consistently goes above and beyond for both our patients and the colleagues she works alongside.

She is always willing to go the extra mile to make sure patients receive the best possible experience and that her colleagues feel supported. Lisa has an incredibly positive outlook and brings that positivity to the team every day. Even when faced with challenging or busy situations, she approaches them with a calm, helpful and solutions-focused attitude. She is always willing to help others, and nothing ever seems too much trouble.

What really stands out about Lisa is how much she genuinely cares. She demonstrates kindness, openness and excellence through the way she treats patients and colleagues, and she can always be relied upon to do everything she can to help.

Her positive attitude, commitment and willingness to go above and beyond make a real difference to both our patients and the wider team. Lisa is a real asset to the department and thoroughly deserves to be recognised for the difference she makes every day.

Em Beckford, Senior Healthcare Assistant **York** **Nominated by a relative**

She really showed that despite how busy a department is that people can still be prioritised. My grandfather was in the waiting room for an entire day, and she showed him patience when his confusion acted up, remembered his name despite there being dozens of patients in the room, and managed to make my grandfather feel special despite how long we were waiting. I also watched her make everyone else feel like the centre of her attention when she talked to them. It was refreshing to see. And even though she was obviously very busy and on her own, she never cut anyone off or came across as rude, even to the drunk man screaming or the girl that vomited on her shoes. Basically, she radiates warmth and the hospital could use more of her.

Megan Hirstle, Healthcare Assistant **Scarborough** **Nominated by a relative**

Megan has looked after my mum many times during her long stay on Oak Ward. My mum has normal pressure hydrocephalus and so her behaviour can be quite erratic. Megan seems to have a calming influence on my mum and helped mum with personal care which was one thing mum generally hasn't adapted well to accepting that she needs.

Megan always greets you with a smile and the care and kindness she showed my mum was truly appreciated by me. She spent time with my mum and helped calm her rather than speaking to mum like she was stupid. I will always be grateful to Megan for the kindness shown to my mum. My mum was a lifelong carer and the kindness, compassion and patience Megan showed reminded me very much of my mum when she was working in the caring profession. I found I could talk to Megan about my mum's health, and she listened and gave me time to get things off my chest as I was trying to cope with the situation surrounding my mums deteriorating health.

Tonisha McKeown, Stoma Care CNS **York** **Nominated by a relative**

Tonisha goes above and beyond with her standard of care. She is very professional whilst also being so kind and caring. Nothing is too much trouble for her. My husband does not like going to the hospital, but he actually looks forward to his meetings with Tonisha because she has put him at ease from the first time they met. He said that, after going through two major operations, he doesn't think he would have got through it without her.

We can't praise her enough; she is a very special person.

Fady Napoleon, Paediatric Consultant **York** **Nominated by a relative**

Dr Napoleon diagnosed and treated my two-year-old daughter for a suspected bone infection. Dr Napoleon spoke to my partner and I in layman's terms, ensuring we understood what he suspected.

He gave us all the information for us to make our own informed decision regarding our daughter having an MRI scan. Our daughter's MRI scarn overran by two hours, and Dr Napoleon waited behind (on his last shift of the set) to go through the findings with us.

We loved his open and honest approach - he admitted that he was in the minority of thinking our daughter had a bone infection and even after the MRI (as we had been anxious about general anaesthetic) reassured us in our feelings and said he would have understood if we didn't go ahead with the MRI.

We had been at the hospital for some days, put into isolation due to a positive swab for cold but symptomless and my daughter was on IV antibiotics. At this point, there were four failed cannula attempts, and we needed to save space for a cannula for the MRI. There were seven failed cannulas in total!

Dr Napoleon advocated for us and our daughter and after doing his own research on IV versus Oral Antibiotics, he recommended we switched to Orals. This meant we could go home on an evening, my daughter could play with her own toys, we could all sleep in our own beds and be much more rested and return first thing in the morning.

I could never express the amount of thanks and credit to Dr Napoleon. We are now two months post-infection and we still talk about how thankful we are of him, firstly for diagnosing her quickly, secondly for speaking to open and honestly, and thirdly for advocating for her. He made it feel like he genuinely cared and it felt that he was a paediatric doctor for the right reasons! Thank you Dr Napoleon, we will forever be thankful!

Amy Johnson, Sister/Charge Nurse **York** **Nominated by a relative**

After 3.5 difficult hours in paediatric ED with my daughter who has additional needs, Amy's appearance completely changed our evening. She immediately sensed that my daughter needed to be sorted out sooner as she was rapidly becoming over stimulated and difficult to manage. She took us through to our own cubicle, treated us both with compassion and humanity and got the Max-Facs opinion we'd been waiting for more than two hours for in the next 15 minutes. She treated my daughter with kindness and immediately built trust with her in a way few people have.

As a doctor, I understand how difficult working in acute services is, and Amy was an exemplary example of the kind of person you want looking after you. It has helped restore some faith in humanity. Thank you.

Martha Hodge, Specialist Occupational Therapist **York** **Nominated by a relative**

My husband Tim had a fall and was taken by ambulance to York A&E. Everyone involved, from the trainee paramedic who was working as volunteer, the ambulance ladies, and the whole team involved were very professional and caring with Tim and myself. We spent a while in EEmac. Martha Hodge was extremely caring and organised for Tim to be transferred to Nelson's Court. She made the whole trauma more bearable, and we both (Tim and I) would like her efforts to be rewarded and acknowledged.

Jamie-Lee Carter, Midwife **York** **Nominated bya relative**

I would like to express my sincere gratitude and appreciation for Jamie-Lee and the exceptional care she provided throughout our experience. Jamie demonstrated excellent communication with both us and the doctors, ensuring that we always felt informed, listened to and reassured. Her bedside manner was outstanding, and her kind, compassionate and professional approach made us feel completely supported during what was such an important and emotional time for our family.

Jamie also showed brilliant clinical judgement and decision-making when the situation required the consultant to be involved and the decision was made to proceed with a C-section. We had complete confidence in her judgement and felt that she handled everything calmly and professionally. I will never be able to thank Jamie Lee enough for everything she did in helping to deliver our baby and for the wonderful care she gave to Jess. Her support, compassion and dedication made such a huge difference to us, and we will always be incredibly grateful to her for the care she provided.

Lydia Rands, Specialist Speech and Language Therapist **Scarborough** **Nominated by a relative**

Lydia has nothing but patience for my very active very distracted six-year-old. She finds new ways every session to keep him concentrating and he is making so much progress with his speech. She is calm and silly, and I am so happy she is helping my boy. She genuinely cares and never gets fed up with his antics.

Thank you, Lydia.

Bernadette Foster, Palliative Care Nurse Specialist **York** **Nominated by a relative**

Berni demonstrated exceptional kindness, openness and professionalism while supporting our family through end-of-life care.

During an incredibly difficult and emotional time, she consistently went above and beyond to ensure both the patient and our family felt cared for, respected and supported. Her compassionate approach, reassuring presence and willingness to take the time to listen made an immeasurable difference to our experience.

Berni treated us with genuine kindness and dignity, keeping us informed and involved throughout the journey. Her professionalism and dedication helped make an extremely challenging situation more bearable, providing comfort and reassurance when we needed it most. Through her actions and behaviour, she truly embodied the Trust's values of kindness, openness and excellence, and made a lasting positive impact on our family that we will never forget.

Karen Couchie, Receptionist **Selby** **Nominated by a visitor**

I called at MIU reception after visiting my aunt on the ward. I had been bitten at home, and it appeared to be infected. At the time there was a long wait to be seen in minor injuries, so Karen gave me the option to wait or try the pharmacy. This proved to be the best option for me and was much appreciated.

I called in reception the following day and filled this information on an 'experience matters form' and suggested she be nominated for a Star Award.

Committee Report

Item 10

Report from:	Quality Committee Chair's Report
Date of meeting:	17th November 2026
Chair:	Lorraine Boyd

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

ALERT
* **Triangulated complaints, concerns and external Healthwatch feedback** has resulted in an emerging consistent signal: compassionate and clinically good care from individual staff can be undermined by delays, poor communication and fragmented coordination across the wider patient pathway. Progress in these areas needs to be sustained alongside action to address the principal risks to patient and carer experience. This reinforces the need for improvement actions to focus not only on individual services or episodes of care, but also on how patients experience the whole pathway. ***Theatre resilience** is a growing concern as a result of multiple compounding challenges relating to estates, infrastructure, equipment failures and resilient staffing models, leading to capacity, productivity, patient safety and patient experience risks. Greater Board visibility of the interacting risks, mitigations and management and impact on outcomes is recommended. ***Coming Off Corridors** in the context of rising activity levels (ambulance arrivals and self referrals) remains a significant cause for concern in spite of substantial improvement work and executive oversight. Engagement across the Trust remains high currently but is expected to become more challenging as operational pressure rises over winter. Improvement metrics are not yet demonstrating the anticipated impacts of the improvement activity, however, through the high profile of the work streams the culture that has previously normalised corridor care is changing.
ASSURE
*Pressure Ulcer Performance, a True North metric, remains off trajectory but early evidence of positive impacts though improvement work is beginning to emerge. *Surgery Care Group shared evidence of improving safety governance. Overdue Mortality reviews are falling and no overdue patient safety incident, outstanding SI reports or SI actions was reported. However, outstanding actions following

complaints is rising and further assurance that learning is happening and resulting in improvement is needed. A clinician led Non Elective Laparotomy Audit (NELA) group has been formed in response to previously raised concern and a new bowel obstruction pathway is in place. VTE prevention has been a significant focus, working with pharmacy colleagues, and a plan is in place. Outcome data will be required to strengthen assurance in both cases.

*Patient Experience Q2 Report outlined a progress update on the Improvement Plan providing assurance on focus and engagement, although this is not yet demonstrably improving outcomes, particularly complaints which continue to increase in numbers and complexity. Care Group learning from complaints was shared providing assurance that information is being used to guide improvement plans and in some cases improved patient experience was demonstrated.

*Complaints and complex complaints closure continued to steadily improve but remains below 90% target, with overall rate of 77% and 66% for the complex. Complex complaints have increased by 43% (from 105 to 150) in the reporting quarter and the potential causes and implications was discussed.

* Maternity National Safety Initiative Updates were reviewed and ongoing progress noted. No new concerns were identified. Diabetes, Epilepsy and Smoking cessation service provision remain a risk to MIS8 compliance.Mitigations are in place, there is a confidence that definitive solutions will be deliverable and assurance that no related harms have been identified.

* Maternity Quality Safety Metrics were reviewed and remain within expected variations

* Perinatal Mortality Review Tool Q2 update confirmed that compliance with MIS8 reporting standards and processes are in place to support multidisciplinary review, parental engagement, identification of learning, and the implementation of improvement actions arising from reviews. Ongoing monitoring is undertaken through established maternity governance structures,

* Maternity Equity and Outcomes Paper was received and provided assurance that the Trust is taking steps to identify inequalities and associated outcomes with an initial focus on preterm birth and late booking by Index of Multiple Deprivation (IMD), providing assurance that inequality is being actively explored with a view to understanding and closing gaps in equity and outcomes, supported by MNVP to ensure the patient voice is being heard.

* Maternity Learning Themes Q1&2 update provided assurance that a structured process is in place to ensure learning themes are identified, through triangulation of all information sources, and acted upon. Complaints, PPH and unanticipated admission to Special Care Baby Unit (SCBU) are themes currently in focus.

Assurance will be further strengthened when delivery of agreed actions and their outcomes can be evidenced.

*IPC Update provided mixed assurance with some improvements but assurance overall remains limited. IPC Governance and Care Group ownership have strengthened through monthly oversight, PSIRF reviews and targeted ward plans resulting in demonstrable improvements. The Winter Resilience Plan has been developed and approved (and is currently being tested in real time) and the IPC Improvement Plan is being refreshed. However Health Care Acquired Infection performance remains a significant cause for concern: CDI, MSSA, E Coli, and Pseudomonas remain above trajectory and the Trust is a regional outlier for several indicators. Continued high levels of scrutiny is required.

*Safeguarding Update provided good assurance that statutory arrangements are in place and compliant with regulations. Safeguarding Level 3 compliance is improving following the decision to recognise experiential learning and is now 82% against 90% target.

ADVISE

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

* MNVP Engagement EDI Report outlined the range of communities and groups engaged to contribute to the patient voice and support improvement activity.

* Maternity Feedback Survey in conjunction with MNVP continues to develop and grow, providing timely insights, although still limited by small number of respondents.

* Perinatal Culture and Improvement Plan was received and discussed in line with Maternity Incentive Scheme requirements. Of 76 improvement actions, 9 high level and 67 milestone, 41 are complete. 19 are off track, 2 in progress and 5 not started as a consequence of the Board approved pause of the Maternity and Neonatal Single Improvement Plan.

*AGNI (Attorney General Northern Ireland) judgement has been reviewed by the Safeguarding Team and the implications for the management of Mental Capacity Assessments (MCA) and Deprivation of Liberty (DOL) Assessment is being considered in conjunction with the Local Authorities.

*A ' National Patient Surveys Governance, action planning and assurance framework' has been written and approved by PESC in August 2026. The paper outlines the governance arrangements for reviewing, responding to and monitoring

improvement actions arising from national patient surveys. It establishes a consistent Trust-wide approach.

*Digital dependencies continue to create quality assurance gaps, including nursing dashboards, reasonable adjustment flags, VTE functionality and aspects of safeguarding and patient experience systems.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

STRATEGIC RISKS

* **PR1** was addressed through all agenda items, with particular focus on health care acquired infections, corridor care / winter resilience, VTE (venous thromboembolism) prevention, delayed and fragmented pathways, Theatre resilience.
* **PR3** - partial/ indirect coverage through safeguarding report highlighting multi agency working
* **PR4** - limited indirect coverage.

CORPORATE RISK REGISTER

*__CRR32__ relating to Patients with No Criteria to Reside was noted to have increased as a result of an increase to the impact score. More detail on the rationale for the increase was requested, and the Committee will consider how this might affect the assurances required
* **CRR 1016** relating to stroke consultant capacity which remains at 20, with limited evidence on the CRR of active review.
*__CRR 866__ relating to IPC was discussed through the quarterly update report.

OTHER RISKS

*__BAPM compliant neonatal staffing__, particularly at Scarborough remains an ongoing risk with plans and mitigations in place.
*__Maternity Regulatory Requirements__ are growing and risks capacity being drawn away from the Single Improvement Plan.

ASSURANCE GAINED

MODERATE ASSURANCE OVERALL

The information provided and discussed demonstrated moderate assurance on clinical pathways and quality of care, with evidence that risks are increasingly well recognised, governance arrangements are strengthening and credible mitigations are in place, particularly in patient experience, maternity safety, safeguarding, patient safety governance and health inequalities.

However, assurance is more limited that the highest risks are reducing consistently in terms of patient outcomes. The principal gap is between evidence of activity and

evidence of impact. The need to distinguish action completion from measurable impact on harm, infection, delays and experience was discussed.

In summary:-

Surgery Care Group - moderate assurance

Maternity - moderate assurance

IPC - limited assurance

Safeguarding - moderate assurance

Patient Experience - moderate assurance

Patient Safety and Clinical Effectiveness - moderate assurance

Emergency and Corridor Care - limited assurance

Committee Report

Report from:	Resources Committee
Date of meeting:	17 November 2026
Chair:	Helen Grantham

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

ALERT

- **2026/27 WRAP delivery**
  - As at M7 WRAP delivery was £30.65m YTD - £6.8m behind target of £37.5m. Full-year savings delivered are £40.7m against a £65.8m target. While there was continued strong performance against prior years, the trend of monthly underperformance against plan was continuing.
- **2026/27 plan/cash**
  - The Trust is continuing to underperform against plan, reporting a year-to-date deficit of £21.9m against a planned deficit of £10.5m (£11.3m adverse variance, before any DSF adjustments).
  - Delivery of the £18.5m deficit plan and receipt of full support funding remain at risk and a discussion took place on the mid-range forecast of £31m (£12.5m worse than plan) and a worst-case forecast of £45.6m. The Committee asked that they be provided with the actions (with associated financial impact) which would need to be delivered to meet the mid-range and best-case position
  - Key drivers for underperformance remained as for prior months - WRAP under delivery, medical bank spend and drug costs.
  - Whilst agency spend was below plan, bank spend was £21.4m YTD against a plan of £15m (£6.4m adverse), although there had been some positive impact of recent process improvements.
  - Cash closed at £5.5 m against a £2.3 m plan - the deteriorating performance against better payment practice code was noted. The Committee noted the forecast cash position and current forecast requirement for £15m of further Revenue Support PDC during Q4. It was anticipated that a request for cash support would be submitted in December for receipt in January) and the Committee recommended this course of action to the Board.
- **Sickness absence**
  - Remained high in comparison to where we had hoped to be at this point in the year. An update was provided on the flu vaccination campaign and policy changes. Stress and anxiety remained the top reason for absence
- **Operational performance:**
  - UEC and flow remained the most significant operational and patient safety concerns – ECS at 65.2% v trajectory of 75.8%. Length of stay, discharge timeliness and 12-hour waits remain off plan
  - RTT showed further deterioration – TWL of 58,696 v 52,865 trajectory – 57.8% within 18 weeks, 1303 over 52 weeks and five over 65 weeks
  - Faster diagnosis standards, patient initiated follow up, rapid access chest pain, children and young person long waits and community speech and language therapy remain below plan, with delivery constrained by workforce, diagnostic capacity, affordability and system dependencies

- **Diagnostic – progress report**
  - CT, NOUS, echocardiography and urodynamics continue to require targeted recovery and sustainability action – radiographer and sonographer recruitment challenges
  - Current performance is reliant on insourcing and temporary resource
  - Challenges remain with capital programs and there was a need for focused oversight of MRI3 and MRI4 delivery, confirmation of CT1/CT2 milestones and demand growth
  - See also **ASSURE**

ASSURE

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- **Operational performance**
  - Cancer performance was 71.8% in August v 70.7% trajectory, with Breast and Upper GI above 75%
  - Urgent community response performance has improved and hosptial at home pathways continue to develop
  - Outpatient productivity remains a relative strength – DNA rate at 4.4%, advice and guidance utilisation remains above 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
- **Diagnostic– progress report**
  The Committee received an update on diagnostic performance:
  - Performance improved to 81.7% in October against a trajectory of 78.6% - the highest trust performance since February 2020
  - 6-week breaches reduced from 2.722 to 2.382 in October
  - CT3 became fully operational at the end of October and mobile CT has stopped
  - See also **ALERT**.
- **Ethnicity and gender pay gap**
  - The Committee reviewed the ethnicity and gender pay gap reports as at 31 March 2026
  - There was no overall ethnicity pay gap in favour of white colleagues, although significant pay gaps remain for medical and dental roles with the gap reducing compared to 2025 but with no improvement relating to consultant bonuses (clinical excellence awards)
  - The headline gender pay gap has improved with the median pay gap having reduced substantially. Women are underrepresented generally in the upper pay quartile. Clinical excellence award gaps remain substantial.
- **Research and Innovation Bi-Annual Update**
  The Committee reviewed the bi-annual (April – October 26) research and innovation report. Key points below:
  - 1332 patients had been recruited into clinical trials
  - strong commercial pipeline with 6 studies in set up and submission of 16 research grant applications and 6 innovation grant applications
  - an innovation manager has been appointed and staff training has been developed along with an Ideas Hub.

- **NHS England Annual Self-assessment report**
  - The Committee reviewed the report relating to the Trust's education and training provision for 2025/26 ahead of its review by the full Board and submission to NHSE
  - On the whole, the report was positive with some areas of partial assurance around facilities, protected educator time, speaking up confidence and assurance data.
  - The Committee also reviewed information relating to improving the working lives of resident doctors with gaps noted.
- **Emergency Planning Resilience and Response – annual self assessment**
  - the Trust's EPRR annual self-assessment report shows an overall rating of *partially compliant* with 52 of 62 applicable core standards (84%) fully compliant, an improvement on prior year
  - Outstanding compliance gaps concern EPRR resources, countermeasures and excess fatalities plans, incident communications and business continuity assurance
  - An action plan was provided and noted with associated RAG rating

ADVISE
Nothing to report

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- **2026/27 WRAP/plan/cash:** the potential failure to meet the trust plan and WRAP target and associated impact on the Trust's cash position.
- **UEC:** the risk that UEC performance would not improve to meet trajectory
- **RTT:** the risk that RTT performance would not improve to meet trajectory or deteriorate further.
- **General G&A beds:** the increase in impact (from 3 to 4) of the risk that more than 10% of General G&A beds have patients with no criteria to reside
- **Workforce:** the risks associated with increased level of colleague sickness absence and level of bank usage
- **Facilities:** risks relating to the Trust premises – a review would be undertaken of the property related risks on the risk register.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

TRUST PRIORITIES REPORT

November 2026

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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"):
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.

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	2026-10		F	15.8%	6.6%	5%
ED - Conversion rate (Proportion of Type 1 attendances which had an inpatient admission with a length of stay greater than zero)	2026-10	L	?	22.4%	28.5%	28%
Cancer - Faster Diagnosis Standard - Declared Position	2026-09		F	68.3%	81.4%	84.3%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-10	H	F	62.6%	65%	67.1%
2-hour Urgent Community Response (UCR) Compliancy %	2026-10	H	?	82.2%	70%	70%
Total Number of Trust Onset MSSA Bacteraemias	2026-10		?	5	7	7
Response rate overall for complaints and concerns	2026-10		P	68.2%	90%	90%
Monthly sickness absence	2026-09	H	F	6.1%	5.1%	4.7%
Variance year-to-date to financial plan	2026-10			-2.1%	0%	0%

National Oversight Framework performance overview

Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

Q1 2026/27 remains the latest published NHS Oversight Framework assessment. York and Scarborough Teaching Hospitals is in segment 3, ranked 102nd of 134 acute providers, with an average metric score of 2.68. NHS England identifies financial deficit as the reason for the segment cap and records an Amber/Red capability assessment. These published findings predate October performance.

The internal position at the start of Q3 remains mixed. October results cover urgent and emergency care, diagnostics and provisional elective performance, and the October scorecard includes finance indicators. Cancer reporting follows national guidelines and remains one month behind. Different reporting periods and validation stages limit direct comparisons, and the internal results do not establish a new national segment.

Elective access remains a significant concern. The provisional October waiting list stood at 58,153 against a trajectory of 52,231. Performance within 18 weeks was 57.0%, below the 63.7% trajectory. A total of 1,349 patients had waited over 52 weeks, equivalent to 2.3% of the list, and eight had waited over 65 weeks. These results remain subject to validation. Through the Focus on First programme, the Trust provisionally delivered 108% of its first outpatient appointment plan in October. The Trust anticipates the RTT impact in November.

Urgent and emergency care continues to face substantial operational and patient-safety pressures. October four-hour performance was 64.6% against a 77.3% trajectory. Among Type 1 patients, 15.8% spent more than 12 hours in an emergency department against 6.6% planned. Non-elective length of stay averaged 8.1 days against 6.1 days. Discharge on the discharge-ready date reached 85.9% against 88.5%, with an average subsequent delay of 4.9 days against 3.4 days. Staffing gaps and limited community and social-care capacity continue to hinder recovery. Corridor care averaged 98 episodes per day against 75 planned, comprising 70 emergency-department episodes and 28 inpatient episodes. These figures count episodes, rather than unique patients.

Diagnostics improved materially in October. Performance within six weeks rose to 81.7%, above the 78.6% trajectory and the highest reported Trust performance since February 2020. Six-week breaches fell from 2,722 in September to 2,382 in October. However, the waiting list increased to 13,046, including 340 patients waiting over 13 weeks. Workforce capacity and equipment resilience remain important to sustaining improvement and addressing longer waits. September Cancer results remained below trajectory. Performance against the 62-day standard was 69.1% against 75.9%, and the Faster Diagnosis Standard reached 68.3% against 81.4%. Diagnostic pathway delays continue to constrain recovery. The NOF 90-day clinical-trial setup measure reached 100% in Q2, providing positive research assurance while remaining a quarterly result.

In community services, the Speech and Language Therapy long-wait cohort fell to 249 in October, ahead of the 267 trajectory.

Workforce and quality indicators remain broadly stable, with positive performance evident across several community, research and quality measures.

Financial sustainability remains a material constraint. The October scorecard records an overall finance score of 4, unchanged from Q2. The year-to-date variance from financial plan remains worse than trajectory, underlining the need for recurrent savings and expenditure recovery.

Overall assessment: October shows improvement in diagnostics and the Speech and Language Therapy backlog, alongside increased first outpatient activity. Emergency flow, provisional elective access and the latest cancer results remain below plan. Financial performance remains a material area of concern, with delivery against plan and productivity expectations continuing to require close oversight. Alongside this, workforce and quality indicators remain broadly stable, with positive performance evident across several community, research and quality measures. The published Q1 segment 3 position remains separate from the emerging internal Q3 assessment.

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%	Sep-26	57.79%	Sep-26	57.79%	
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Jun-26	1.93%	Sep-26	2.22%	Sep-26	2.22%	
Percentage of diagnostic waits over 6 weeks	Jun-26	20.64%	Oct-26	18.26%	Sep-26	21.98%	
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q1 2026/27	72%	Oct-26	61%	Q2 2026/27	66%	
Percentage of emergency department attendances spending over 12 hours in the department	Q1 2026/27	10.22%	Sep-26	13.85%	Q2 2026/27	14.18%	
Percentage of patients treated for cancer within 62 days of referral	Q1 2026/27	71.15%	Sep-26	69.09%	Q2 2026/27	71.83%	
Percentage of patients waiting less than 18 weeks for community care	Jun-26	60.12%	Oct-26	60.12%	Sep-26	54.97%	
Percentage of patients waiting over 52 weeks for community services	Jun-26	22.47%	Oct-26	14.08%	Sep-26	21.14%	
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q1 2026/27	73.56%	Sep-26	68.32%	Q2 2026/27	71.79%	
Number of patients cared for in corridors (ED only)	-	-	Oct-26	2174	Q2 2026/27	5808	
Percentage of intermediate care beds occupied by patients without criteria to reside	Q1 2026/27	15.61%	Oct-26	35.75%	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	-	-	Aug-26	-0.66%	Q2 2026/27	-0.59%	
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)	Q1 2026/27	1.11	Sep-26	1.08	Q2 2026/27	1.08	
Rate of C. difficile (rolling 12 months)	Q1 2026/27	0.91	Sep-26	1.13	Q2 2026/27	1.13	
Number of neonatal deaths and stillbirths per 1,000 births	-	-	2024	3.95	2024	3.95	
Delayed inductions rate	Q1 2026/27	17.8	Q2 2026/27	19.8	Q2 2026/27	19.8	
Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Q4 2025/26	52%	Aug-26	51%	Q1 2026/27	51%	
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	-	-	Oct-26	3.89%	-	-	
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	Q4 2025/26	5.79%	Sep-26	6.02%	Q1 2026/27	5.40%	
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	Oct-26	4	Q2 2026/27	4	
Data Quality Maturity Index score	Apr-26	92.20	Oct-26	91.1	Q2 2026/27	91.1	
Planned surplus/deficit	Q1 2026/27	-2.56%	Oct-26	-2.01%	Q2 2026/27	-2.03%	
Relative difference in costs	Q1 2026/27	86.27%	Oct-26	94%	Q2 2026/27	94%	
Variance year-to-date to financial plan	Jun-26	-1.33%	Oct-26	-2.09%	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

November 2026

Operational Activity and Performance

Chief Operating Officer Report - Executive Summary

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Performance remains mixed, with credible improvement evident in several priority areas, although overall recovery is not yet secure. The Trust continues to experience significant pressure across urgent and emergency care, elective recovery and cancer pathways; however, there is increasing evidence that focused operational interventions are beginning to deliver measurable improvement.

Areas to Recognise

- Diagnostics improved to 81.7% in October against a trajectory of 78.6%, representing the strongest performance since February 2020 and supported by CT3 becoming fully operational at the end of October.
- Community services also continued to improve, with Speech and Language Therapy long waits reducing to 249 patients against a trajectory of 267, alongside improved Urgent Community Response performance and continued development of Hospital at Home and the wider community model.
- Outpatient productivity remains a relative strength. Clinic utilisation reached 91%, DNA rates remained low at 4.4%, and consultant-to-consultant referrals are reduced by 11% year-to-date. Focus on First also provisionally delivered 108% of the October first outpatient plan, creating a stronger platform for RTT recovery.

These improvements demonstrate that focused operational action is beginning to deliver benefit and should be recognised.

Emerging Improvement Rather Than Sustained Recovery

- Whilst encouraging, most of these improvements remain relatively recent and should be regarded as emerging rather than sustained recovery. Increased first outpatient activity has not yet translated into improvement in RTT performance, with the anticipated impact expected to become evident during November from Focus on Firsts. Similarly, whilst diagnostic performance has improved, the overall waiting list remains 13,046, including 340 patients waiting over 13 weeks.
- The strongest evidence of consistent delivery remains within outpatient productivity measures, where utilisation, referral management and DNA performance have remained favourable over a longer period.

Principal Risks

- Urgent and emergency care remains the Trust's most significant operational risk. October Emergency Care Standard performance was 64.6% against a trajectory of 77.3%, with 15.8% of Type 1 patients waiting over 12 hours, average length of stay of 8.1 days, and corridor care averaging 98 episodes per day against a planned level of 75. These pressures continue to reflect whole-system flow constraints rather than solely Emergency Department performance.
- RTT recovery also remains high risk. The provisional waiting list stood at 58,153 against a planned position of 52,231, with 57.0% of patients waiting less than 18 weeks against a trajectory of 63.7%. There were 1,349 patients waiting over 52 weeks and eight patients waiting over 65 weeks. Children and Young People remain an area requiring focused oversight, with 20 patients waiting over 52 weeks, including 17 within Oral Surgery.
- Cancer performance remains below trajectory, with September 62-day performance at 69.1% against 75.9% and Faster Diagnosis Standard performance at 68.3% against 81.4%.

Management Response - Management action remains focused on:

- addressing medical rota gaps and strengthening senior clinical decision-making to improve urgent and emergency care flow;
- improving discharge performance through ward and board-round improvements, criteria-led discharge and enhanced escalation arrangements;
- converting Focus on First activity into RTT recovery through specialty oversight, validation, chronological booking and recovery actions targeted at long waits; implementing the ICB-approved Pain referral threshold and continuing specialty-level RTT recovery programmes;
- recovering cancer pathways through tumour-site actions, pathway redesign and diagnostic capacity improvements;
- sustaining diagnostic improvement whilst addressing workforce and equipment constraints within key modalities;
- maintaining weekly oversight of CYP long waits and delivery of the Q3 paediatric recovery plan; and
- continuing development of Hospital at Home, Urgent Community Response, SPoA and the wider community operating model.

Executive Assessment

There is credible improvement in diagnostics, community waiting times and outpatient productivity, and these achievements should be recognised. However, the Trust's overall risk profile continues to be driven by urgent and emergency care flow, RTT recovery and cancer performance. The position is therefore best characterised as improving, but not yet consistently delivering the level of recovery required, and Board scrutiny should remain focused on whether recent operational gains translate into sustainable improvements in waiting times, access standards and patient experience.

Operational Activity and Performance
Chief Operating Officer Report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Priority Area	Current Position	Recovery Actions	Key Dependency / Risk
UEC & Flow	High Risk. ECS 64.6% vs 77.3% trajectory. Type 1 12-hour waits 15.8%. Length of stay 8.1 days. Corridor care averages 98 episodes daily vs 75 planned.	Address medical rota gaps, strengthen senior decision-making, refresh EAU/EEMAC pathways, improve discharge processes and system escalation.	Workforce availability, discharge capacity and wider system flow.
RTT & Long Waits	High Risk. Waiting list 58,153 vs 52,231 plan. 57.0% within 18 weeks vs 63.7%. 1,349 patients waiting >52 weeks and eight >65 weeks.	Focus on First, specialty oversight, validation, chronological booking, weekly long-wait review and implementation of the Pain referral threshold.	Referral growth, capital delays and specialty capacity constraints.
Children & Young People	High Risk. 20 CYP patients waiting >52 weeks, including 17 within Oral Surgery.	Weekly oversight and Q3 paediatric recovery plan continue. Oral Surgery forecasts elimination of 52-week waits by the end of Q3, subject to staffing.	Delivery remains dependent on staffing and treatment capacity.
Cancer	Moderate-High Risk. 62-day performance 69.1% vs 75.9%. FDS 68.3% vs 81.4%.	Tumour-site recovery plans, pathway redesign and diagnostic capacity improvements.	Pathology, colonoscopy and imaging constraints.
Diagnostics	Emerging Improvement. DM01 81.7% vs 78.6%. Waiting list 13,046. 340 patients waiting >13 weeks.	Sustain CT3 benefit and targeted recovery of long waits.	Workforce and equipment pressures across MRI, NOUS, Echo and Urodynamics.
Community Services	Emerging Improvement. SLT long waits reduced to 249 vs 267 trajectory. UCR performance improving.	Community Assessment Days, recruitment and delivery of Phase 1 community model.	Workforce availability and commissioning decisions.
Outpatients & Productivity	Mixed but Improving. Utilisation 91%. DNA 4.4%. C2C referrals down 11% YTD. PIFU and RACP remain below plan.	Sustain productive clinic utilisation whilst recovering PIFU and RACP performance and converting increased first outpatient activity into RTT improvement.	Capacity pressures and workforce availability.
Transformation & Demand Management	Positive Direction. Benefits not yet fully realised.	SPoA rollout, Hospital at Home development, UCR improvements and implementation of Pain threshold changes.	Clinical engagement, digital delivery, affordability and system support.

Operational Activity and Performance

Acute Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

Headlines:

- The October 2026 Emergency Care Standard (ECS) position was 64.6%, behind the monthly planned improvement trajectory of 77.3%. 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 September 2026 (latest available national data) the Trust ranked 107th out of 118 providers and 11th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group (August performance saw the Trust at 103rd and 10th respectively).
- Average ambulance handover time in September 2026 was behind trajectory at 21 minutes 55 seconds against trajectory of 18 minutes 44 seconds.
- 15.8% of Type 1 patients spent over 12 hours in our Emergency Departments during October 2026, behind trajectory of 6.6%.
- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 8.1 days in October 2026, behind the trajectory of 6.1 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 October 2026 was 85.9%, against the trajectory of 88.5% submitted as part of the 2026/27 annual planning process. The average delay (number of days after the DRD that a patient was subsequently discharged) was 4.9 days, behind the submitted trajectory (3.4 days).

Factors impacting performance:

- Staffing issues continue, with instances of high levels of absence - medics and nurses - and the need for internal aid.
- 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 November 2026:

- Multi-agency Discharge Event (MaDE) starting 30th November.
- Launching additional frailty at front door capacity and new process at both sites
- Trialling additional cardiology input in York ED and York EAU one day per week
- Exploring options for increasing minor illness capacity at York over winter
- Agreeing a Clinical Lead for Extended Emergency Medicine Ambulatory Care (EEMAC) and progressing the reset.

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 - 12 hour trolley waits - Declared Position * ED - Proportion of Ambulance handovers waiting > 240 mins * ED - Ambulance average handover time (number of minutes)	* ED - Proportion of Ambulance handovers waiting > 45 mins
COMMON CAUSE / NATURAL VARIATION	* ED - A&E Attendances - Types 2 & 3 - Declared Position		* ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - Total waiting 12+ hours - Actual number of all Type 1 attendances * ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs) * ED - Emergency Care Standard (Type 1 level) - Declared Position * ED - Proportion of Ambulance handovers over 15 mins
SPECIAL CAUSE CONCERN		* ED - A&E attendances - Type 1 - Declared Position	

Acute Flow (1)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Proportion of all attendances having an initial assessment within 15 mins	2026-10			77.2%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-10	L		4.9%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-10		F	15.8%	6.6%	5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-10		F	2070	736	558
ED - 12 hour trolley waits - Declared Position	2026-10	L	?	332		0
ED - Emergency Care Attendances - Declared Position	2026-10			19926		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-10		F	64.6%	77.3%	82%
ED - Emergency Care Standard (Trust level) - Declared Position	2026-10	L		61.3%		
ED - A&E attendances - Type 1 - Declared Position	2026-10	H	?	13122	11573	11309
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-10		F	45.4%	61.2%	70.1%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-10		P	6804	8517	8324
ED - Median Time to Initial Assessment (Minutes)	2026-10	L		3		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-10	L		32.2%		

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

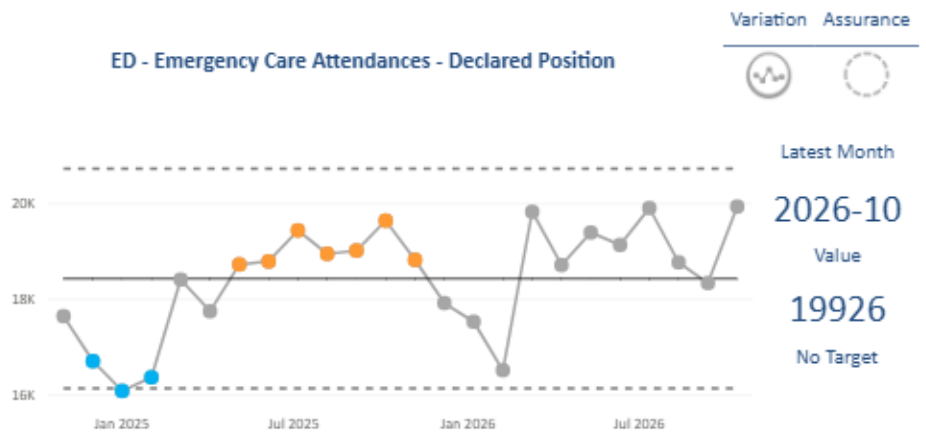
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of SDEC attendances	2026-10			6882		
Proportion of SDEC attendances transferred from ED	2026-10			44.5%		
Proportion of SDEC attendances transferred from GP	2026-10			14.8%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-10			97.8%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-10			25.1%		
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	2026-10			31.6%		
ED - Proportion of Ambulance handovers over 15 mins	2026-10			68.4%	52.3%	49.6%
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-10			20.9%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-10			3.3%	0.8%	0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-10			0%		0%
ED - Number of ambulance arrivals	2026-10			4922		
ED - Ambulance average handover time (number of minutes)	2026-10			22	18	19

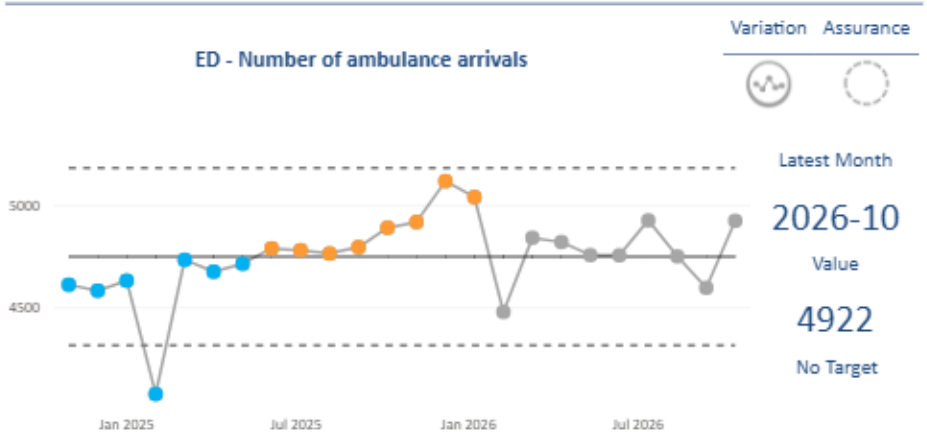
Executive Owner: Claire Hansen

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 **deteriorated** from the previous month, with a difference of **1597.0**.



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 **328.0**.

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?

Ambulance arrivals are broadly in-line with numbers seen last year. There is an ongoing data issue with double-counting some minor illness and injury patients which is inflating total attendances. A task and finish group is being led by the ACOO for Medicine to resolve this.

Following a doubling in the number of daily attendances to York ED by patients aged 18-22 during late September and early October, the Medical Director wrote to the universities to request additional communications to students about GP registration. Local GPs have also been advised through a neighbourhood working group and a 'mythbusting' information sheet is being developed to share with both York universities.

What is the expected impact?

Correcting data quality issues may reduce total attendances by up to 600 patients per month, pending further work in the new group.

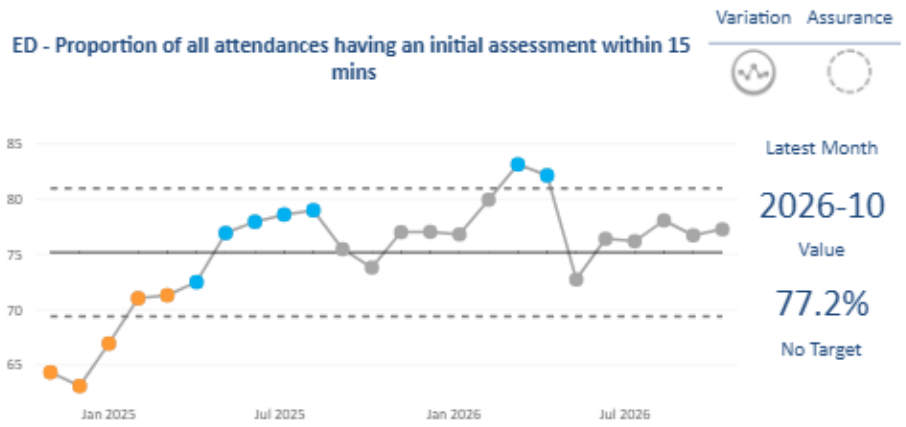
Working with the universities may have limited impact this year since the start of year surge has already occurred. Building connections could support a lower impact in future September/October periods.

Potential risks to improvement?

There is a risk that the data quality issues cannot be resolved in a way that is acceptable to all partners, including frontline clinicians, Digital team and the ICB. This will be mitigated through involvement via the new group.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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Rationale: : To monitor waiting times in A&E. Patients should be assessed promptly by within 15 minutes of arrival based on chief complaint or suspected diagnosis and acuity.
Target: No target

What actions are planned?

The proportion of patients having an initial assessment within 15 minutes is stable and in-line with levels achieved last year.

What is the expected impact?

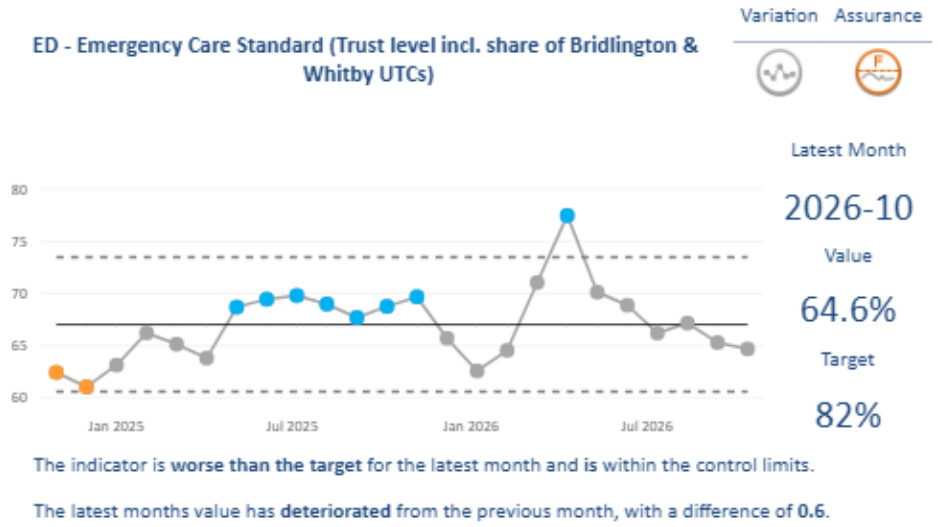
A delay to initial assessment contributes to time in the department and can leave patients with a level of uncertainty about 'what next' for their care.

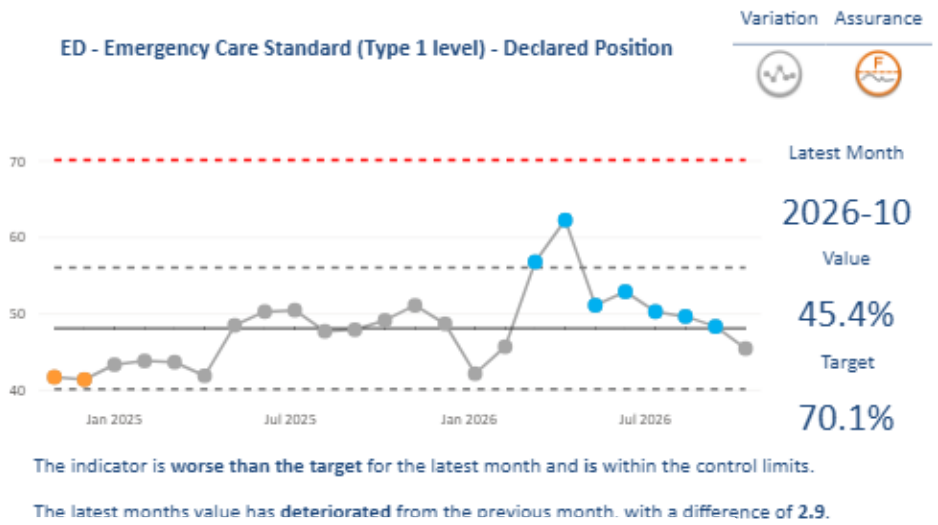
Potential risks to improvement?

- High nursing absence levels
- Ongoing surges in attendances with 20+ patients arriving every hour for multiple hours.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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?

Two big opportunities for improving ECS performance are:

1) increasing GP availability and utilisation, by funding an additional ledger and working with streaming teams to send more patients to the GP and
2) resetting the EEMAC pathways at both sites (starting with York) and ensuring as many appropriate patients as possible are put onto this pathway.

These opportunities are being prioritised for consideration of investment, both financial and clinical leadership time. An Expression of Interest process is being followed to appoint a Clinical Lead for EEMAC.

What is the expected impact?

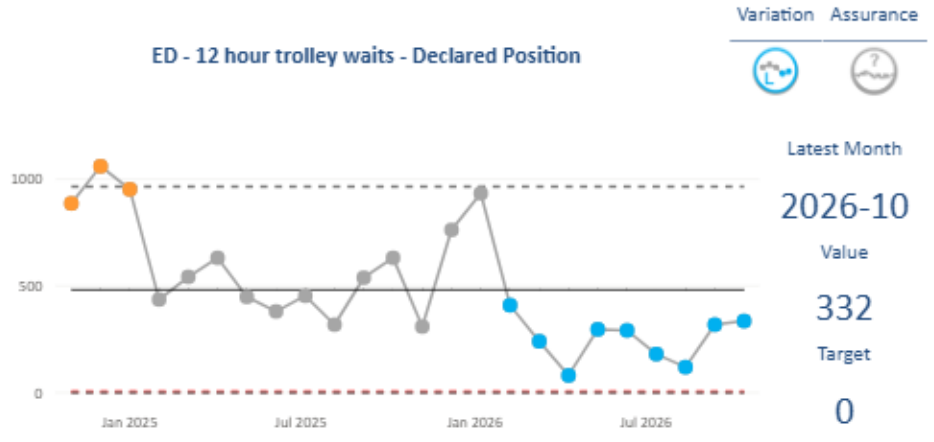
An additional ledger could lead to an additional 40 patients per day going to the UTC at York Hospital. At the same time, an additional 10 patients per day could be sent to EEMAC at York. This would increase overall Trust ECS performance. It would also decompress the main department and support improvements for patients on other pathways, as well as staff experiences.

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

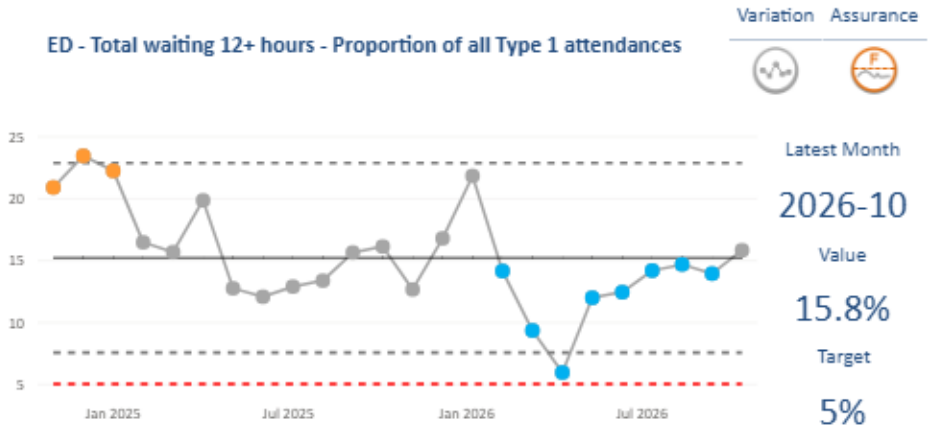
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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**.



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**.

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 Type 1 patients spending over 12 hours in ED remains higher in Scarborough (19%) than York (14%) though Scarborough has improved this month despite ongoing challenges with senior medical cover and limited uptake of available shifts.

The Coming off Corridors programme has now launched a board/ward round and criteria-led discharge project with pilot wards to support flow.

Clinical Leads for Medicine attended a workshop to make coordinated joint plans towards an improved model of care. There will be increased presence of senior decision makers from Frailty and Cardiology at York ED from November. The process for EAU at both sites will be reviewed and refreshed to be user-friendly and provide clarity on its role.

What is the expected impact?

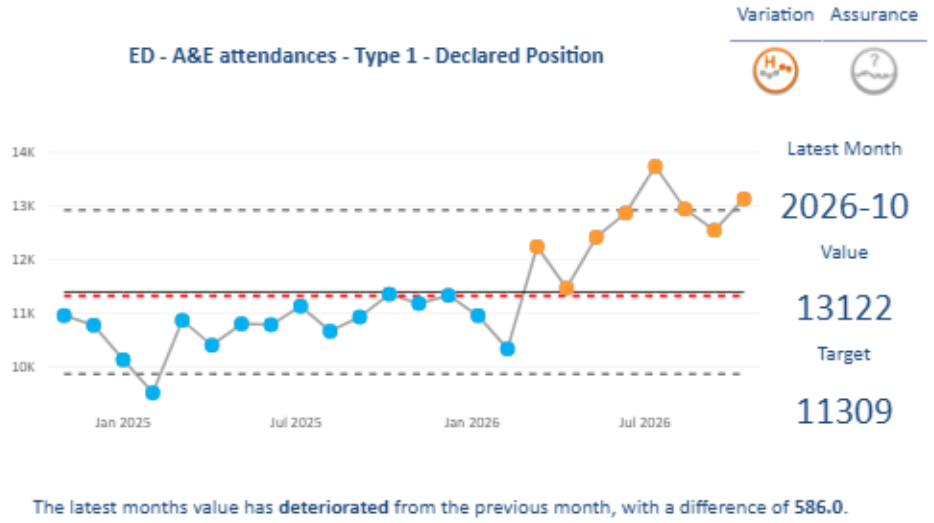
- A continuation of inconsistent performance at Scarborough due to variation in medical cover level.
- Increased utilisation and appropriate use of EAU at both sites.
- Continued focus on ‘turnaround’ and fewer admissions.

Potential risks to improvement?

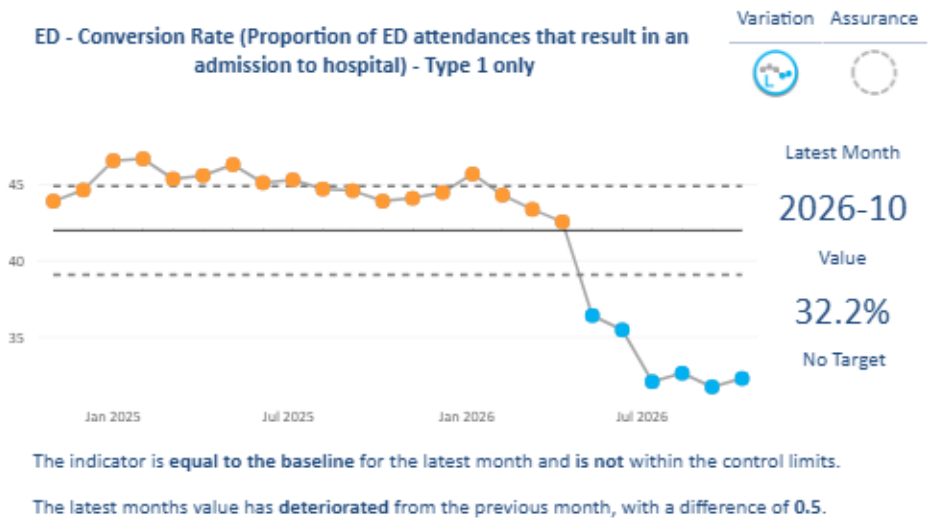
- Continued gaps in medical rosters.
- Insufficient community health and social care capacity.
- Limited capacity in ED and acute teams to complete actions.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **deteriorated** from the previous month, with a difference of **586.0**.



The indicator is **equal to the baseline** 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 **0.5**.

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 conversion rate measure remains low, we require sufficient senior medical staff from ED, Acute and Frailty to cover all front-door areas every day. Additional funding for Frailty at the Front door has been agreed for winter, with a new SOP being trialled in November.

Once a week, starting mid-November, a senior cardiologist will be based in ED/EAU to support chest-pain pathways and avoid admissions. A grant proposal is also being written for consideration by the British Heart Foundation for funding to support further work next financial year.

The business case for substantive increases to medical cover is still progressing, with a further review taking place in November.

What is the expected impact?

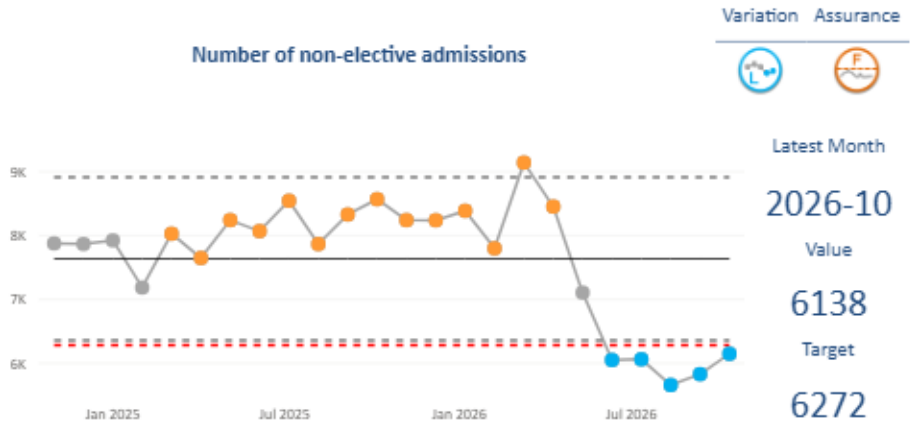
Strengthening our frailty at the front door capability will support successful turnaround, which will improve patient experiences and outcomes.

Potential risks to improvement?

There is a risk that the workforce model required to sustain all pathways may exceed the current identified envelope.

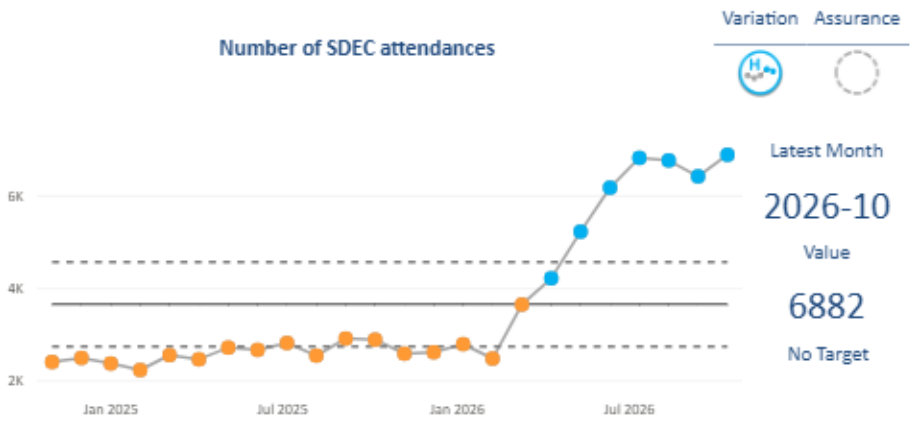
Executive Owner: Claire Hansen

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 **319.0**.



The latest months value has **improved** from the previous month, with a difference of **466.0**.

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?

York EEMAC saw an average of 10 patients per day in October, down from 11 in September, with 29% of those staying in EEMAC over 8 hours (up from 25%).

Scarborough EEMAC saw an average of 14 patients per day in October (same as September), with 41% staying over 8 hours (down from 44%).

A multi-disciplinary workshop was held in October to agree an approach for 'resetting' EEMAC with an agreed ambition to reduce time in EEMAC to enable more patients to be seen through the pathway. Expressions of Interest are being sought for a clinical lead for EEMAC. There is £15k funding available from NHS England to support this work.

What is the expected impact?

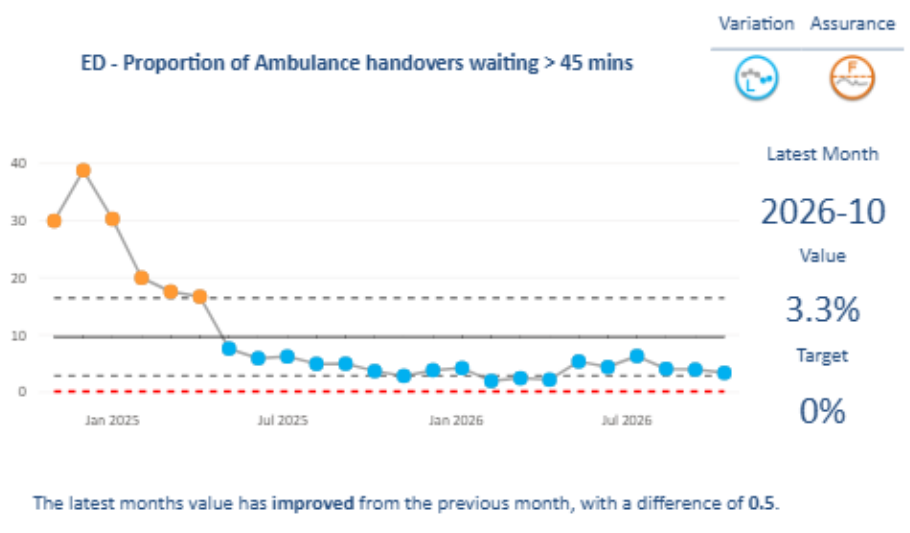
The impact will be realised in phases. Opportunities are plentiful and include quicker decision to send to EEMAC (since many patients have already breached before they go), reducing time in EEMAC, and increasing utilisation.

Potential risks to improvement?

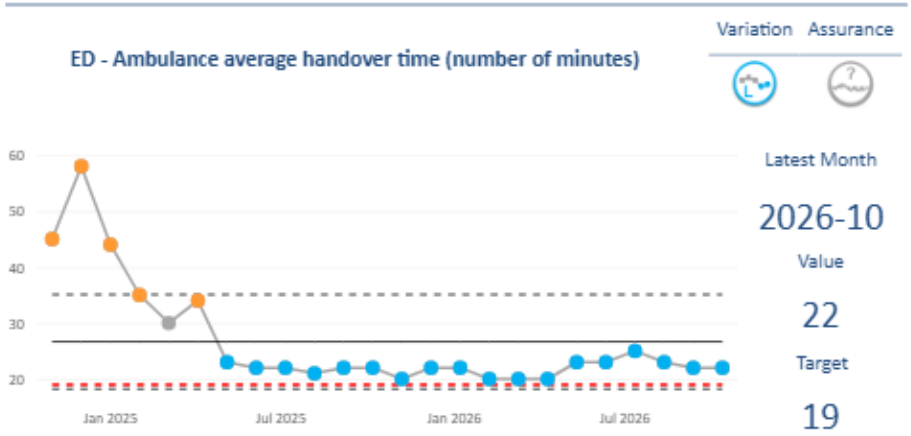
- Varied support levels for the EEMAC pathway leading to inconsistent use
- Medical staffing levels

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **0.5**.



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: 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?

Medicine Care Group representatives continue to meet regularly with Yorkshire Ambulance Service (YAS), to reduce ambulance handover delays. These have held a good position despite surges in arrivals and multiple competing priorities in our departments.

W45 principles have been recirculated to all crews and fit-to-sit is being safely applied where possible and appropriate.

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

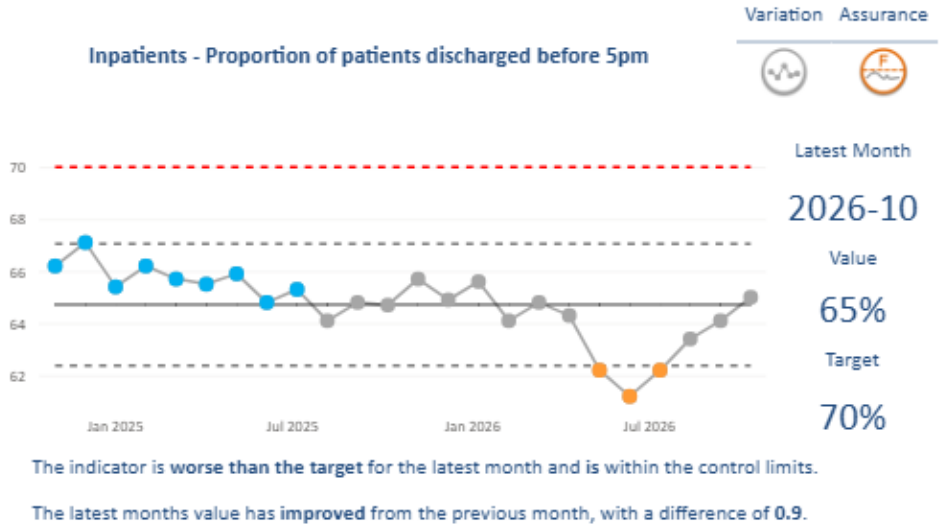
York and Scarborough Teaching Hospitals NHS Foundation Trust

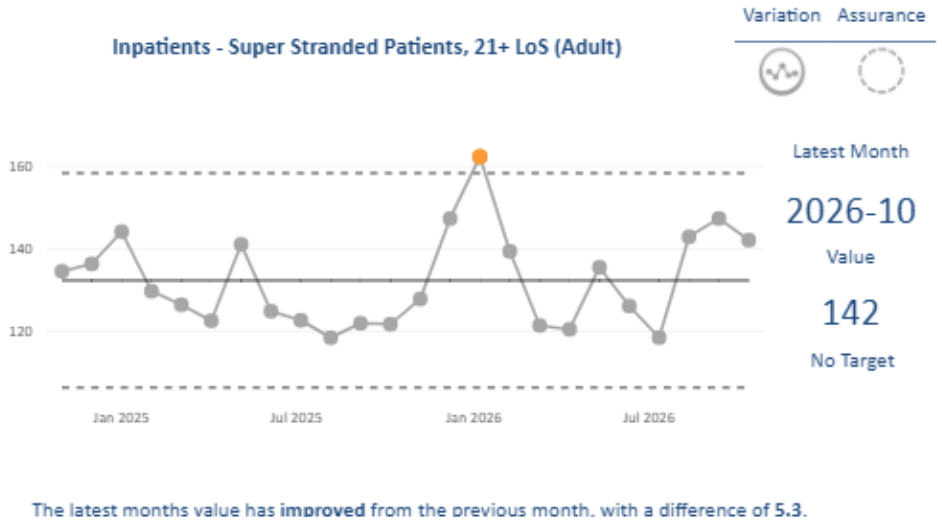
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

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	2026-10		F	65%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-10	H		1564		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-10	H		18.3%		
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-10	H	?	4.9	3.4	3.7
Number of non-elective admissions	2026-10	L	F	6138	7940	6272
Number of zero day length of stay non-elective admitted patients	2026-10	L		1045		
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-10			142		
Overnight general and acute beds open	2026-10	L	P	873	843	843
Of those overnight general and acute beds open, proportion occupied	2026-10		?	92.1%	92.4%	93.2%
Community bed occupancy/availability	2026-10		?	93.2%		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?

- Following some disruption to data recording at the introduction of Nervecentre the Trust has returned to previous levels of discharges before 5pm.
- The Coming off Corridors programme will support further improvements to this through one of its five key projects - ward/board round improvements.
- A multi-agency discharge event is taking place late November and will include joint system-partner reviews of long length of stay patients.

What is the expected impact?

- More efficient discharge decisions and processes will result in earlier discharges and improved flow, with a possible further impact of reduced 12 hour delays in ED.

Potential risks to improvement?

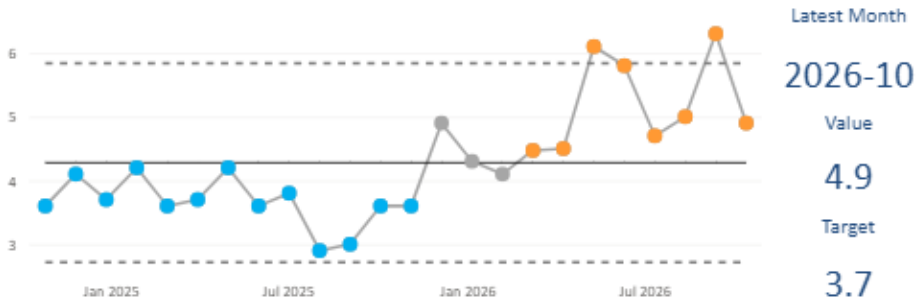
- Ongoing limitations in community health and social care capacity.
- Cultural change at ward level will take time to achieve, and the Coming off Corridors team has raised a risk linked to clinical leadership time.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

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

Variation Assurance

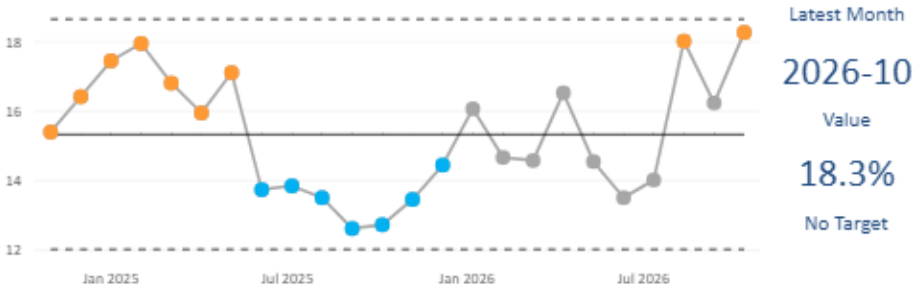


The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **1.4**.

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

Variation Assurance



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 **2.1**.

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: SPC1: To reduce the average number of beds days between the time a patient is assessed and fit for discharge to when a patient returns to the place they call home to less than 3.7 days by March 2027.

What factors are impacting performance?

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 team have moved into the new Discharge Command Centre space at York, with system partners present.
- Delays between discharge readiness and actual discharge are being more closely monitored and escalated both internally and with partners.
- The MaDE event at the end of November will support timely discharges.

What will the impact be?

Co-location and closer working with system partners (including during MaDE) will support timeliness of discharges due to working together on solution for patients.

Being unable to discharge some patients over weekends will limit the impact of the criteria-led discharge project taking place through Coming off Corridors.

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 has now ended.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait - treatment within 31 days of a decision to treat for all cancer patients- Declared position	* Cancer - Faster Diagnosis Standard - Declared Position * Cancer - 62 Day First Definitive Treatment Standard - Declared Position
SPECIAL CAUSE CONCERN			

CANCER
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
Cancer - Faster Diagnosis Standard - Declared Position	2026-09		F	68.3%	81.4%	84.3%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-09		F	69.1%	75.9%	80%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-10	L		176		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-10			8.3%		
Cancer 31 day wait - treatment within 31 days of a decision to treat for all cancer patients- Declared position	2026-09		?	95%	96.1%	96.3%
Total Cancer PTL size	2026-10			2326		

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

- The Cancer performance figures for September 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 68.3% behind the monthly improvement trajectory of 81.4%. This is 8.8% higher than the same month in 2025. In the latest available national data (August 2026) the Trust ranked 93rd out of 119 NHS providers nationally and 7th out of 11 against our Model Hospital peer group (July: 104th and 9th respectively). **This is a True North Metric.**

- 62 Day waits for first treatment service standard in September 2026 was 69.1% , against a monthly trajectory of 75.9%. In the latest available national data (August 2026) the Trust ranked 68th out of 119 providers nationally and 5th out of 11 against our Model Hospital peer group (July: 48th and 3rd respectively).

Factors impacting performance:

- The following cancer sites achieved or exceeded 80% FDS in August 2026: Breast & Non-Site Specific . Non-Site Specific & 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. Colorectal, Urology and Head & Neck achieved above their internal trajectory.

- 31-day treatment standard was 93.6% overall, which was marginally below the national service standard of 96%. This was driven by primarily by Breast surgical capacity and Colorectal theatre capacity.

- At the end of September, 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 and August. Colorectal and Skin 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.

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

Actions:

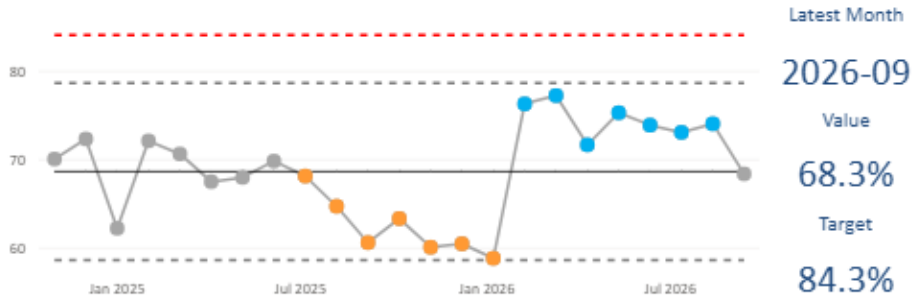
- Please see following pages for details.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Cancer - Faster Diagnosis Standard - Declared Position



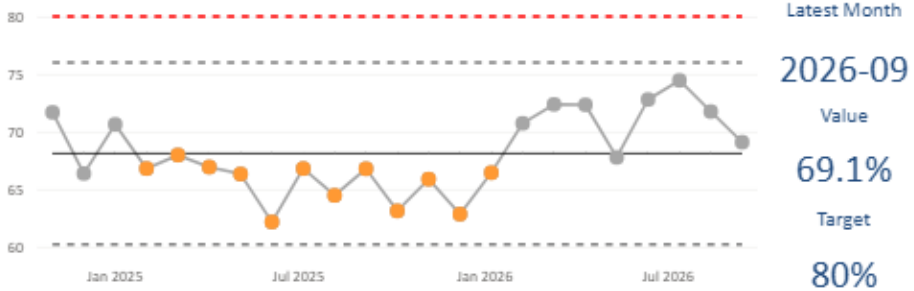
Latest Month
2026-09
Value
68.3%
Target
84.3%

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

The latest months value has **deteriorated** from the previous month, with a difference of **5.7**.

Variation Assurance

Cancer - 62 Day First Definitive Treatment Standard - Declared Position



Latest Month
2026-09
Value
69.1%
Target
80%

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: 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?
Second 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. Actions, transformation schemes and operational processes opportunities being discussed.
Colorectal Plan : Provisional FDS position of 62.4% against internal trajectory of 75.5%. Review of Prof Rutter report and recommendations for maximising endoscopy capacity. Interim additional FT capacity being provided to reduce current waits, particularly on East Coast. Awaiting alliance input on Colofit next steps, alongside pathology interface feasibility. Change of clinical lead, small MDT streamlining project introduced and changes in progress. Observations of MDT taking place. Review of surgical theatre capacity and demand
Gynaecology Plan : Provisional FDS position of 65.6% against internal trajectory of 70%., Working group initiated for IOTA ADNEX one stop model and SOP progressing, with alliance funded national training course booked. Senior operational gaps mitigated in part with involvement of head of cancer running tumour site PTL meetings with ops appointments now complete.
Skin : Provisional FDS position of 68.8% against internal trajectory of 80%. Ongoing risk around dual running of telederm and non telederm pathway (c.30% refs received do not have image). Additional capacity actively being sought for recovery of current position with risk to both FDS and 62 day. Discussions with plastics around capacity for treatment, however FDS breaches causing impact on 62- day performance.
Lung: Provisional position of 78.3% against internal trajectory of 80%. Operational manager change and flux escalated to ACOO for additional support. Six new Respiratory consultants commenced in post, 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 developed and endorsed. Focus on maintaining and sustaining improved performance, whilst transformational actions also run in parallel.
Potential risks to improvement?
Patient related factors in September account for over 20% breaches. August account for 16.5% as primary reason (compared to 9.6% in July and 7.3% June)
Colorectal : Endoscopy capacity, particularly on East Coast, for both colonoscopies & OGD's. WLI's re-commencing. Gynaecology: Colposcopy nurse sickness – covered by consultant capacity & FT capacity on East Coast. Lung: Service provision in SGH over summer prior to new contracts commencing, waits for CT guided biopsy and EBUS and lung screening activity movement to SGH for 9 months compounding FT capacity Skin: Volume of referrals received increased risk of patients breaching due to capacity. Additional is being sourced wherever possible.

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 October 2026, the Trust had eight **Referral To Treatment (RTT) patients waiting over sixty-five weeks**. All of the patients were within the pain speciality and a combination of late decisions for treatment on pathway due to capacity and patient choice.

- The Trust's **RTT Total Waiting list position** provisionally ended October 2026 behind the trajectory submitted to NHSE as part of the 2026/27 planning submission: 58,153 against the trajectory of 52,231 (+5,932).

- 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 October: 57.0% against 63.7%. In the latest available national data (August 2026) the Trust ranked 110th worst out of 118 NHS providers and 9th worst out of 11 in our Model Hospital peer group (July: 108th and 9th respectively).

- The Trust is provisionally behind the **RTT patients waiting over fifty-two weeks** trajectories submitted within the 2026/27 planning submission; 1,349 waiters and 2.3% of the total RTT Total Waiting list against the trajectories of 412 and 0.8%, respectively (+937 and 2.5%). Validation before submission is expected to improve but not deliver performance against the trajectories. In the latest available national data (August 2026) the Trust was ranked 92nd 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 (July: 90th and 7th respectively). Nationally at the end of August 2026 there were 6,682,788 patients on the national TWL, of which 105,918 (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 62.6% against the end of October 2026 ambition to be above 65%. There is no nationally available comparative data for this metric. **This is a True North Metric.**

Factors impacting performance:

- 4.2% increase in GP referrals compared to 2025/26 (3,778 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, +5.5% September from September 2025 and +1.2% October versus October 2025 (4.2% YTD). There have been significant increases in several specialties, namely; Pain Management (+32%), Paediatrics (+14%), Respiratory (+25%), Neurology (+20%) and Gastroenterology (+50%). 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 .

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

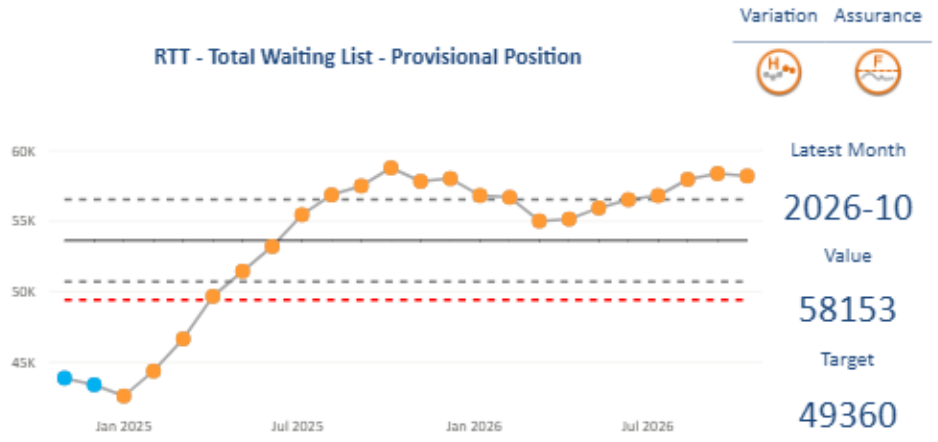
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2026-10	H	F	58153	52231	49360
RTT - Waits over 78 weeks for incomplete pathways - Provisional Position	2026-10	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Provisional Position	2026-10	L	?	8		0
RTT - Waits over 52 weeks for Incomplete Pathways - Provisional Position	2026-10	H	F	1349	412	0
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-10	H	F	57%	63.7%	67.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-10	L		17.6		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-10	L	F	2.3%	0.8%	0%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-10	H	F	62.6%	65%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-10	H		2.1%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-10	H		12.4%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-10	H		68.6%		

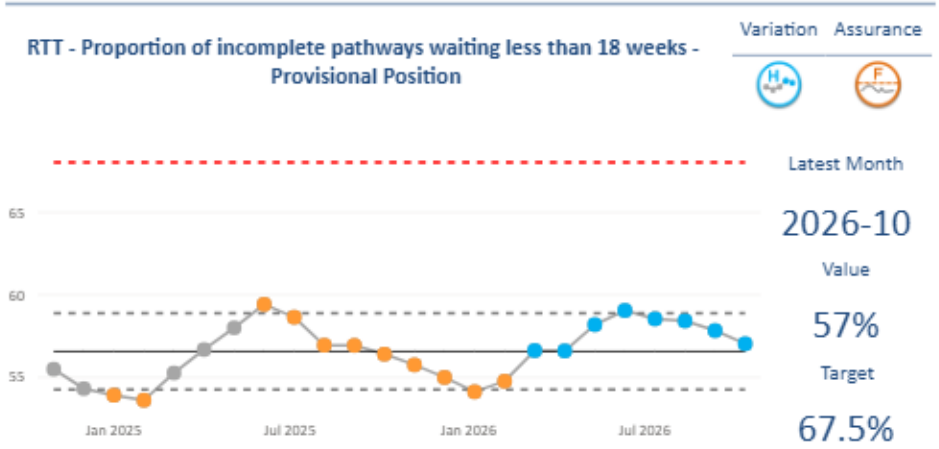
Executive Owner: Claire Hansen

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 **improved** from the previous month, with a difference of **174.0**.



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 **0.8**.

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.
- 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 is being supported by 5 sprints and daily stand ups with care group general managers. The Trust provisionally delivered 108% of the Outpatient first appointment plan in October. The RTT impact of this project is expected in November.
- ICB approved pain referral threshold in October, work to implement has started with significant RTT improvements expected.

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?

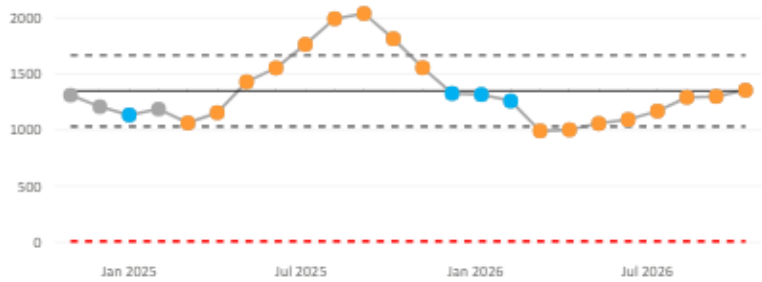
- Increase in GP referrals in YTD 2026/27 compared to 2025/26 (up 4.2%).
- Impact of delayed capital builds (Hybrid theatre, MRI, VIU, SGH Roof and RAAC), resulting in inability to delivery planned levels of activity and increasing waiting times.
- Proportion of first attendances of all attendances remains 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 (High) | Assurance: F



Latest Month: 2026-10

Value: 1349

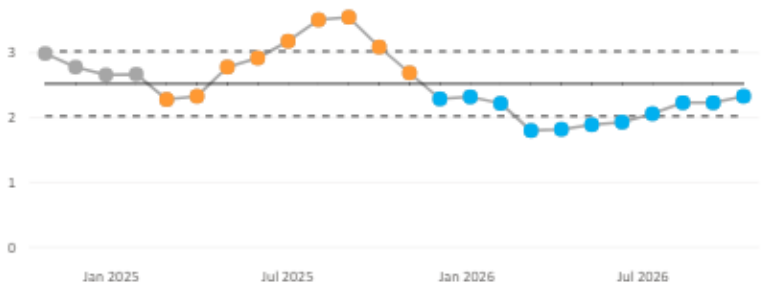
Target: 0

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 **55.0**.

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

Variation: L (Low) | Assurance: F



Latest Month: 2026-10

Value: 2.3%

Target: 0%

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

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

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.

Target: SPC1 & SPC2: Aim to have zero patients waiting more than 52 weeks by March 2027 as per activity plan.

What actions are planned?

- Weekly monitoring of RTT52 week waits throughout the month with weekly trajectory in place. Scope of weekly meeting expanded in April 2026 to monitor full pathway metrics rather than focus on longest waiters. Returning to zero RTT65 week waits is a priority. Twenty CYP patients remained waiting over 52 weeks at the end of October, including 17 within Oral Surgery. Performance is being reviewed through weekly oversight arrangements and the Q3 paediatric recovery plan. Oral Surgery is forecasting elimination of CYP 52-week waits by the end of Q3, subject to staffing and delivery of planned activity. Progress against the trajectory and any forecast exceptions will continue to be reviewed weekly through elective recovery governance.
- 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. ICB approved pain referral threshold in October, work to implement has started with significant RTT improvements expected.
- Focus on scheduling long waiters in 2-weeks of RTT outpatient clinics to be held in each specialty during Q3 and repeated in Q4.
- 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 October 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 5.9% with performance of 5.1%. 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 28.5% below the target of 99% (September: 43.6%). RACP performance deterioration has been driven by reduced clinic capacity on the Coast following a reduction in locum consultant hours and prolonged staff absence. Additional clinics have supported recovery In November, with the waiting list on 9th November reducing from 25 to 10 patients and no patients now waiting over 14 days, compared with six previously. Planned clinic capacity is expected to maintain this improvement through November and return performance to target for December activity, with short-notice sickness or unplanned absence remaining the principal delivery risk.

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 - Final preparations are underway to prepare for go live. The training videos are being completed and discussions to agree data change to put the new functionality live for all staff who create clinical letters. The dashboard to allow us to monitor the printing numbers has been developed and is being signed off.

- Improvement actions for PIFU for agreed specialties are delivering sustained improvement in PIFU. Focus on work in respiratory medicine and audiology to make improvements through Q3.

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

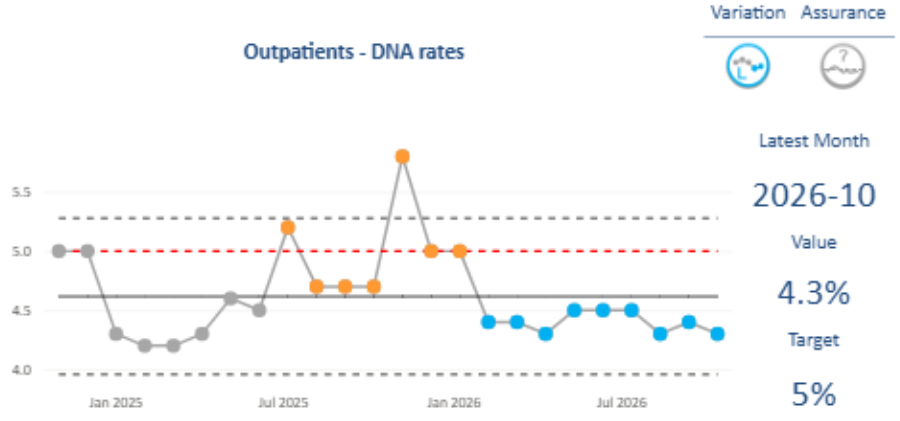
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2026-10	H	F	22.6%		25%
Outpatients - DNA rates	2026-10	L	?	4.3%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-10		?	21320	20524	23266
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-10		P	41555	54405	55935
Outpatient procedures	2026-10			13484		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-10	H	F	34019		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-10	H	F	5.1%	5.9%	6.6%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-10		F	28.5%		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*	2026-10		?	5		0
Day Cases (based on Activity v Plan)	2026-10		?	6957	7164	7781
Electives (based on Activity v Plan)	2026-10		?	619	680	660
Proportion of elective admissions which are day case	2026-10		P	91.8%		85%
Outpatients: All Referral Types	2026-10			26179		
Outpatients: Consultant to Consultant Referrals	2026-10			2530		
Outpatients: GP Referrals	2026-10			12229		

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

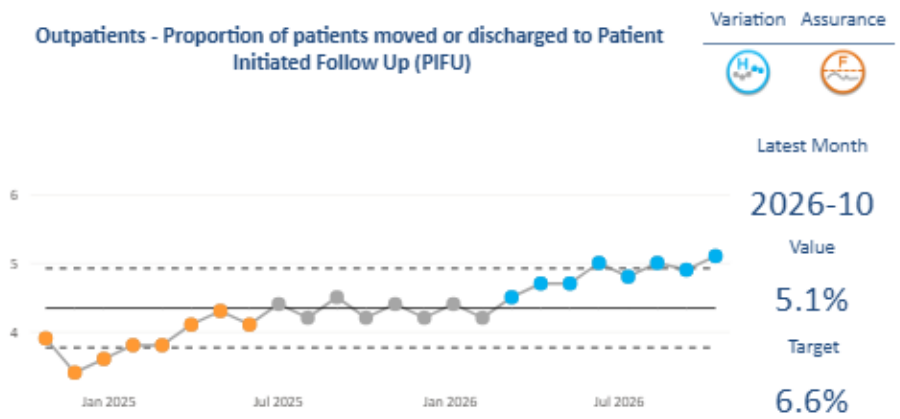
Outpatients - DNA rates



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

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

Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)



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

The latest months value has **improved** from the previous month, with a difference of **0.2**.

Rationale: SPC1: Need to reduce instances where people miss their outpatient appointments ('did not attends' or 'DNAs') to improve patient experience, free up capacity to treat long-waiting patients and support the delivery of the NHS's plan for tackling the elective care backlog. **SPC2:** Helps empower patients to manage their own condition and plays a key role in enabling shared decision making and supported self-management in line with the personalised care agenda.
Target: SPC1: Internal target of less than 5%. **SPC2:** Above 6.6% by March 2027.

What actions are planned?

- A PIFU rate of 6.6% by March 2027 was included in the submitted plan. Specialties identified for rapid improvement work using the GIRFT pathways for implementation. 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, with Oct at 91% for consultant led clinics.
- DNA reduction project also commenced with targeted specialties with higher DNA rate. Focused analysis on new versus follow up DNA to target interventions.

What is the expected impact?

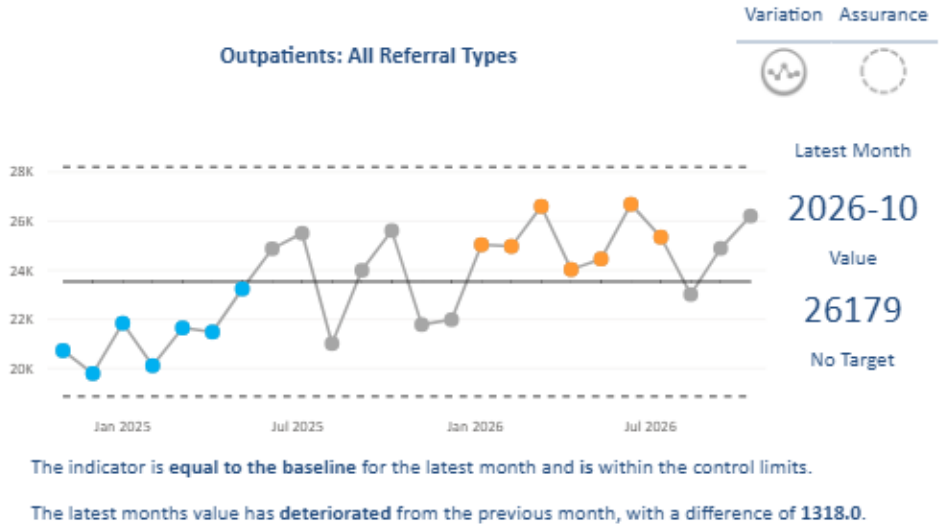
- PIFU improvement to 6.6% (March 2027).
- Delivery of 1st Outpatient plan and reduction in new to follow up ratios.
- Reduced demand for high-cost additional capacity.

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 **1318.0**.



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 **9.0**.

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?

- Ongoing oversight to reduce consultant to consultant referrals (C2C) by 10% from April 2026 (compared to 2025/26). YTD C2C are down by 11% (-2,386 referrals) compared to the same period in 2025/26.
- ICB conducting review of GP referrals to identify outlying practices for further discussion and education.
- The Trust will complete technical migration to SPoA across 10 new specialties by the end of November. Work will continue to refine the plans within specialties to align job plans and triage processes to optimise the benefits of SPoA which will likely lead to a phased adoption of SPoA principles using current CPD and eRS systems. The future integration of SPoA into Nervecentre has encountered some technical issues that the project team and Y&S Digital are now working through.

What is the expected impact?

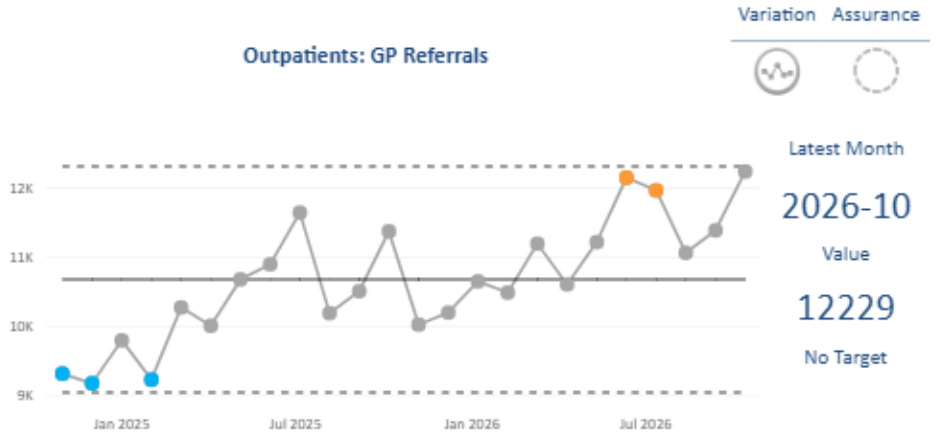
- Reduction in internal demand and reduction in open referrals**.**
- Reduction in GP demand.
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

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 **850.0**.

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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 October 2026 was 81.7% ahead of the trajectory of 78.6%. This is the highest Trust performance since February 2020.

- Total waiting list increased from 12,397 in September to 13,046 in October, but 6-week breaches reduced from 2,722 to 2,382. 13-week breaches decreased by 1 from 341 to 340. This is the first month that the total waiting list has exceeded 13k since March 2026, however it is also the lowest number of 6-week breaches since that period leading to above trajectory performance.

- In the latest available national data (August 2026) the Trust ranked 62nd worst out of 117 NHS providers and 6th worst out of 11 in our Model Hospital peer group (July: 74th and 6th respectively).

Factors impacting performance:

- Six-week breaches reduced from 2,722 in September to 2,382 in October, while waits over 13 weeks reduced only marginally, from 341 to 340. The improved six-week position therefore coexists with a growing total waiting list and a persistent long-wait cohort.

- CT, NOUS, Echocardiography and Urodynamics continue to require targeted recovery or sustainability action. MRI has only 42% of radiographer establishment in post and York NOUS approximately 40% of sonographer establishment. UDS substantive recovery is not anticipated until trained staff can deliver capacity, likely mid to late 2027/28.

- Demand is a growing risk. The total diagnostic waiting list increased from 12,397 in September to 13,046 in October. Growth in the shorter-wait cohort may indicate additional diagnostic demand arising from the focus on first outpatient appointments which is likely to increase throughout November; modality demand monitoring is underway.

- Current performance remains reliant on insourcing and temporary workforce support in several modalities. CT3 became fully operational at the end of October, allowing CT mobiles to stop, but MRI remains dependent on insourcing to retain core capacity until recruitment can be completed to return to full substantive establishment.

- Capital and data risks remain material. MRI4 is now likely to become fully operational in Q4 2026/27; MRI3 has potential to slip into the next financial year, and MRI1/MRI2 have no agreed date. CT1/CT2 enabling-work has been delayed to circa April 2027 due to capital delays. Echocardiography and Sleep Studies reporting does not yet provide full visibility of unbooked outpatient referrals.

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 - Colonoscopy * Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy * Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	* Diagnostics - Proportion of patients waiting <6 weeks from referral * Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI * Diagnostics - Proportion of patients waiting <6 weeks from referral - CT * Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema
COMMON CAUSE / NATURAL VARIATION		* Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound * Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral * Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies * Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	* Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics
SPECIAL CAUSE CONCERN		* Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	

DIAGNOSTICS – National Target: 95%

Scorecard

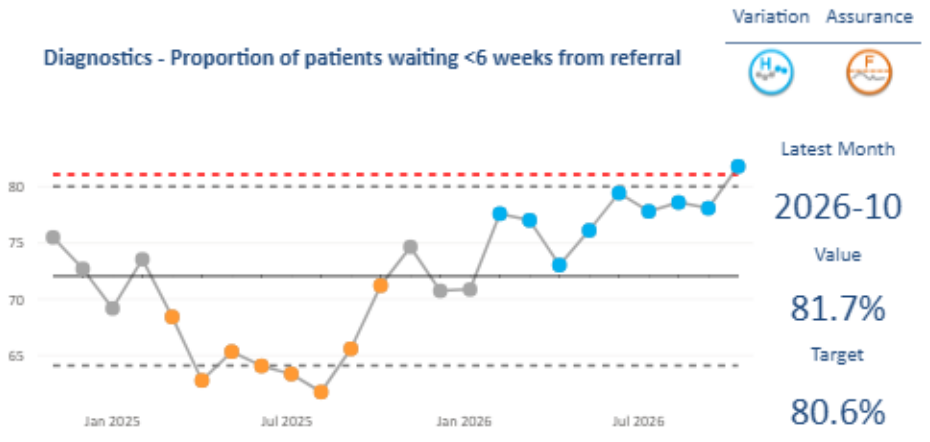
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Diagnostics - Proportion of patients waiting <6 weeks from referral	2026-10	H	F	81.7%	78.6%	80.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-10	H	F	92.9%	85.7%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-10	H	F	86.3%	90.9%	91.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-10		?	74%	77%	77.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-10	H	F	100%	88%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-10	H	?	100%	83.5%	86.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-10	H	?	96.2%	78.1%	80%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-10	L	?	35.8%	79.3%	79.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-10		?	100%	95.9%	95.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-10		?	89.2%	94.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-10		F	48.6%	77.3%	84.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-10	H	?	89.6%	83%	86%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-10	H	?	80.7%	84.4%	85.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-10		?	78.3%	67.3%	69.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-10	H	?	87%	84.6%	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: Substantive staffing ran room 7 two to three days weekly by June. Recruitment continues to staff Monday–Friday by March 2027, with insourcing reduced gradually as staff become available. Centralised Bridlington preassessment started in October, releasing three York registered nurses to support room 7. Clinical endoscopist signed off mid-October; remote supervision in November and independent lists from December. Additional four weekly lists will include DM01 and non-DM01 activity. Agreement to reduce STT from two units to one from 1 November, allowing approximately one additional patient per list.

Imaging: RMS insourcing maintains core capacity for MRI. Workforce review developed; retention and recruitment premium approved by Executive Committee in October. Five new starters for CT in training; vacancies remain at 2.2 WTE Scarborough and 3.4 WTE York. Clinical urgency prioritised. CT3 fully operational at end October; mobiles stopped. CT1 and mobile breakdowns affected October activity. CT1/2 enabling works delayed; concurrent replacement creates operational risks. Contrast CT at Scarborough CDC planned for January 2027. Scarborough cardiac enablement being explored and requires a business case; York/Selby contrast provision requires discussion with HUTH. Approximately 40% sonographer establishment at York which impacts NOUS. One-year YHS emergency award insufficient for recovery. Procurement model review; premium proposal targeted for end-November consideration. Three consultant vacancies; candidate and agency-to-substantive options being explored.

Physiological: **Sleep Studies:** Cross-site sleep action group created; postal CPAP embedded. Additional-device tender and demonstrations in first half November, followed by business case/MERG. Possible funding conversion for insourced reporting under discussion.
Echocardiography: Bank clinics delivered. Additional equipment/facilities funding requested. TTE business case in development. Scientist-led expansion business case submitted to care group board. If approved, elective recovery forecast within 22 months. **UDS**: Two trained BUNS nurses; one new nurse commenced and part-time applicant expected January 2027. Training can take up to 12 months. Alternative YMS support awaits second training-session dates after concerns with procedures/documentation; rotas reviewed.

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

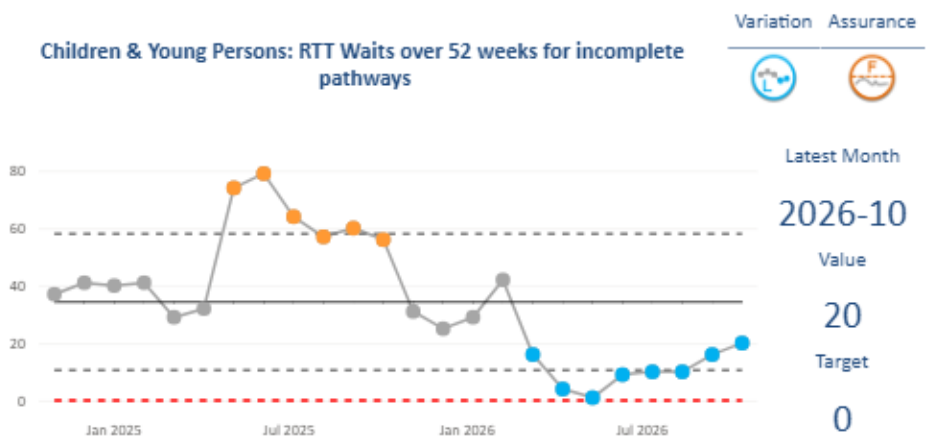
Executive Owner: Claire Hansen

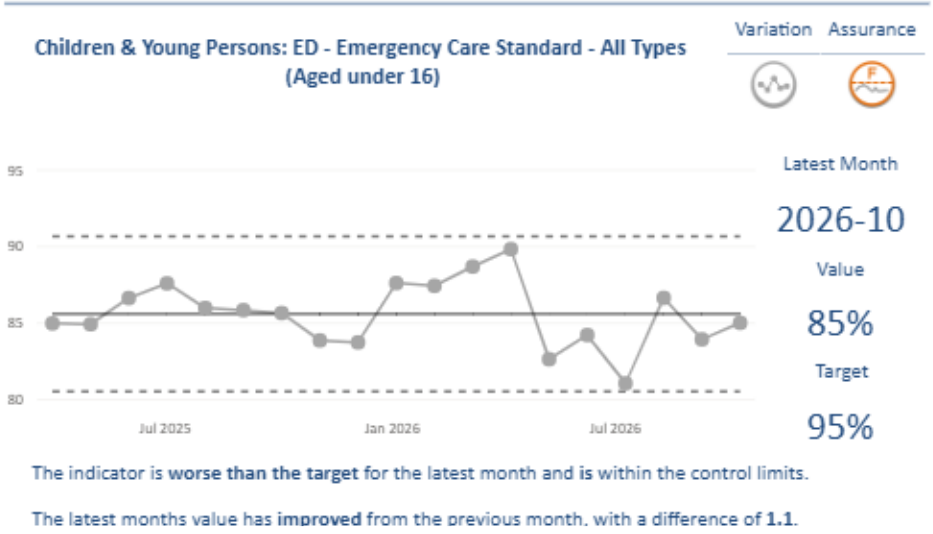
Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2026-10		?	11		0
Children & Young Persons: ED - Emergency Care Standard - All Types (Aged under 16)	2026-10		F	85%	95%	95%
Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Aged under 16)	2026-10			79.8%	95%	
Children & Young Persons: ED Attendances - Type 1 only (Aged under 16)	2026-10	H		2336		
Children & Young Persons: RTT - Total Waiting List	2026-10			4322		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-10	H	F	68.8%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-10	L	F	20	0	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi





Rationale: SPC1: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients. **SPC2:** To monitor waiting times in A&E and Urgent Care Centres.

Target: SPC1: Internal aim to have zero patients waiting more than 52 weeks by end of quarter one 2026/27. **SPC2:** Internal objective to improve A&E waiting times so that no less than 95% of CYP patients are seen within 4 hours by March 2027.

What actions are planned?

SPC1:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 weeks wait for patients aged under eighteen.
- There were twenty patients waiting 52 weeks or more at month end. Oral Surgery; 17,ENT; 1, Plastic Surgery; 1 and Upper GI; 1. Due to clinician staffing levels Oral Surgery are not forecasting recovery and delivery of zero until end of Q3.

SPC2:

- The Paediatric ED action plan is being monitored through a weekly meeting and progress is reported through Urgent and Emergency Care board. Quality is to be considered alongside performance.
- Discussions are progressing well with use of Children's Assessment Unit at York for some children awaiting specialty review. Criteria to be agreed.

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 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		* Proportion of intermediate care beds occupied by people with no criteria to reside	

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	2026-10	H	?	35.8%	22.5%	20%
Number of open Virtual Ward beds	2026-10		P	33	33	33
Proportion of Virtual Ward beds occupied	2026-10		?	78.8%	82%	82%
Community Response Team (CRT) Referrals	2026-10			680		
Total Urgent Community Response (UCR) referrals	2026-10	H	?	665	602	514
2-hour Urgent Community Response (UCR) care Referrals	2026-10	H		228		
2-hour Urgent Community Response (UCR) Compliancy %	2026-10	H	?	82.2%	70%	70%
Attended Community Care Contacts	2026-10		?	38617	37882	41283
Number of District Nursing Contacts	2026-10			20736		
Number of Selby CRT Contacts	2026-10			2640		
Number of York CRT Contacts	2026-10	H		4937		
Referrals to District Nursing Team	2026-10			2140		

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	2026-10			437		
Number of CYP (0-17 years) on community waiting lists per system	2026-10			1331		
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	2026-10			59.8%	66.9%	78%
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	2026-10			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	2026-10			46.6%	50.1%	63.7%
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-10			249	267	0

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Number of open Virtual Ward beds

Variation Assurance



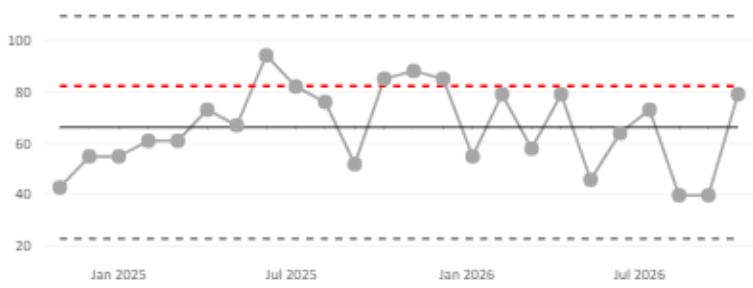
Latest Month
2026-10
Value
33
Target
33

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
2026-10
Value
78.8%
Target
82%

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

The latest months value has **improved** from the previous month, with a difference of **39.4**.

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?

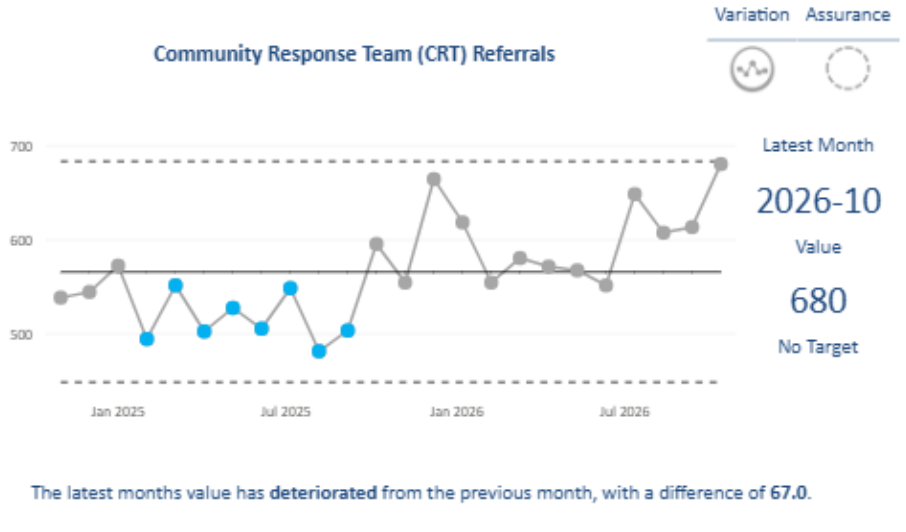
- Frailty Hospital at Home has high utilisation and an increase in referrals from York EAU. ICB team visited York Hospital at Home team in October.
- The Frailty Virtual Ward / Hospital at Home model remains keen to expand to Selby following a successful test, and a business case for the additional nurse resource is progressing (linked to shifting from Community IPU to home based teams).
- Medical recruitment for hospital at Home (Frailty virtual ward) has been successful.
- The Heart Failure team runs an admission avoidance pathway at York and operates an early support discharge pathway. Charitable funds are being used for the required Band 7 nurse for 6 months from November. Requirements for substantive staffing are being considered through current planning round.
- Medicine exploring respiratory virtual ward. This would be dependent on Charitable Funds as per the heart failure project.

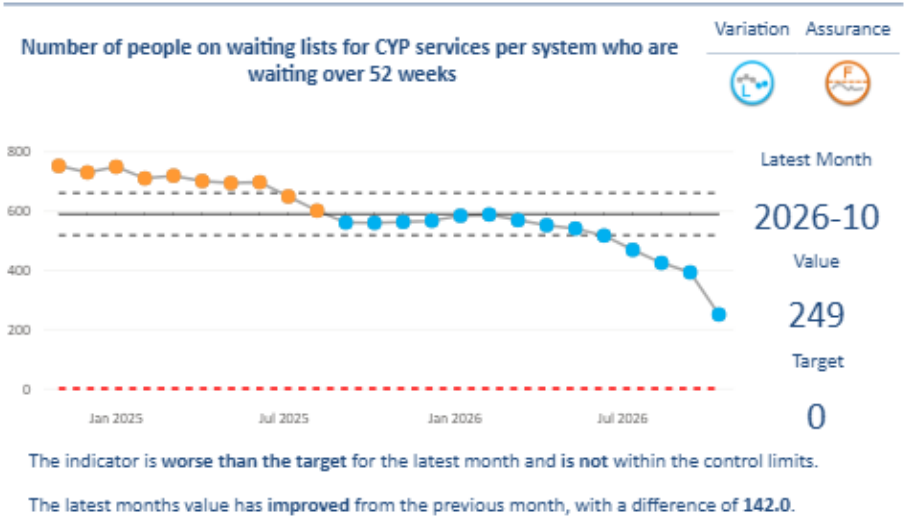
Potential risks to improvement?

- Challenges regarding medical cover cause instability in services – recent attempt to increase Hospital at Home capacity were unsustainable.

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.

SPC2: Speech and Language Therapy: the Trust is involved in regional and national work. Additional WTE mitigation included in 2026/27 plan. Service ahead of the trajectory for the end of October (249 against end of month ambition to be at or below 267). A Community Assessment Day (CAD) has been planned for the 17th November with 110 of the patients in this cohort invited. Further CADs will take place early and mid December. A CAD was held in Scarborough during October and was the main driver for the improvement seen last month. 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

November 2026

Executive Owner: Karen Stone and Joe Hague

York and Scarborough Teaching Hospitals NHS Foundation Trust

Highlights: IPC

- The IPC improvement plan is being refreshed following a review meeting with the Chief Nurse on 14th October.
- Ward 31 is going water lite following the ward refurbishment programme.
- September and October have been 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 **1 case over** year-to-date threshold (improved position in October).
- MRSA bacteraemia **1 case** reported in August against a zero tolerance.
- E.coli bacteraemia - **equal** to the year-to-date threshold (improved position in October)
- Pseudomonas bacteraemia – **11 cases over** the year-to-date threshold and we have breached the year end threshold.
- Klebsiella bacteraemia **6 cases over** the year-to-date threshold (declined position in October).
- An on-going potential outbreak of CPE linked to ward 11 (total of 3 cases identified), samples being submitted to external reference lab for typing.

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 October, 52 Category 2 pressure ulcers were reported, against a monthly target of 60. Achieving the Trust 20% reduction target and across all care groups.
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.
- Increase in community pressure ulcer reporting during October, including Deep Tissue Injuries.

Next Steps:

- **Patient seating**: a Trust wide audit has commenced and will be completed by the end of November with report and costings available by mid December.
- **Ward 28:** Higher levels of Category 2 pressure ulcers continue to be monitored. An improvement plan commenced on 1 October 2026, including the introduction of new patient seating. A slight reduction in Category 2 pressure ulcers was observed during October. A focused meeting has taken place with the Ward 28 leadership team to review the position, understand contributory factors, agree actions and provide additional support. Progress against the improvement plan and emerging themes will continue to be monitored through the Professional and Quality Standards Group (PQSG), providing senior oversight and assurance. Ongoing support is being provided by the Tissue Viability Nursing team and Quality Matron.
- **QI Learning:** Ward 28 and Ward 15 to present and share their PU QI work at the December Connecting Leaders in Care (CLIC) meeting
- **Cat 2 PU Validation**: Development of a dashboard to support Matrons in validating incidents remains ongoing, target for completion is Jan 2027. In the interim, validation continues through the Tissue Viability Nurse (TVN) Lead and Quality Matron.
- **Category 3/4 review:** Collaborative work with the Palliative Care Lead will commence end of Nov following identification of themes relating to end-of-life care.
- **Community pressure ulcers:** Deep-dive review to be undertaken by Care Group following increased reporting, including Deep Tissue Injuries. Results to be presented at PQSG in December
- **Wound photography:** SOP in development to standardise practice and expectations, supported by further staff training.
- **Community reporting:** Development of a pathway is underway to improve consistency and alignment of pressure ulcer reporting from residential homes.
- **Safeguarding:** Review of pressure ulcer incident processes to commence in November to ensure learning and themes are consistently identified and captured.

Quality & Safety
Scorecard (1)

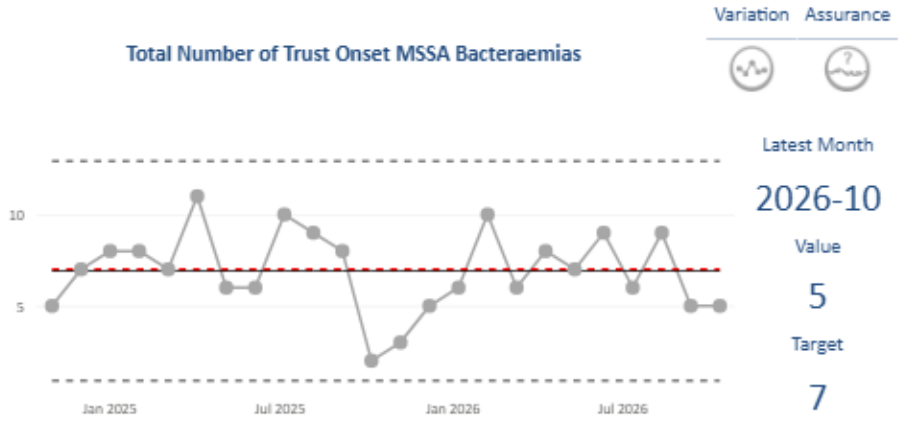
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2026-10			5	7	7
Total Number of Trust Onset MRSA Bacteraemias	2026-10			0		0
Total Number of Trust Onset C. difficile Infections	2026-10			11	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-10			12	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-10			11	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-10			1	1	2
Pressure Ulcers per thousand Bed Days	2026-10			3.1		4
Patient Falls per thousand Bed Days	2026-10			8.9		8.7
Medication incidents per thousand bed days	2026-10			6.2		6

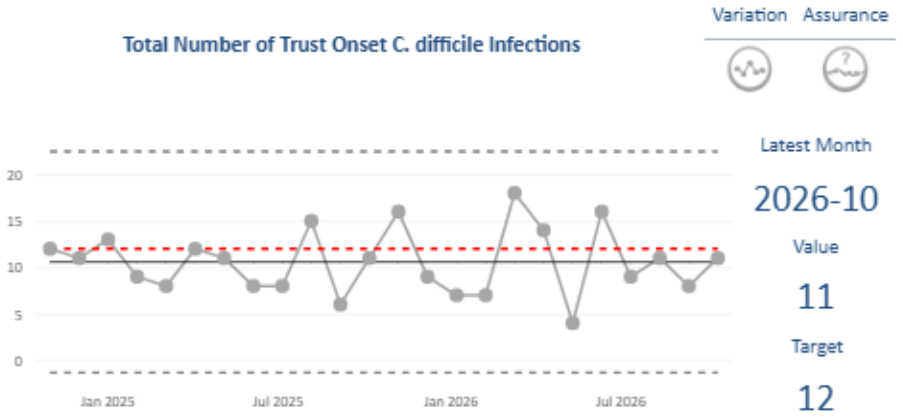
Executive Owner: Joe Hague

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



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

The latest months value has **deteriorated** from the previous month, with a difference of **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 **1 case over** year-to-date threshold (improved position in October).
- MRSA bacteraemia **1 case** reported in August against a zero tolerance.
- E.coli bacteraemia - **equal** to the year-to-date threshold (improved position in October)
- Pseudomonas bacteraemia – **11 cases over** the year-to-date threshold and we have breached the year end threshold.
- Klebsiella bacteraemia **6 cases over** the year-to-date threshold (declined position in October).
- An on-going potential outbreak of CPE linked to ward 11 (total of 3 cases identified), samples being submitted to external reference lab for typing.

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 following review meeting with the Chief Nurse on 14th October 2026
- There has not been a case of C.difficile on Ward 36 following the IPC improvement work undertaken in August 2026. The ward has the highest number of attributed CDI cases
- Ward 31 is going water lite following the ward refurbishment programme.
- September and October have been the months of quality for IPC, a series of walk rounds, awareness sessions, and fun activities for raising IPC awareness and compliance have been 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	2026-10			55.2		57
Harmful Incidents per thousand bed days	2026-10			20.2		18
Total Number of Never Events Reported	2026-10			0		0
In-Hospital Deaths	2026-10			188		
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	2026-10			157		
Antepartum Stillbirths	2026-09			0		
Intrapartum Stillbirths	2026-09			0		
Early neonatal deaths (0-7 days)	2026-09			1		
PPH > 1.5L as % of all women - York	2026-09			3.6%		
PPH > 1.5L as % of all women - Scarborough	2026-09			1%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-09			61.5%		

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

Harmful incidents increased to 20.2 per 1,000 bed days, above the target of 18 and an increase of 1.5 from the previous month. The latest value is on the upper control limit. Patient Safety has undertaken further analysis of the data and identified the increase is due to low harms rather than any moderate and above incidents. This could be attributed to an increase in reporting culture.

Medication Safety Group Incidents Summary

In September, 152 medication incidents were reported, close to the long-term monthly average of 155. Encouragingly, incidents involving harm from anticoagulation have reduced, while insulin incidents causing harm have fallen for the 11th consecutive month. One severe and two moderate harm incidents were reported. Improvement work includes strengthening electronic prescribing safeguards, arrangements for urgent neonatal medicines and safe insulin switching. Further work includes learning from discharge prescribing, updated oral/enteral syringe guidance, monitoring missed doses of critical medicines, and reinforcing learning from medication incidents across the Trust.

Great-ix

There were 89 Great-ix submissions in October. Highlights from the month's submissions are provided below. **October Great-ix Highlights:**

"I was really struck with X's calm, mature, and professional attitude to what was an incredibly difficult and busy environment"

"She provided comprehensive, compassionate information and advice using a range of teaching styles"

"She is attentive to detail and takes the time to understand each patient's individual needs and personal preferences, ensuring they feel respected, valued and well cared for"

"What stood out was her ability to navigate challenging conversations in a respectful manner, ensuring colleagues felt heard while maintaining focus on safe patient care and the safe management of the department"

"During a very stressful and distressing incident, she remained very calm, she led the team exceptionally well, ensured all staff had been checked up on afterwards. She should be very proud with how she conducted herself"

Executive Owner: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy



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

The latest months value has **improved** from the previous month, with a difference of **2.0**.

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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:

Trust complaints continue to demonstrate special-cause variation, with volumes remaining above the historical baseline. October reduced slightly to 157 complaints(compared to 159 in September 26), but the sustained increase requires further analysis of the services and themes driving the change. Complaint volume alone is not a measure of patient experience and should be considered alongside activity and wider patient experience intelligence.

70% of complaints were closed in 30 days (compared to 77% in September 2026) and 67% of complex complaints were closed in 45 days (compared to 66% in September 2026). Performance continues to remain below the expected compliance rate of 90%.

Emergency Medicine has the highest number of complaints (36) reflecting the operational pressures and high demand the service.

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 has continued.
- Care Groups continue to work towards achieving the 90% target for complaints/complex complaints responses.
- Over the forthcoming financial year, we will continue to deliver 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.
- The guidelines to support Investigating Officers have been updated to provide additional support to them alongside the Investigating Officer development sessions planned for November.
- 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 of complaints.
- In November we are scoping out a programme of work with Healthwatch to understand the experience of discharge for patients and carers to help inform our improvement plans.
- We will be participating in a deep dive of the NHS Experience Excellence Framework to explore how patients and carers experiencing prolonged waits for admission or transfer from ED can be better informed and supported.
- A six-week pilot has commenced across five wards to support earlier more coordinated discharge once pre-agreed clinical and multidisciplinary criteria have been met.

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	2026-10			100%		100%
Percentage of studies recruiting their first participant in our hospitals within 30 days of opening to recruitment	2026-10			100%		100%
Percentage of commercial studies that are on target to recruit the set number of patients within our hospitals the study requires	2026-10			60%		100%
Percentage of non commercial studies that are on target to recruit the set number of patients within our hospitals the study requires	2026-10			66.7%		100%
Total number of participants recruited into research studies this year within our hospitals	2026-10			1332		3500

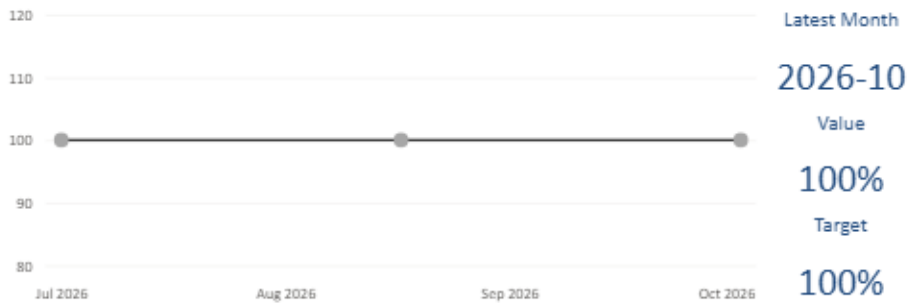
Executive Owner: Karen Stone

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 **improved** from the previous month, with a difference of **100.0**.

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)
The Trust continues to deliver strong study set-up performance, achieving 100% across both the 60-day and 30-day metrics in October.

Additional information
Recruitment to NIHR Portfolio Studies
The Trust continues to support 79 active research studies, unchanged from the previous month. New studies have opened during the reporting period; however, this has been offset by studies closing, resulting in the overall number of active studies remaining stable.

NHS Oversight Framework: 90-Day Metric
Further national guidance published in October 2026 confirms that the 90-day study set-up metric is calculated the same way for both the NHS Oversight Framework (NOF) and the NIHR Research Delivery Network funding model. It measures the time to open a study at the Trust (60 days) plus the time to recruit the first participant (30 days), excluding delays outside the Trust's control. This supersedes the description in the September report and aligns with the measures R&I already monitors (60 days + 30 days metrics).

The metric is used in two ways:

- NOF: reported quarterly and scored as part of the Trust's overall NHS England performance assessment. Performance of 95% or above achieves the highest score.
- NIHR funding: studies set up within 90 days contribute to the performance-based element of the Trust's annual research funding allocation.

R&I will report the 90-Day Metric performance quarterly in this section staring from November 2026.

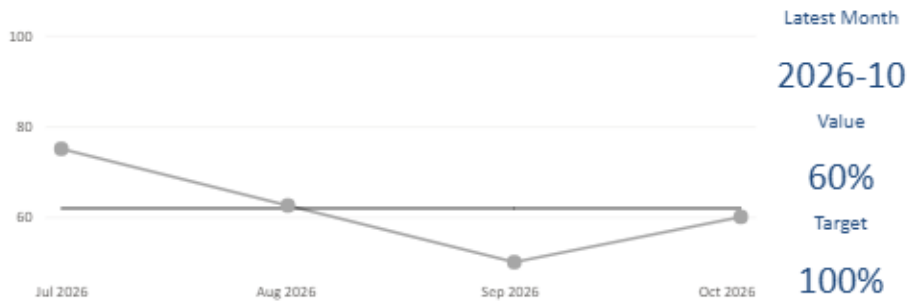
Executive Owner: Karen Stone

Operational Lead: Lydia Harris

Rationale: To monitor the National Research Delivery Network targets
Target: To meet the National Research Delivery Network targets

Percentage of commercial studies that are on target to recruit the set number of patients within our hospitals the study requires

Variation Assurance

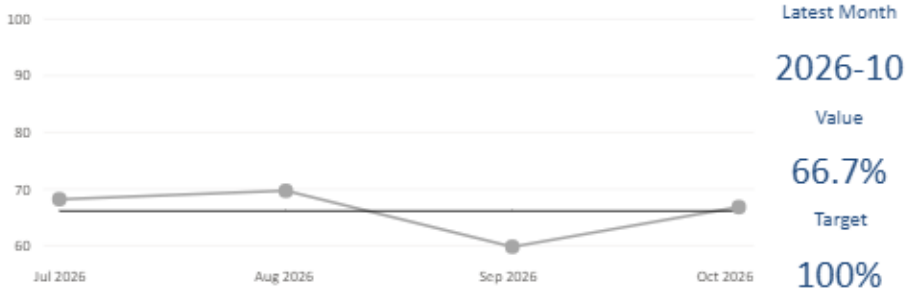


The indicator is **worse than the target** for the latest month and **is not** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **10.0**.

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 **improved** from the previous month, with a difference of **7.0**.

Commercial Research target

Commercial RTT improved from 50% in September to 60% in October. Performance remains below the 80% target and continues to be affected by the small commercial portfolio, where individual studies can have a significant impact on month-to-month performance. Studies at risk of under-recruitment continue to be actively monitored.

Non-Commercial Research target

Non-commercial RTT improved from 59.7% in September to 66.7% in October. Performance remains below the 80% target, with under-recruitment concentrated within a small number of studies. These are actively monitored through monthly Portfolio Review Meetings, with actions agreed to support recruitment.

Overall, October shows improvement in RTT performance across both commercial and non-commercial portfolios.

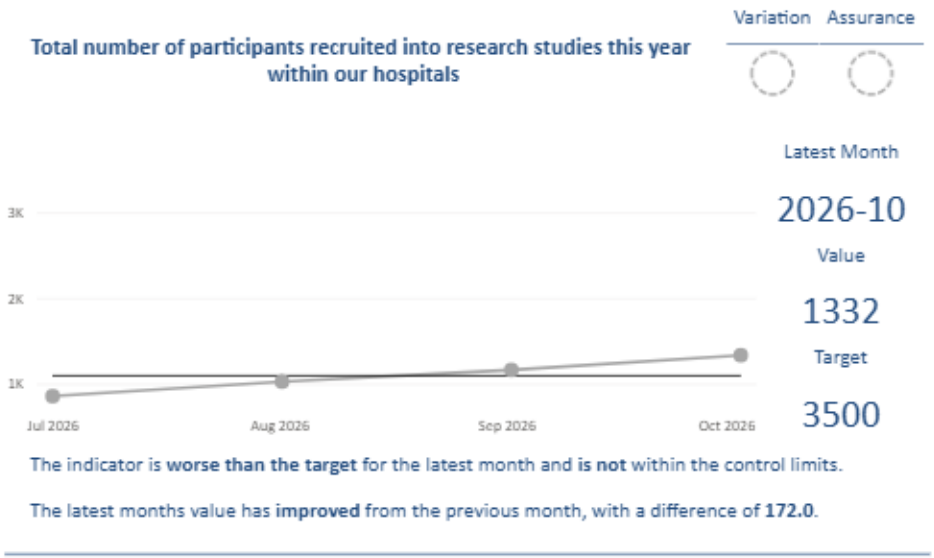
Additional information

Commercial Research

Commercial activity continues to develop positively. The Trust is currently the top recruiting site nationally for the Precision ophthalmology study, outperforming Manchester and Moorfields Eye Hospitals. The pipeline remains strong, with five new commercial studies expected to open over the coming months.

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

Patient recruitment to research studies increased from 1,160 participants in September to 1,332 in October, an additional 172 participants, achieving 38.1% of the annual target of 3,500.

BaBi, delivered by the maternity teams, remains the Trust's highest recruiting study.

Additional information

Research and Community Engagement

SHARC continued to strengthen research engagement across coastal and rural communities. October activity included engagement with 247 young people at Scarborough STEM and a Community Voices session involving approximately 38 local residents. Three abstracts have also been submitted to the Research Development Forum 2027 Conference, supporting the Trust's growing national profile in coastal, rural and smaller hospital research.

Grants and Research Capacity

A £750 award from York St John University was secured to support development of Allied Health Professional research capacity across rural and coastal communities, with a focus on health equity and under-represented groups. The partnership with York St John University continues to develop, including discussions on joint funding and additional capacity to support the growing SHARC programme. A further fee-waived PhD opportunity has also been agreed, expected to commence in June 2027.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

November 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 * 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		* Emergency caesarean - Scarborough	

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2026-09		P	83		169	Target
No. of women delivered - Scarborough	2026-09		?	94		112	Target
Births - Scarborough	2026-09		?	97		113	Target
Induction of labour - Scarborough	2026-09		?	41.5%		42.6%	Baseline
Elective caesarean - Scarborough	2026-09		?	11.3%		16.9%	Baseline
Emergency caesarean - Scarborough	2026-09	H	?	48.5%		29.1%	Baseline
BBA - Scarborough	2026-09		?	0		2	Target
Total number of Stillbirths - Scarborough	2026-09			0			No Target
Neonatal Death - Scarborough	2026-09		?	0		0	Target
Number of maternity diverts/unit closures - Scarborough	2026-09			1			No Target
Homebirth service suspended - Scarborough	2026-09		F	30		3	Target
SCBU at capacity - Scarborough	2026-02			0		0	Baseline
% of 3rd and 4th degree tears - Scarborough	2026-09			0%			No Target
L/W Co-ordinator supernumerary % - Scarborough	2026-09	H	?	100%		100%	Target
Breastfeeding Initiation rate - Scarborough	2026-09		?	79.4%		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	2026-09			0		0	Target
% of women seen within 15 minutes in triage - Scarborough	2026-09			9490%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - Scarborough	2026-09			1			No Target
Number of babies transferred out for cooling - Scarborough	2026-09			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - Scarborough	2026-09			3			No Target
Number of babies born with an Apgar of 7 at 5 mins - Scarborough	2026-09			3			No Target
Number of maternal deaths - Scarborough	2026-09			0			No Target
Number of midwifery red flags - Scarborough	2026-09			0			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - Scarborough	2026-09			0			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - Scarborough	2026-09			1			No Target
Number of planned caesarean sections > 24 hours - Scarborough	2026-09			2			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 * 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		* Elective caesarean - York	* 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	2026-09			257		295	Target
No. of women delivered - York	2026-09			222		242	Target
Births - York	2026-09			226		245	Target
Induction of labour - York	2026-09			41.4%		42.5%	Baseline
Elective caesarean - York	2026-09	H		1712%		16.7%	Baseline
Emergency caesarean - York	2026-09			24.8%		24.1%	Baseline
BBA - York	2026-09			1		2	Target
Total number of Stillbirths - York	2026-09			0			No Target
Neonatal Death - York	2026-09			1		0	Target
Number of maternity diverts/unit closures - York	2026-09			2			No Target
Homebirth service suspended - York	2026-09	H	F	27		3	Target
SCBU at capacity - York	2026-02			0		0	Baseline
% of 3rd and 4th degree tears - York	2026-09			0.5%			No Target
L/W Co-ordinator supernumerary % - York	2026-09		P	100%		100%	Target
Breastfeeding Initiation rate - York	2026-09			76.1%		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	2026-09			0		0	Target
% of women seen within 15 minutes in triage - York	2026-09			89.4%			No Target
Number of delays greater than 30 mins for Category 1 Caesarean Section - York	2026-09			2			No Target
Number of babies transferred out for cooling - York	2026-09			0			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - York	2026-09			2			No Target
Number of babies born with an Apgar of 7 at 5 mins - York	2026-09			5			No Target
Number of maternal deaths - York	2026-09			0			No Target
Number of midwifery red flags - York	2026-09			0			No Target
Number of inductions of labour (IOL) delayed > than 24 hours - York	2026-09			0			No Target
Number of delays to artificial rupture of membranes (ARM) > than 24 hours - York	2026-09			0			No Target
Number of planned caesarean sections > 24 hours - York	2026-09			0			No Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

November 2026

Workforce

Director of Workforce and Organisational Development Report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Sarah Dexter-Smith

1. Highlights

- Medical bank usage reduced by 14% in October following the introduction of strengthened approval controls, alongside further progress converting agency workers to bank and substantive roles.
- Recruitment continues across key clinical groups, including permanent medical appointments, newly qualified nurses and midwives, with the number of qualified Nursing Associates increasing to 60.
- The workforce has remained stable during the first six months of the year, with total workforce at 9,973 whole time equivalent in September, 22 above plan.

2. Concerns

- Annual sickness absence remained above plan at 5.7%, with stress and anxiety accounting for almost a third of absence during September.
- Mandatory training compliance remained at 88% in October, below the 90% target, with compliance affected by the national suspension of deprivation of liberty safeguards training.
- The workforce remains 87 whole time equivalent above the planned March 2027 position, requiring continued workforce controls and progress towards the planned year-end establishment.

3. Future

- Staff Survey participation will remain a focus ahead of its closure on 27 November, with targeted communications continuing to encourage colleagues to take part.
- Work will continue to reduce temporary staffing costs, with a particular focus on delivering the required reductions in medical bank and agency usage.
- Flu vaccination activity and sickness absence will continue to be closely monitored through the period of increased seasonal respiratory illness.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* 12 month rolling turnover rate Trust (FTE) * Overall corporate induction compliance * A4C staff corporate induction compliance	* Registered Nursing vacancy rate * Total Bank Whole Time Equivalent Filled * Medical & dental staff corporate induction compliance	* Total Agency Whole Time Equivalent Filled * Overall stat/mand training compliance
COMMON CAUSE / NATURAL VARIATION		* Overall vacancy rate * Midwifery vacancy rate * Medical and dental vacancy rate * AHP vacancy rate * A4C staff stat/mand training compliance	* Medical & dental staff stat/mand training compliance * Appraisal Activity
SPECIAL CAUSE CONCERN		* HCSW vacancy rate	* Monthly sickness absence * Annual absence rate

Workforce
Scorecard (1)

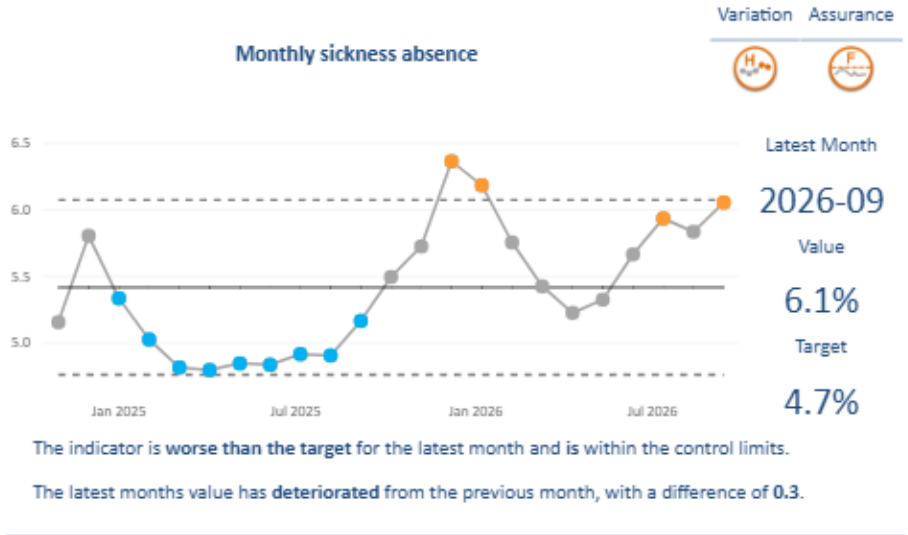
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

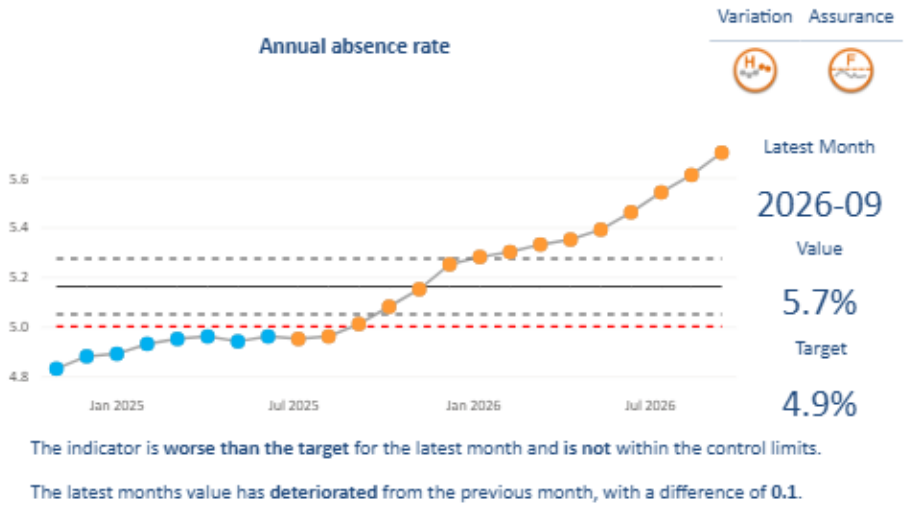
Executive Owner: Sarah Dexter-Smith **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-09	H	F	6.1%	5.1%	4.7%
Annual absence rate	2026-09	H	F	5.7%	5.2%	4.9%
Total Agency Whole Time Equivalent Filled	2026-09	L	F	39.7	42	52
Total Bank Whole Time Equivalent Filled	2026-09	L	?	479.4	526	536
12 month rolling turnover rate Trust (FTE)	2026-10	L	P	6.8%		8.5%
Overall vacancy rate	2026-10		?	7.9%		7.7%
HCSW vacancy rate	2026-10	H	?	11.9%		8%
Midwifery vacancy rate	2026-10		?	0.2%		0%
Medical and dental vacancy rate	2026-10		?	2.1%		6%
Registered Nursing vacancy rate	2026-10	L	?	3.7%		5%
AHP vacancy rate	2026-10		?	6%		7%

Executive Owner: Sarah Dexter-Smith

Operational Lead: Lydia Larcum





Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.9% annual absence rate (March 2027)

Factors impacting performance and actions:

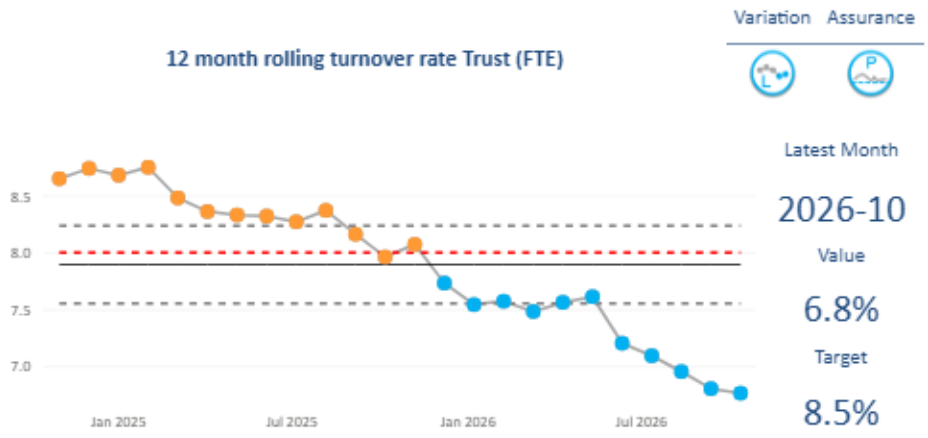
The number of absences in September increased from August by 23 WTE (570 WTE in comparison to 547 WTE the previous month). Stress and anxiety remains the leading contributor to overall absence and contributed to nearly a third of all absences in September (31%). Absences attributable to musculoskeletal problems and cold/cough/'flu were the second and third leading known causes of absence in the Trust during the month.

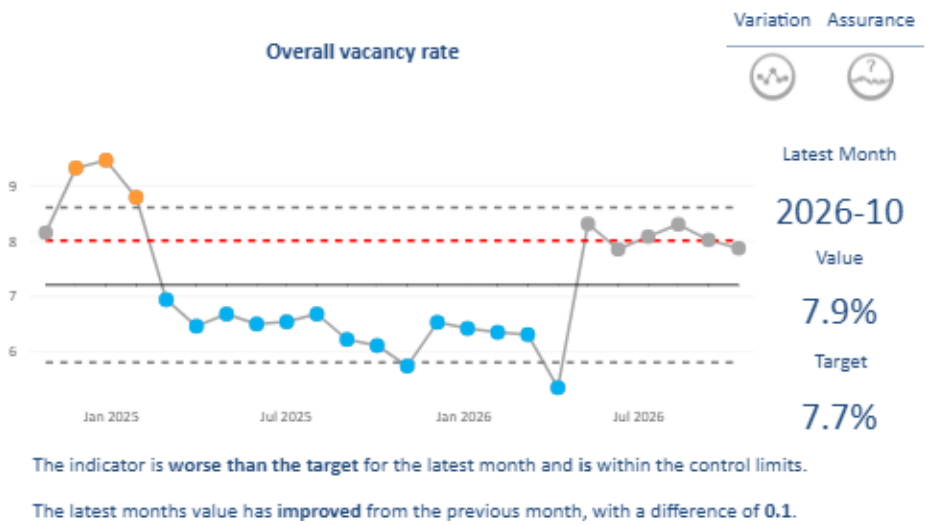
The Trust's colleague 'flu vaccination campaign has continued throughout October and November, alongside the expected seasonal increase in respiratory illness. By the end of the first full week of November, 4,571 colleagues had been vaccinated through drop-in clinics and trained peer vaccinators operating within colleagues' workplaces, with a further 130 colleagues reporting vaccination through other providers. Overall, 32% of frontline colleagues were recorded as vaccinated.

At the end of September, the annual absence rate was 5.7% across the Group. This is 0.5% higher than the trajectory in the workforce plan.

Executive Owner: Sarah Dexter-Smith

Operational Lead: Lydia Larcum





Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 8.5% Vacancy Rate 7.7%

Factors impacting performance and actions:

In September 2026, the Group's total workforce WTE was 9,973, which was +22 above plan (compared with the WTE plan for September). The workforce size has been stable across the first six months of the year, with variations in the range of -21 and +16 WTE recorded between each month thus far.

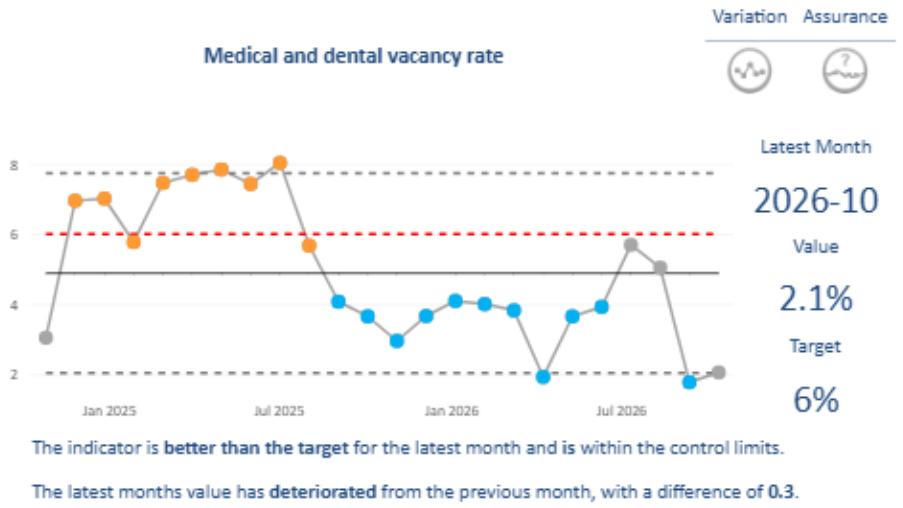
The table below shows the position in September broken down into substantive, bank and agency WTE and compared with the planned WTE outturn position for 2026-27:

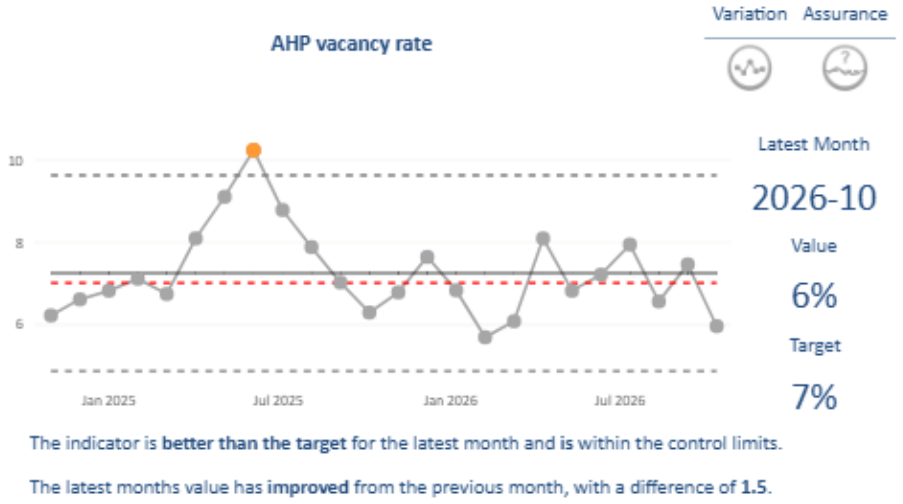
Staff Group	Sep-26 WTE actual	Mar-27 WTE plan	Variance (Plan – Actual)
Substantive	9454	9314	-140
Bank	479	524	45
Agency	40	48	8
Total	**9973**	**9886**	**87**

The Trust is continuing to operate a rigorous vacancy control process while ensuring recruitment proceeds for roles which are safety-critical. 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





Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 7%

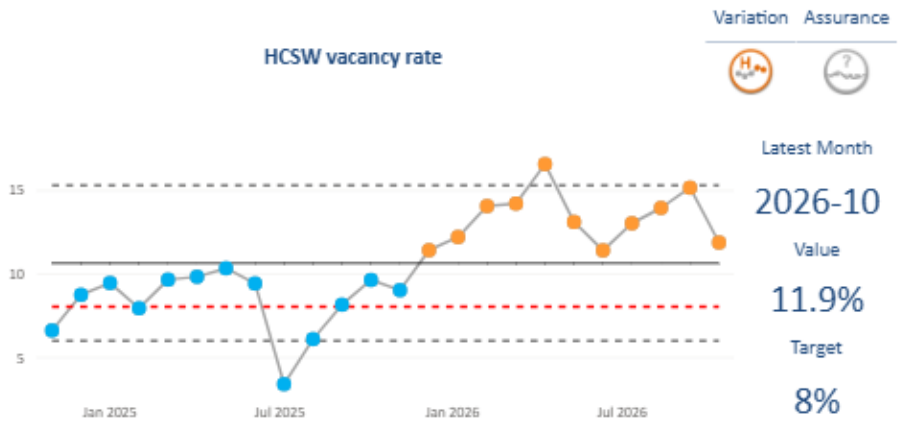
Factors impacting performance and actions:

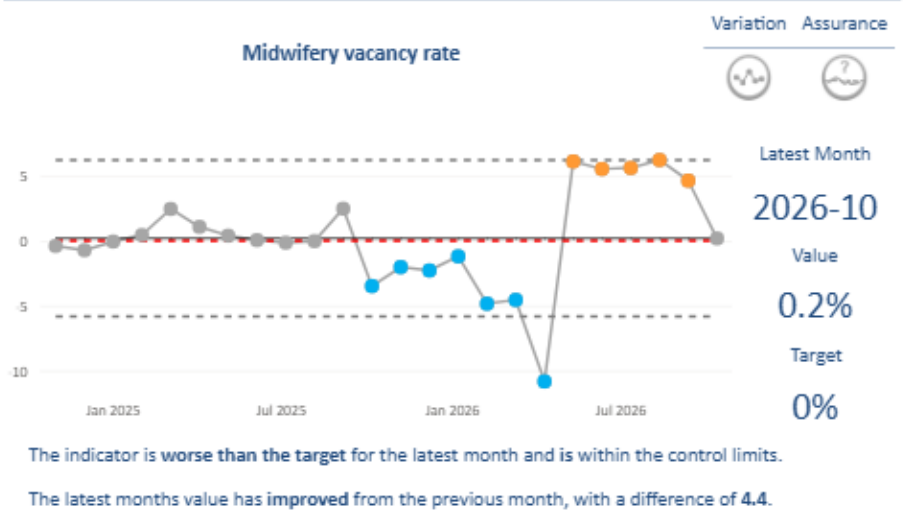
In October, the organisation welcomed nine new medical colleagues, including two permanent Consultants within Sexual Health and Oral and Maxillo-Facial Surgery. The Trust also made 14 offers for medical posts, including five permanent Consultant posts in Urology, Radiology and Oral and Maxillo-Facial Surgery.

Seven pre-registered nurses commenced with the Trust in October. On completion of their registration with the Nursing and Midwifery Council, it is expected that the Trust's vacancy rate for registered nurses will reduce from its current level of 3.7%.

Executive Owner: Sarah Dexter-Smith

Operational Lead: Lydia Larcum





Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 8%, Midwifery vacancy rate 0%

Factors impacting performance and actions:

In October, the HCSW (Band 2-3) vacancy rate decreased by -45 WTE. This was driven by a change in the established skills-mix in Maternity and Renal Medicine following recent job evaluation exercises, meaning there are now fewer roles in these pay bands.

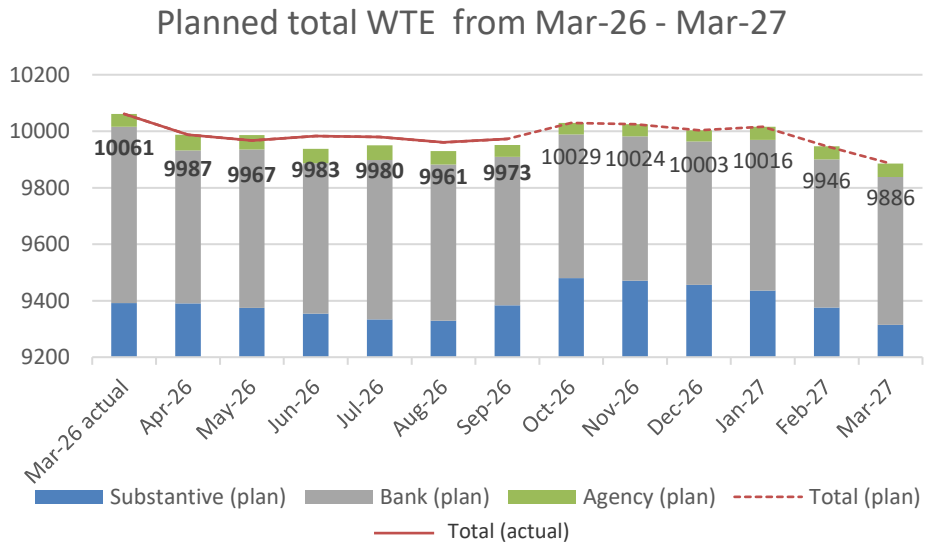
The Trust has relaunched information sessions for HCSWs to support recruitment to this role. This approach supports better quality applications and retention, as candidates must attend a session to learn about the role before they can apply for a position with the Trust. The next sessions are scheduled on 11th November in Scarborough and and 20th November in York, with 41 and 58 individuals booked to attend the respective events.

Meanwhile, 16 HCSWs began their induction in the Academy during October. A further 21 are scheduled to join the programme in November.

The number of qualified Nursing Associates within the Trust has increased to 60, up by seven from last month, following the graduation in October of a cohort of Trainee Nursing Associates from their Level 5 Apprenticeship.

The Midwifery vacancy rate decreased by 10 WTE in October following the appointment of a cohort of newly qualified Midwives.

Executive Owner: Sarah Dexter-Smith **Operational Lead:** Lydia Larcum



The table below shows actual WTE totals for Bank and Agency in September and October 2026.

Staff Group	Bank		Agency	
	Sep-26	Oct-26	Sep-26	Oct-26
Medical & Dental	67	61	17	19
Nursing & Midwifery	150	162	17	16
Support Workers	233	241	0	0
NHS Infrastructure	18	20	0	0
Scientific Therapeutic & Technical	12	14	6	5
Total	**479**	**498**	**40**	**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 shifts from 1st October. Following its implementation, medical bank shifts have reduced by 14% with 9,652 medical bank hours filled in October compared to 11,201 in September.

The Trust continues to negotiate with agency providers to reduce costs and convert agency workers on block bookings into bank or substantive positions. The Trust has recently ended agency bookings within Histopathology and Theatres. In addition, the organisation has successfully converted two Consultants onto bank contracts (within Elderly and Emergency Medicine) and is in the process of undertaking pre-employment checks to support a Radiographer joining the Trust substantively.

October shows another slight increase in administrative bank activity with 616 shifts worked in October compared to 593 shifts in September. Overall, activity remains notably lower than previous months where activity ranged between 897 and 744 shifts a month – this was prior to system permissions being adjusted as part of stronger governance controls. The Trust continues to monitor this activity closely.

Workforce
Scorecard (2)

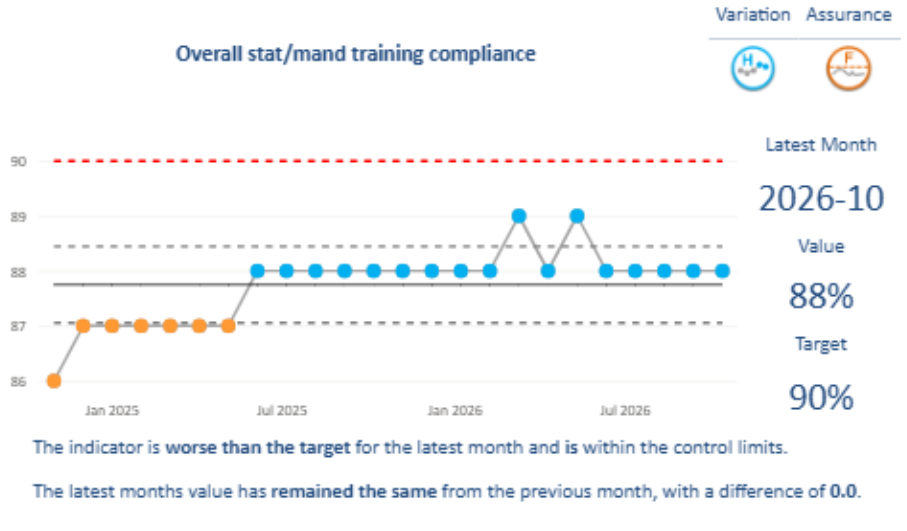
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-10	H	F	88%		90%
Overall corporate induction compliance	2026-10	H	P	98%		95%
A4C staff stat/mand training compliance	2026-10		?	89%		90%
A4C staff corporate induction compliance	2026-10	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2026-10		F	75%		90%
Medical & dental staff corporate induction compliance	2026-10	H	?	97%		95%
Appraisal Activity	2026-10		F	33.7%		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 October, mandatory training compliance maintained at 88%.

Compliance is continuing to be constrained by the suspension nationally of Deprivation of Liberty Safeguards eLearning following legal changes affecting deprivation of liberty guidance. The Trust continues to seek guidance on this issue during the intervening period, with no replacement training expected before December.

The 2026 NHS Staff Survey remains open until 27 November, with 36% of colleagues having completed the survey during the first five weeks, compared with 44% at the same point in 2025. This is currently in line with the national average, where participation is also below last year's level. Response rates are being monitored across the organisation, with targeted communications continuing to encourage participation ahead of the survey closing.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

November 2026

Executive Owner: James Hawkins

Highlights

EPR implementation:

- Nervecentre Tranche 2 went live successfully across York, Scarborough, Bridlington, Selby, Easingwold and Malton, and continues to be optimised.
- Nervecentre was also launched in our day units across York, Scarborough and Bridlington.
- 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, and progressing a pilot in SDEC.
- 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

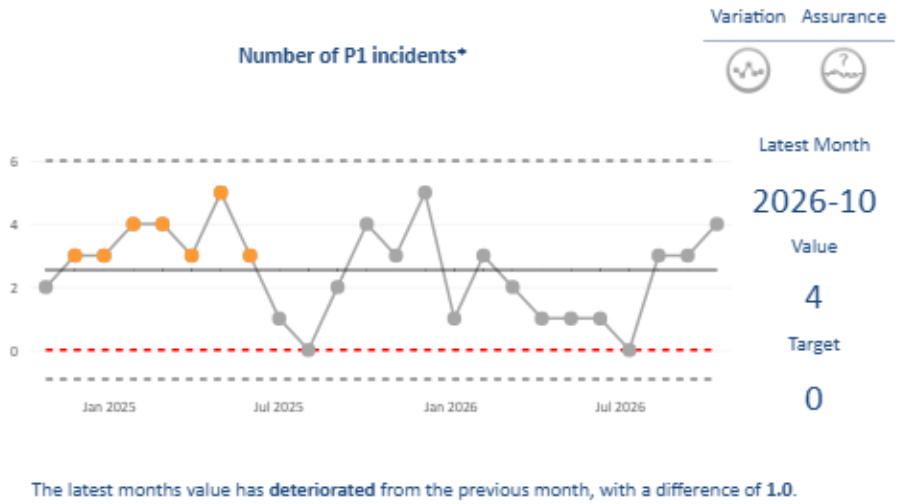
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* Percentage of FOIs and EIRs responded to within 20 working days (monthly)	* Number of P1 incidents*	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	

Executive Owner: James Hawkins

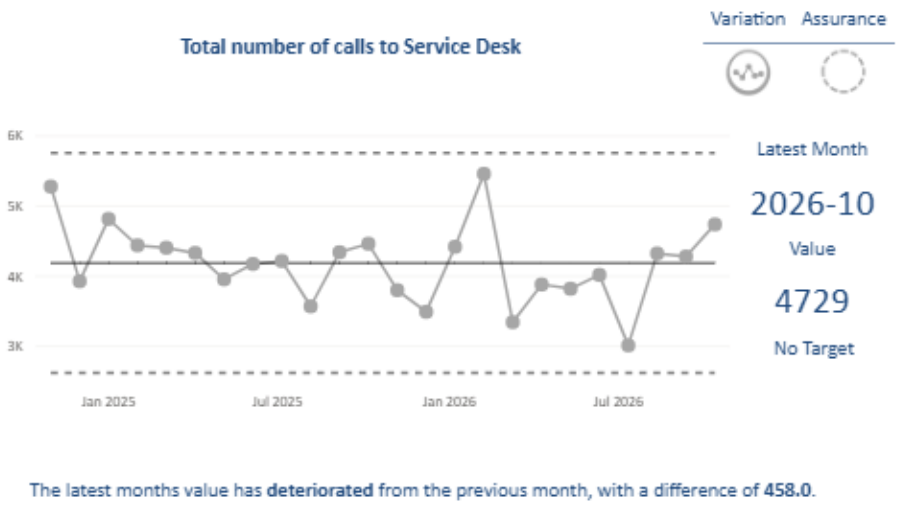
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-10		?	4		0
Total number of calls to Service Desk	2026-10			4729		
Total number of calls abandoned	2026-10			1668		
Number of information security incidents reported and investigated	2026-10			40		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-10			367		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-10			231		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-10	L	?	51%		80%
Number of FOIs and EIRs received (monthly)	2026-10			107		
Number of FOIs and EIRs completed (monthly)	2026-10			77		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-10		P	96%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



The latest months value has **deteriorated** from the previous month, with a difference of **1.0**.



The latest months value has **deteriorated** from the previous month, with a difference of **458.0**.

Rationale: Reduction in P1 Incidents and Service Desk Calls are a proxy for better digital service

Target: 0 P1 Incidents

Factors impacting performance:

4x P1 incidents occurred in October.

1. 20/10 Google UK/EU internet services downtime. External network connectivity issues relating to power issues in Google datacentre responsible for internet traffic from 0700 to 1300.
2. 22/10 PHP Security vulnerability. Global response to apply updates required some website services to be offline, including Learning Hub, Trust website and related services linked to this.
3. 23/10 CPD new connections unavailable for 13 minutes from 1221 to 1234. An unexpected software problem occurred within the service that handles logins to CPD. Existing connections were unaffected.
4. 29/10 AOVPN remote access issues affected 2/6 servers. Duration from 0400 to 0930.

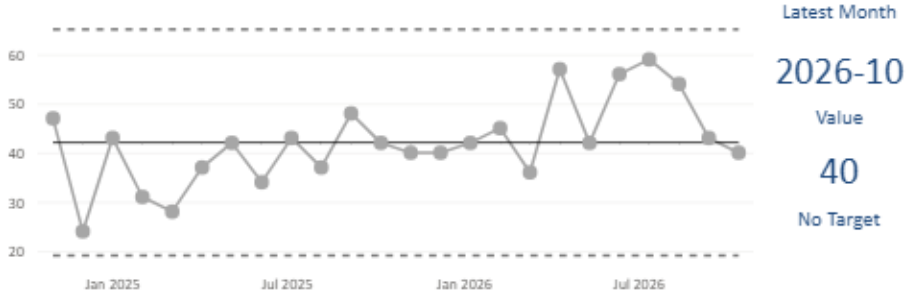
Action: Follow up investigations occurred for the CPD and AOVPN incidents. CPD problem still pending root cause explanation, but mitigations have been put in place to improve event monitoring and detect / restart the affected service if this recurs.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2026-10
Value
40
No Target

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

Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

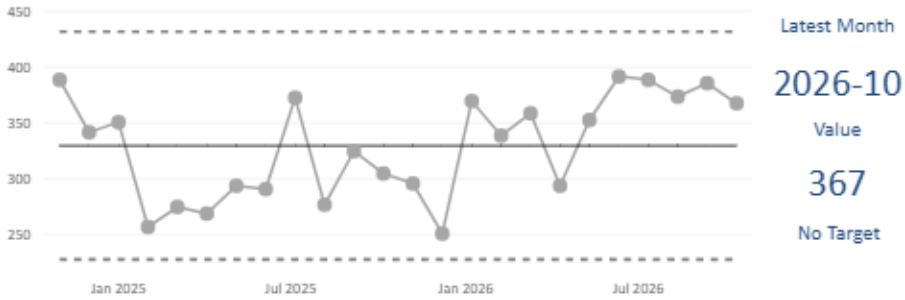
Factors impacting performance:

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
2026-10
Value
367
No Target

The latest months value has **improved** from the previous month, with a difference of **18.0**.

Rationale: Monitoring of Subject Access Requests received to ensure the Trust is managing its statutory obligations under the UK GDPR.

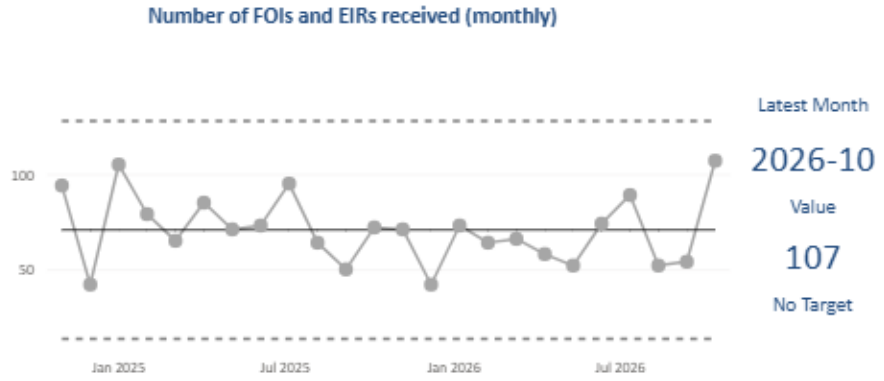
Number of Subject Access Requests (SAR) submitted by patients

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.

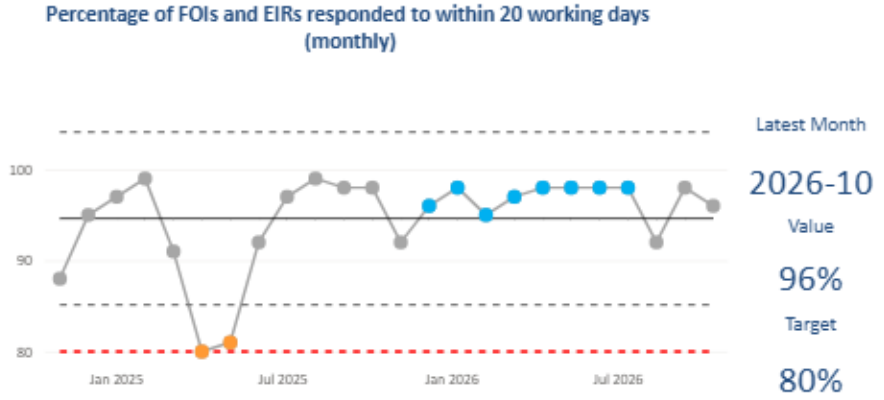
Volumes received have increased; we are still seeing high volumes with other types of information requests. The Trust is currently experiencing a backlog and response times have been impacted. This is being communicated to requesters. We are investing to try and address the significant backlog. The Information Commissioner is aware of the backlog and will be monitoring our progress.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley



The latest months value has **deteriorated** from the previous month, with a difference of **53.0**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **2.0**.

Rationale: 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%.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

November 2026

Executive Owner: Andrew Bertram

Highlights

At the end of October 2026 (**Month 7**), the adjusted year-to-date deficit excluding deficit support funding (DSF) is **£21.9m** against a planned **£10.5m** deficit, an adverse variance of **£11.3m**. October was **£2.1m** adverse on the same basis. Including DSF, the adjusted year-to-date deficit is **£17.2m** against a planned **£0.3m** surplus, **£17.5m** adverse. October was **£3.6m** adverse including DSF.

NHSE has approved the 2026/27 plan at a year-end deficit of **£18.5m** before DSF. The associated **£18.5m** support remains **conditional** on delivery of the agreed plan and its recovery, productivity and control requirements. The Trust received **£4.6m** of DSF in October. Delivery of the deficit plan and receipt of the full allocation would enable the Trust to break even.

The best-case forecast is a deficit of **£18.5m**, assuming **full WRAP delivery**, **£9.9m** of **further run-rate savings** and **£6.6m** activity income. The Trust's **mid-range forecast** is approximately **£31.0m** (**£12.5m** worse than plan). It assumes **£2.5m** WRAP slippage, **a gap in required recovery savings** (**£4.1m**), only **25%** delivery of identified recovery actions (**£4.2m** shortfall) and receipt of **75%** of activity overtrade income (**£1.7m** shortfall). The **£45.6m worst-case forecast** assumes the current expenditure run rate continues with **no further savings or income for activity above plan**.

Closing cash was **£5.5m** against a **£2.3m** plan, with **£9.0m** of supplier payments held. Of the **£8.0m** cash-support request, **£7.7m** has been approved for receipt in November. This will partly settle aged creditors, but payments remain around two weeks overdue. Only **56%** of suppliers received payment within 30 days in October against the **95%** BPPC target. A further cash-support request is required in December for January.

At **Month 7**, capital expenditure is **£10.7m** behind plan, mainly from RAAC slippage. The forecast is now **£55.1m** against a **£63.4m** plan following reprofiling of RAAC expenditure and PDC funding between years. Other slippage has enabled prioritised schemes to proceed within the forecast.

Concerns

WRAP remains the **principal risk**. **Month 7** year-to-date delivery is **£30.6m** against **£37.5m**, a **£6.8m** shortfall. October delivery improved to **£5.9m** against a **£5.7m** plan. Full-year savings delivered are **£40.7m** against a **£65.8m** target. Deferred investment and other **non-recurrent measures** continue to support the position but do not reduce the underlying cost base. Recurrent WRAP and recovery delivery remain essential to achieving the deficit plan.

Workforce and non-pay expenditure remain material pressures. Agency spend is **£3.2m** against **£3.8m**, **£0.6m** favourable. The latest reported bank spend is **£21.4m** against **£15.0m**, **£6.4m** adverse. Employee expenses are **£3.5m** adverse, including **£0.6m** for industrial action cover. October pay was **£51.5m** and other expenditure **£29.3m**, the latter **£2.0m** above the preceding 11-month average. Drugs contribute a **£3.1m** net pressure after income recovery. Vacancy controls and Medical Bank and Agency Panels must continue to support lower temporary staffing costs.

Month 7 activity is provisionally **£5.6m** above plan, including **£1.9m** for high-cost excluded drugs, subject to **final coding, costing and commissioner agreement**. The mid-range forecast assumes **75%** of additional activity income is paid for and only limited expenditure recovery actions are delivered. Income non-recovery or failure to meet DSF conditions would worsen the deficit and cash position. Recurrent savings remain the priority.

Executive Owner: Andrew Bertram

Future

The agreed 2026/27 plan remains a deficit of **£18.5m** before deficit support funding (DSF). The **£18.5m** support remains **conditional** on delivery and **must be earned**. Full receipt alongside delivery of the plan would enable a balanced reported position.

The Trust's mid-range forecast of approximately **£31.0m** (**£12.5m** worse than plan) demonstrates the recovery required. Recurrent WRAP and lower expenditure run rates remain essential to sustainable finances.

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**

Recurrent WRAP delivery remains the immediate priority. At **Month 7**, year-to-date savings are **£30.6m** against **£37.5m**, a **£6.8m** shortfall. Full-year delivery is **£40.7m** against a **£65.8m** target, including **£23.8m recurrent savings**. **Financial Improvement Boards** must address scheme slippage and replace deferred investment and temporary mitigations with lasting cost reductions.

The Executive Committee must validate and deliver the remaining **£5.6m** recovery actions alongside the **£4.4m** managed within WRAP. Insufficient expenditure reduction now requires a further **£4.3m** to balance the plan. **Monthly reporting** must demonstrate lower expenditure, supported by the recovery director and Challenged Provider Programme.

Workforce controls must address the **£6.4m** bank overspend and **£3.5m** employee-expense pressure through vacancy management, substantive recruitment and Medical Bank and Agency Panels. The provisional **£5.6m** activity overtrade requires final coding, costing and **commissioner agreement**. Income recovery remains essential to the forecast and DSF conditions.

Cash management remains critical. Approved support of **£7.7m** is due in November, but supplier payments remain around two weeks overdue. A further request is required in December for January support. Investment approvals must remain affordable, with recurrent staffing investment supported by business cases and capital commitments aligned to the reprofiled programme.

Planning for **2027/28** must progress alongside in-year recovery. As at **4 November**, identified WRAP plans total **£35.8m** against an **indicative £68.2m** target, leaving a **£32.3m planning gap** and **53%** coverage. Care groups must develop deliverable schemes and increase **recurrent savings** to strengthen the underlying position for future years.

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
£21.9m	**£11.3m**	**£2.1m**	**£18.5m**	**£5.5m**	**£8.2m**
Excl. DSF Plan: £10.5m deficit	Up from £9.2m at Month 6	Excl. DSF October adverse	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 October. The formal annual plan is now approved, but delivery remains dependent on recurrent savings, recovery action and income assumptions.

Key subjective variances at Month 7

ICB income	**£18.8m**	**Favourable**	**NHSE income**	**£17.7m**	**Adverse**
Delegated services, high-cost drugs and activity			Delegated commissioning movements		
WRAP	**£6.8m**	**Adverse**	**Employee expenses**	**£3.5m**	**Adverse**
Delivery below the amended financial plan			Workforce pressure, partly offset by CSCS vacancies		
Drugs and devices	**£5.8m**	**Adverse**	**Other non-pay**	**£4.9m**	**Adverse**
Drugs £5.0m, devices £0.8m; net pressure £3.1m			Wider non-pay pressures		

Key Financial Risks

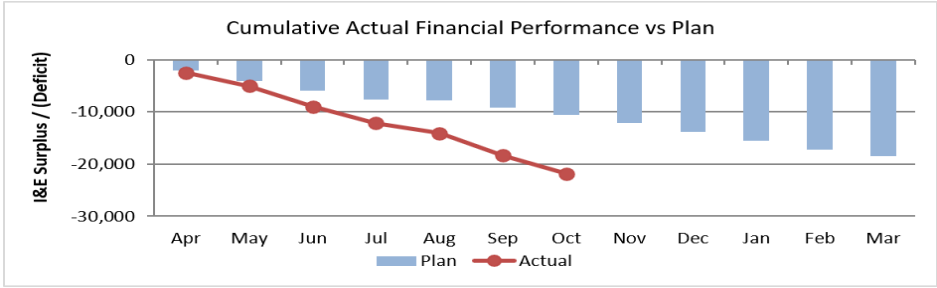
Key Risk Area	Board Level Risk Statement	Mitigations
Mid Range Forecast Deficit Position	Risk that the £30.9m deficit (£12.4m off plan) damages NOF rating and reputation, worsens cash and supplier delays, and puts £18.5m DSF at risk.	• Deliver WRAP and the required £9m recovery plan with clear accountability, 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 January 2027 & will therefore require a further cash support application in December	• 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

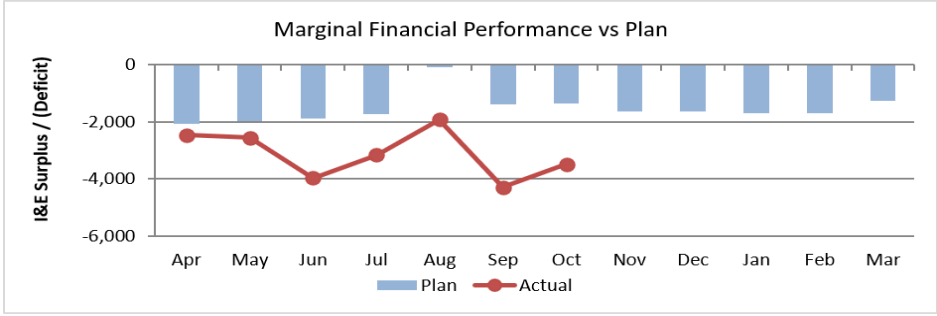
BAF

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	835,474	74,213	69,857	-4,356	487,359	488,433	1,074
Other Income	85,254	7,376	8,409	1,032	49,687	53,197	3,510
Total Income	920,727	81,589	78,266	-3,323	537,045	541,630	4,585
Pay Expenditure	-623,332	-53,289	-51,487	1,802	-358,404	-361,889	-3,485
Drugs	-72,197	-6,142	-6,874	-733	-42,143	-47,141	-4,998
Supplies & Services	-97,486	-8,290	-9,576	-1,286	-57,234	-58,123	-888
Other Expenditure	-148,447	-12,134	-11,738	396	-76,527	-80,483	-3,956
Outstanding WRAP	25,066	-221	0	221	6,825	0	-6,825
Total Expenditure	-916,397	-80,076	-79,676	400	-527,483	-547,636	-20,153
Operating Surplus/(Deficit)	4,331	1,514	-1,410	-2,924	9,563	-6,005	-15,568
Other Finance Costs	-12,677	-1,056	-1,092	-36	-7,395	-7,443	-48
Surplus/(Deficit)	-8,346	457	-2,502	-2,959	2,168	-13,448	-15,616
NHSE Normalisation Adj	8,346	-273	-977	-704	-1,901	-3,786	-1,885
Adjusted Surplus/(Deficit)	0	184	-3,479	-3,663	267	-17,234	-17,501
Remove DSF	-18,500	-1,542	0	1,542	-10,790	-4,625	6,165
NHSE DSF Adjusted Position	-18,500	-1,358	-3,479	-2,121	-10,523	-21,859	-11,336

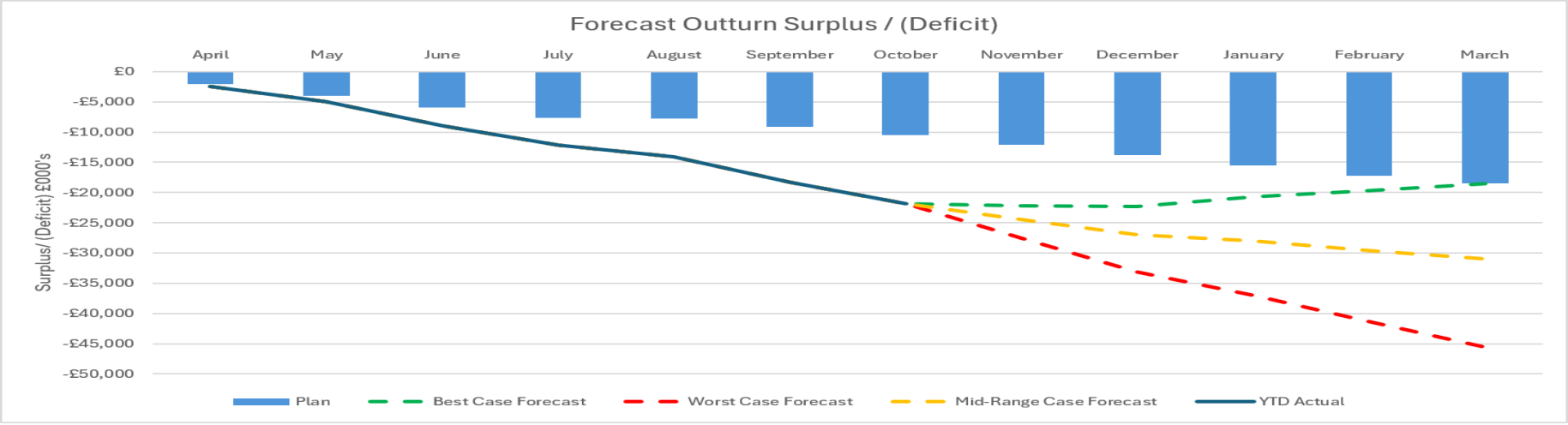
The I&E table confirms an actual adjusted year to date deficit of £17.2m against a planned surplus of £0.3m, leaving the Trust with an adverse variance to plan of £17.5m. The in-month position for October is an adverse variance of £3.6m. The year-to-date adjusted position, excluding Deficit Support Funding (DSF), is a deficit of £21.9m compared to a planned deficit of £10.5m creating an adverse variance of £11.3m.





The charts above show the NHSE approved 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 actual adjusted (excluding DSF) I&E performance at the end of October 2026 is an adverse variance to plan of £11.3m



The graph above presents the forecast outturn deficit compared with the planned deficit (excluding DSF) of £18.5m. It presents the following 3 scenarios:

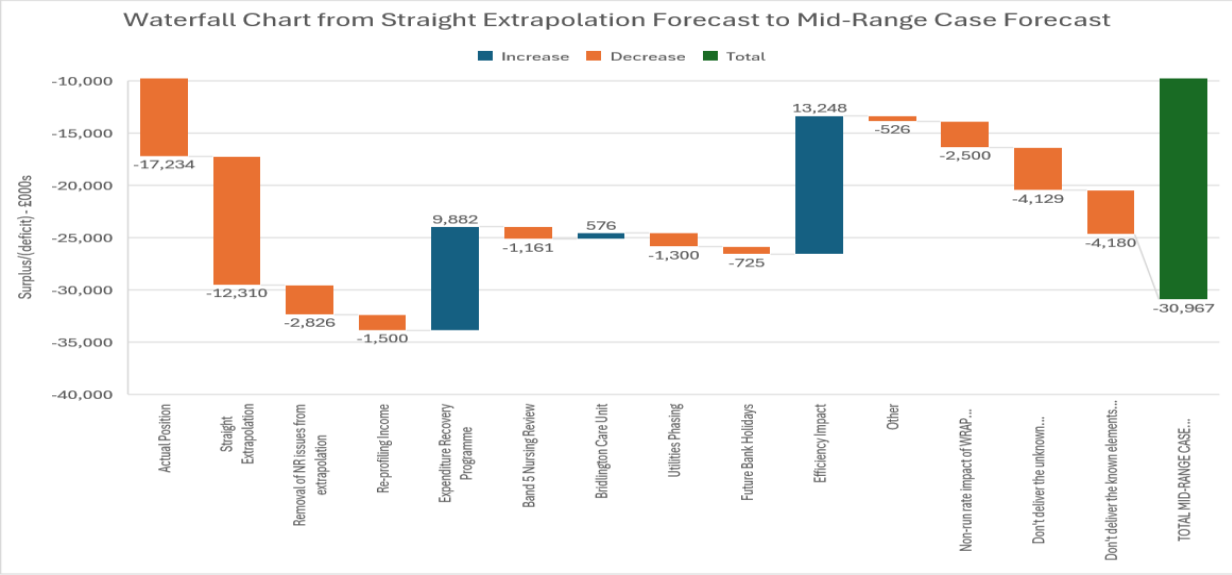
The best-case scenario assumes that the Trust recovers its financial position and delivers an outturn deficit of £18.5m, in line with plan. This assumes full delivery of the WRAP programme, achievement of financial recovery plans that deliver a further £9.9m of savings compared with the current run rate and payment in full for activity delivered ahead of plan (estimated at £6.6m in full year terms).

The mid-range scenario is an outturn deficit of £30.9m, which is £12.5m worse than plan. This assumes a shortfall in run rate savings linked to high-risk WRAP plans (£2.5m), non delivery of the unidentified elements of the recovery plan (£4.1m) and 75% shortfall in delivery of the identified elements of the recovery plan (£4.2m). In addition, this scenario assumes 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 £45.6m which is £27.1m worse than plan.

Forecast Outturn Waterfall Chart

Finance



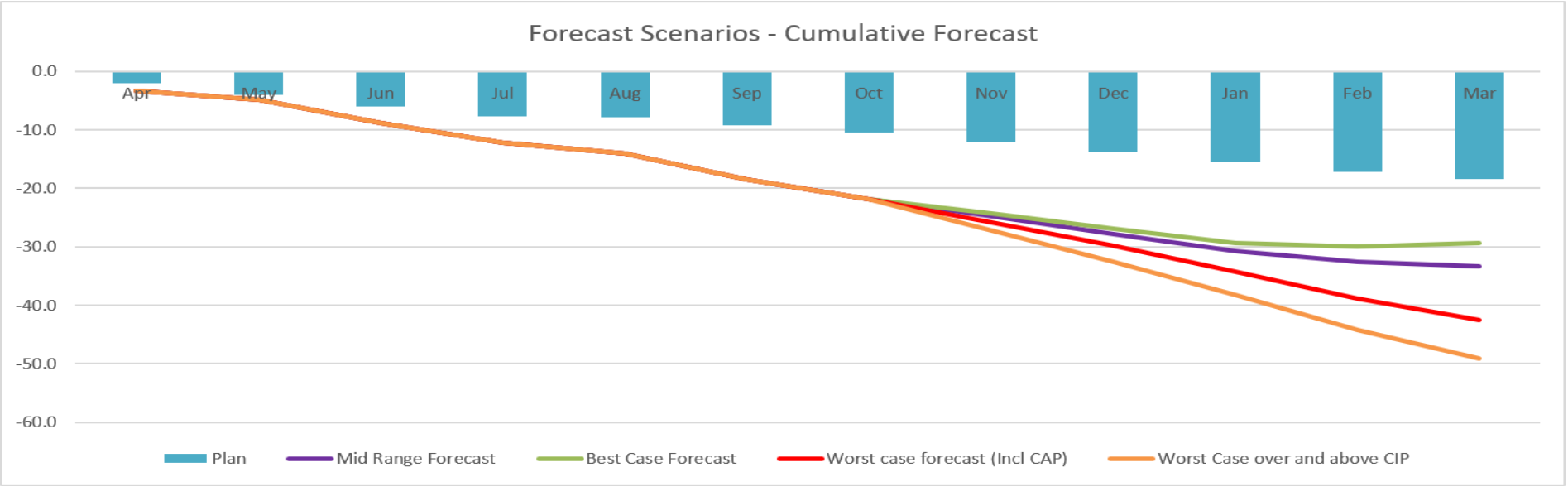
The chart summarises the assumptions behind the mid range forecast, moving from the actual month 7 position (£17.2m deficit) to a straight-line extrapolated outturn position (£29.5m deficit) to the most likely position (£30.9m deficit). Blue bars demonstrate assumptions that improve the position; orange bars show assumptions that make the position worse.

	Full Year Plan	Forecast Actual	Forecast Variance
	£000	£000	£000
Deficit Support Funding	-18,500	-18,500	0
Non-run rate impact of WRAP programme	0	-2,500	-2,500
Don't deliver the unknown elements of the ERP	0	-4,129	-4,129
Assume 75% of additional activity income is received	0	-1,659	-1,659
Don't deliver 75% of the known elements of the ERP	0	-4,180	-4,180
Mid-Range Forecast	-18,500	-30,967	-12,467

	Full Year Plan	Forecast Actual	Forecast Variance
	£000	£000	£000
Deficit Support Funding	-18,500	-18,500	0
Extrapolate Underlying YTD Actual Operational Expenditure	0	-20,429	-20,429
Non payment of additional activity income	0	-6,634	-6,634
Worst Case Forecast	-18,500	-45,563	-27,063

Mid-range: Assumes a £2.5m WRAP shortfall, no unidentified recovery savings (£4.1m), a £4.2m shortfall on identified recovery actions and receipt of 75% of activity overtrade.

Worst case: Assumes current expenditure continues with no further savings (£20.4m pressure) and no additional activity income (£6.6m).



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 £33.4m compared to the planned deficit of £18.5m. The worst-case scenario is a deficit of £42.5m, the best case is a deficit of £29.3m and the worst case over and above CIP is a deficit of £49.2m

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.

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 portfolio 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 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		**9,987**	**4,414**	**5,573**				
Further Recovery actions required		4,309		4,309				
		14,296	**4,414**	**9,882**				

To enable the Trust to meet the agreed plan, recovery actions over and above the WRAP programme are required. As at September £9.9m of recovery actions had been identified of which £4.4m were being managed through the WRAP programme. A further £5.6m had been identified for future delivery. As at month 7, due to the insufficient slow down of expenditure, a further £4.3m will be required to balance the plan.

The best case forecast assumes full delivery of this recovery programme, however the mid range forecast assumes only 25% delivery of the £5.6m additional recovery actions with no delivery against the additional £4.3m required.

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	-£17.7m	NHSE under trade linked to services which have been delegated to ICBs to commission. There is a corresponding over trade on the ICB line below.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27.
ICB Income	£18.8m	ICB over trade linked to services which have been delegated from NHSE to ICBs to commission. The position also includes additional income to fund overtrades on high-cost drugs and variable activity ahead of plan.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27. Contract Management Board engagement re overtrade.
Other Income	£3.5m	£1.5 income brought forward to partially compensate shortfall in delivery of WRAP. This approach has been discussed with NHSE. Research and Development income is also ahead of plan, and this is largely offset by expenditure.	Shortfall in WRAP delivery needs to be recovered, this may be delivered through delay / avoidance of investments included in plan.
Employee Expenses	-£3.5m	Significant pressures in Surgery (£2.7m) linked to overtime worked in Theatres and premium rate cover for resident doctors, in Family Health (£0.8m) linked to premium rate cover for medical and dental staff vacancies and sickness in Community Services and in Medicine (£0.8m) largely linked to industrial action. The adverse variance is being offset by a favourable variance in CSCS (£2.3m) due to significant vacancies. The overall 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	-£5.0m *Net of income: -£3.1m*	Drugs expenditure is £5.0m above plan. £1.9m 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 (£0.7m). 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. High-cost devices are £0.8m 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.
WRAP	-£6.8m	Year to date savings of £30.6m have been delivered compared to a target of £37.5m. This is a shortfall of £6.8m. Savings of £5.9m were achieved in October compared to a plan of £5.7m. In full year terms, £40.7m 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	-£4.9m	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.

Care Group Forecast
Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Year to Date 2026/27 Care Group Financial Position							
Care Group	Annual Adjusted Budget	YTD Budget	YTD Actual	YTD Variance	YTD Adjusted Budget	YTD Adjusted Variance	Key Drivers of YTD Adjusted Variance
	£000	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	249,397	145,215	147,306	-2,092	147,530	223	Position driven by ahead of planned WRAP delivery and ongoing vacancies (5.5%), offset by significant drug overspend (£3.6m) and increased spend on radiology reporting £1.5m ahead of plan.
Family Health Care Group	92,083	53,134	55,338	-2,203	53,659	-1,679	£190k relates to the premium cost of covering medical vacancies, £163k Community Nursing overspend, £145k Sexual Health underspend, £,1810k unachieved CIP / VF.
Medicine	198,055	115,488	120,376	-4,887	116,111	-4,264	£848k overspend on drugs, primarily Gastro; £435k relates to cover of Industrial Action; £2.897m pressure due to shortfall on delivery of WRAP schemes
Surgery	162,682	94,415	103,919	-9,504	95,172	-8,747	Year-to-date pressures include a £3.4m shortfall against the WRAP target, a £1.3m overspend on Clinical Services and Supplies, £638k of insourcing expenditure across H&N and Theatres, and a £930k overspend on Resident Doctor budgets, driven by premium bank and agency staffing.
TOTAL	702,217	408,252	426,939	-18,686	412,472	-14,467	

Full Year 2026/27 Care Group Forecast Financial Position						
Care Group	Annual Adjusted Budget	Forecast Prior to Mitigating Actions	Mitigating Actions	Forecast Post Mitigating Actions	Forecast Variance	Key Drivers of Forecast Variance
	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	249,397	249,384	0	249,384	13	Vacancies projected to continue and Run Rate impacts of WRAP savings along with drug run rate to mirror previous financial years to reduce run rate before year end, work ongoing to reduce run rate further including Headcount reductions.
Family Health Care Group	92,083	95,074	0	95,074	-2,991	£269k relates to the premium cost of covering medical vacancies, £280k Community Nursing overspend, £2,705k unplanned CIP.
Medicine	198,055	205,486	0	205,486	-7,431	£1.455m overspend on drugs, primarily Gastro; £435k relates to cover of Industrial Action; £6.3m pressure due to shortfall on delivery of WRAP schemes
Surgery	162,682	175,748	0	175,748	-13,066	The forecast overspend is primarily driven by a £6.1m shortfall against the WRAP target, a £1.8m overspend on Clinical Services and Supplies, £900k of insourcing expenditure across H&N and Theatres, and a £1.5m overspend on Resident Doctor budgets, driven by premium bank and agency staffing.
TOTAL	702,217	725,691	0	725,691	-23,474	

Investments
Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

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	Apr-Mar
Audiology	312	Apr-Sep
Cardiology	81	Nov
Colorectal Surgery	331	Apr-Dec
Dermatology	181	Sep-Nov
Diagnostics	1,585	Oct-Mar
Endoscopy	-	
ENT	405	Apr-Dec
Gastroenterology	-	
Gynaecology	179	May-Dec
Neurology	356	Jul-Sep & Nov & Jan-Mar
Ophthalmology	16	Nov
Oral Surgery	236	Apr-Dec
Paediatric SaLT	507	Jul-Mar
Pain Management	241	Jun-Sep
Reduced investment due to Wrap	-	
Renal	86	Aug-Jan
Respiratory	74	Jul-Mar
Upper GI	435	Apr-Jan
Urology	125	Apr-Dec
York Discharge BC	54	Sep-Mar
FOF Administration	25	Nov
HOOH Business Case	223	Sep-Mar
Total approved as at 10th November	**6,617**	
Remaining reserve	**679**	

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 £6.6m, leaving £0.7m available to support further specialty investments.

Investments continue to be agreed on a non-recurrent, quarter-by-quarter basis unless by exception.

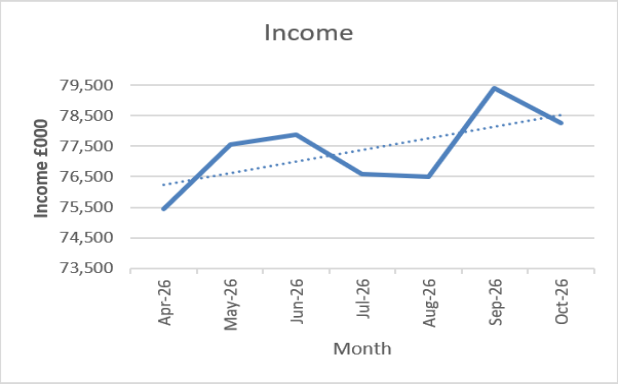
Recurrent investment in staffing is only supported following approval of a business case.

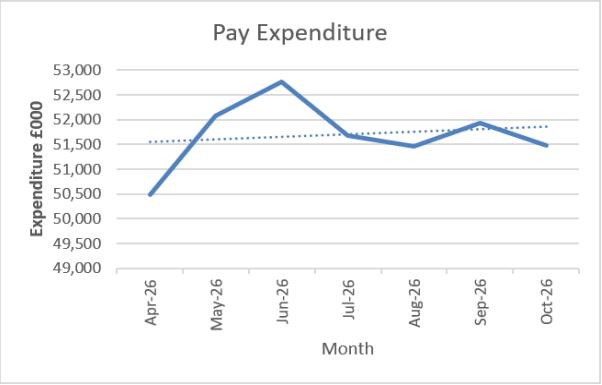
Recurrent investment in non pay is made on a case by case basis.

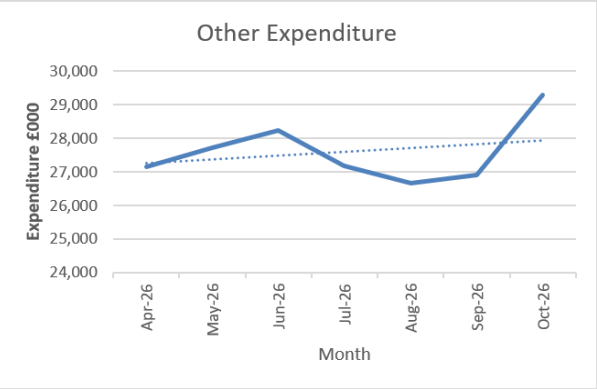
*Note: The shortfall of WRAP adjusted against the reserve remains at £1.5m.The commitment remains to wind this back however this will now be by the end of the financial year rather than Q3 due to the ongoing pressures against the plan.

Income and Expenditure Run Rate

Finance







	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	YTD Average	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	75,011	73,986	74,000	74,268	74,525	75,442	77,557	77,887	76,580	76,502	79,396	78,266	75,923	2,343
Pay Expenditure	50,548	49,895	51,005	51,041	49,416	50,484	52,073	52,761	51,684	51,470	51,929	51,488	51,119	-369
Other Expenditure	27,945	27,683	26,486	27,538	26,333	27,156	27,718	28,248	27,190	26,666	26,917	29,295	27,262	-2,033

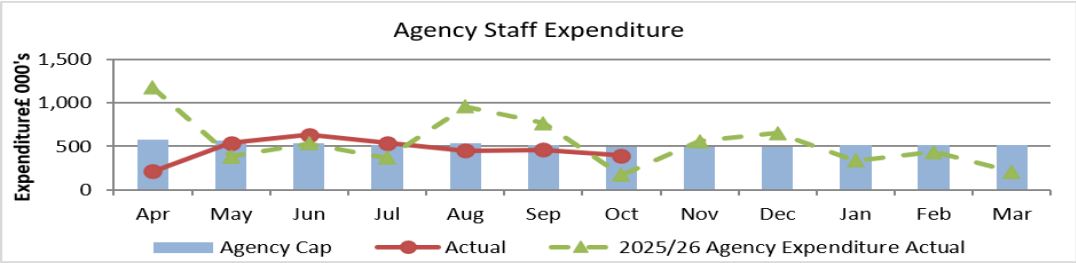
The graph and table above show the monthly run rate for income, pay and other expenditure. The figures for 2025/26 have been normalised through the removal of one – off items including increased pension contributions, impairment, ERF overtrade from 2024/25 write off and sparsity funding.

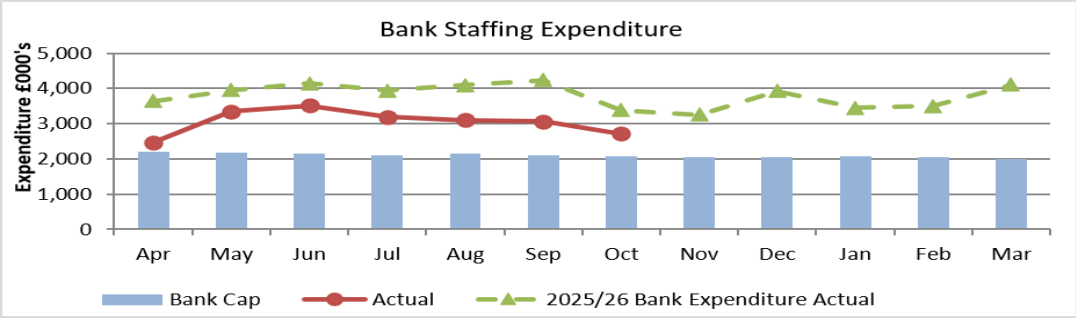
Income in October 2026 was £78.3m, which was £2.3m above the average monthly income for November 2025 to September 2026. This includes inflationary uplift to contract values in 2026/27 to fund pay awards and variable activity ahead of plan.

Pay expenditure in October 2026 was £51.5m which was £0.4m above the average monthly pay expenditure for November 2025 to September 2026. The costs in October are £0.25m lower than the average for 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 £29.3m in October 2026, which was £2.0m higher than the average monthly expenditure for November 2025 to September 2026. This includes increased use of blood products and utilities costs (particularly electricity)

Agency, Bank and Workforce
Finance





	Year to Date Expenditure		
	Budget	Actual	Variance
	£000	£000	£000
Registered Nurses	91,498	93,198	-1,700
Scientific, Therapeutic and Technical	46,790	46,945	-155
Support To Clinical Staff	41,682	39,529	2,154
Medical and Dental	100,817	103,894	-3,076
Non-Medical - Non-Clinical	77,488	76,881	607
Reserves	-1,120	0	-1,120
Other	1,249	1,443	-194
TOTAL	358,404	361,889	-3,485

Agency Controls

The Trust has an agency staffing spend limit of £6.3m in 2026/27. This represents a reduction of 4% on the 2025/26 expenditure level. The year-to-date expenditure on agency staff at the end of October 2026 is £3.2m, compared to a plan of £3.8m, representing a favourable variance of £0.6m.

Bank Controls

The Trust has a bank staffing spend limit of £25.2m in 2026/27. This represents a reduction of 45% on the 2025/26 expenditure level. The year-to date expenditure on bank staff at the end of September 2026 is £21.4m, compared to a plan of £15.0m, representing an adverse variance of £6.4m.

Workforce

This table presents a breakdown, by staff group, of the budget and actual expenditure for the year to date. The table illustrates that the key overspends are on Medical and Dental and Registered Nursing roles. This is due to premium costs for bank and agency staffing covering vacancies. There is a compensating underspend linked to Healthcare Support worker vacancies. The Medical and Dental staffing variance includes £0.6m of cost linked to covering Industrial Action.

Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variable / Blended Activity Performance Report - Month 7

Commissioner	Value VAPR scope Indicative Weighted Values at 26/27 prices	VAPR Month 7 Phase (Av %)	Weighted Activity to Month 7 Actual	Variance - (Clawback Risk) M7
Humber and North Yorks	£464,467,479	£283,121,156	£286,720,546	£3,599,390
West Yorkshire	£1,954,676	£1,137,271	£1,196,999	£59,728
Cumbria and North East	£417,195	£242,760	£240,560	-£2,200
South Yorkshire	£192,047	£110,934	£142,922	£31,988
All ICBs	***£467,031,397***	***£284,612,121***	***£288,301,027***	**£3,688,906**
NHSE Specialist Commissioning	£41,389,000	£29,565,813	£31,449,349	£1,883,536
NHSE Other	£285,266	£169,405	£192,704	£23,299
All Commissioners Total	**£508,705,663**	**£314,347,339**	**£319,943,080**	**£5,595,741**

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.

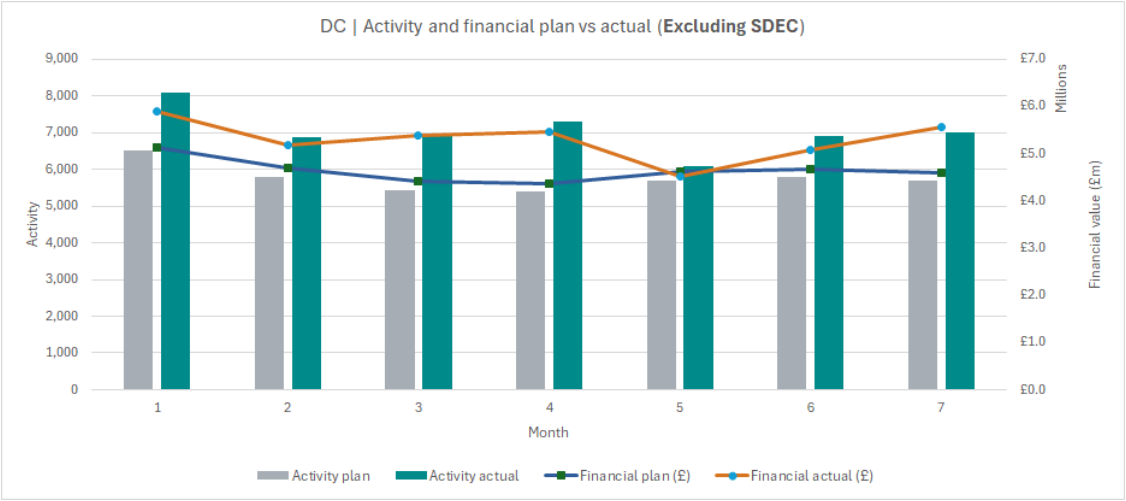
Although the funding for the variable activity is now reimbursed on a cost per case arrangement. HNY ICB is monitoring contract performance via the Contract Management Board designed to support the delivery of the agreed activity, performance, quality and financial plans and to strengthen collaboration 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.

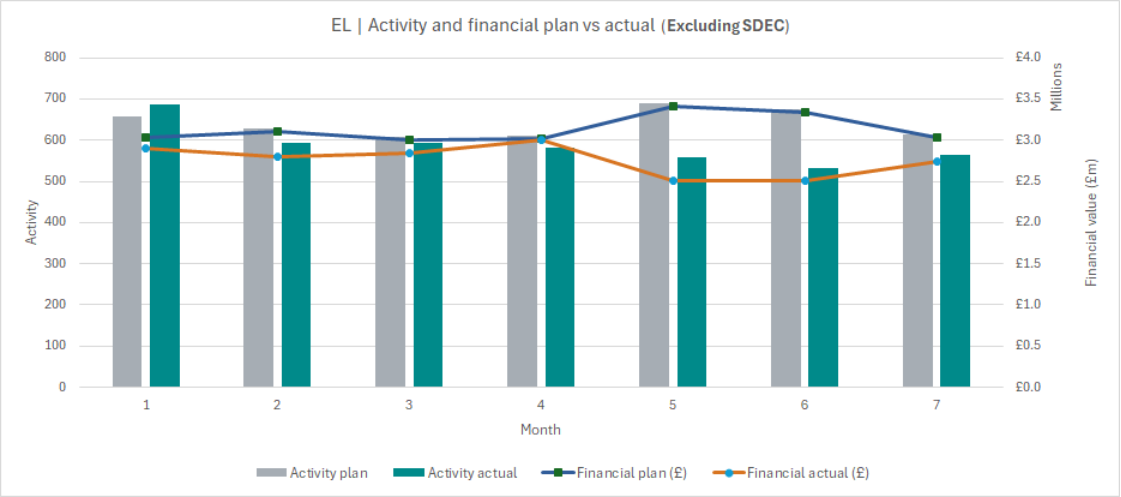
At Month 7, across all commissioners, the weighted activity position is above the planned weighted value by circa £5.6m. This includes expected additional income for High Cost Excluded drugs (£1.9m) and current overtrades in Activity, mainly in Day case & Unbundled Diagnostics Points of Delivery (PoD). 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

Variable Activity – Trading Position – NHSE / ICB Contracts

Finance



Day Case activity is the main source of over trade income for the year to date. The chart shows the plan and actual monthly activity and income between April and October. The run rate actual activity reduced from August although is still above planned levels.

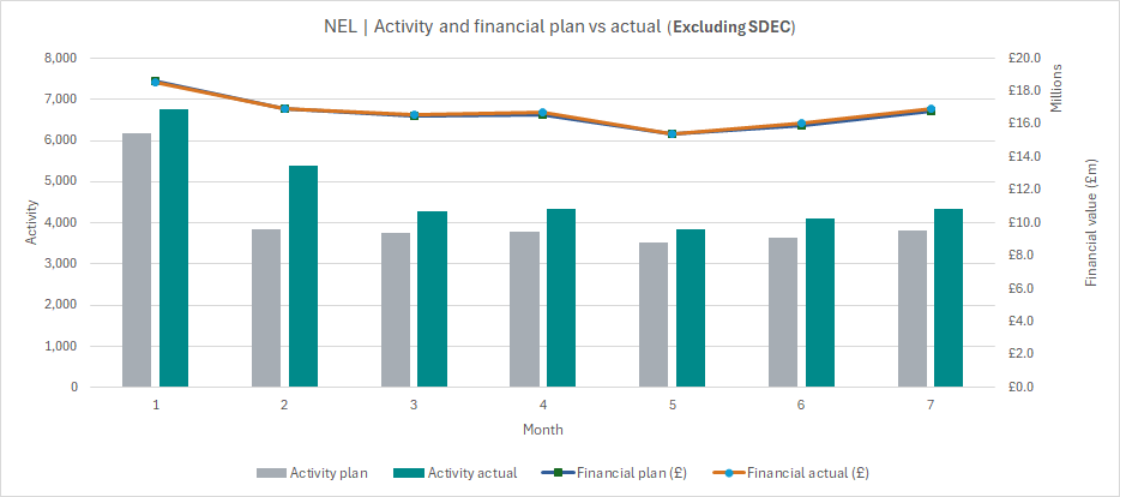


Elective activity has been trading much more in line with planned levels in the first 4 months. From August, a higher phased plan and drop in actual run rate activity, impacted on the income trends reducing the overtrade income seen in earlier months.

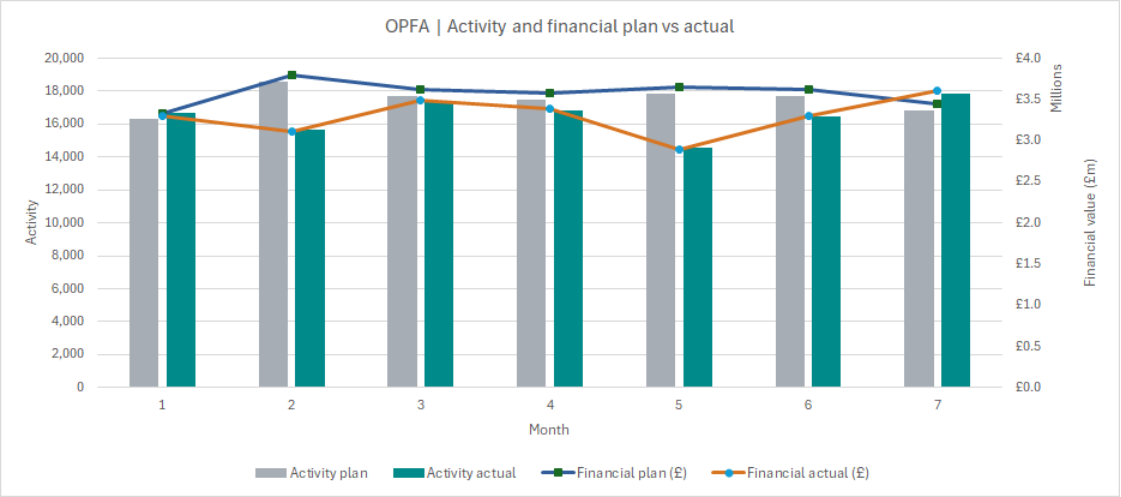
Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust



Non-Elective Activity has consistently been above plan in each month. Despite this overtrade position on activity, under National Payment rules, income above plan is only reimbursed at 20% of tariff so contributes less to the overtrade income position as seen in the income vs plan trend.



First OP Activity performance has been variable against plan with some months achieving plan and others showing a shortfall. Overall YTD we are behind plan and the income impact can be seen in the chart with particular shortfalls in May and August. October traded above plan mainly due to the Focus on First Initiative to reduce long wait patients.

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

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

Executive Summary

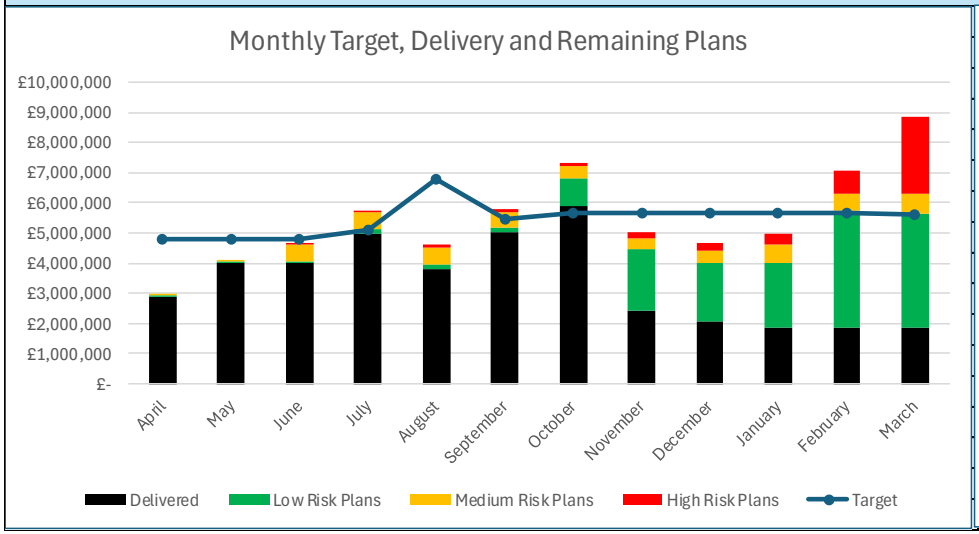
Programme Summary Position	Full Year	YTD Position
Target	£65,785,699	£37,472,082
Delivered	£40,719,237	£30,646,992
Variance	**-£25,066,462**	**-£6,825,090**
Addititional Plans to be delivered		
Planned Low Risk	£15,284,396	£1,478,259
Planned Medium Risk	£5,268,908	£2,659,844
Planned High Risk	£4,513,158	£396,334
Total Additional Plans	**£25,066,462**	**£4,534,437**
(Planning Gap)/Over delivery	**-£0**	**-£2,290,653**

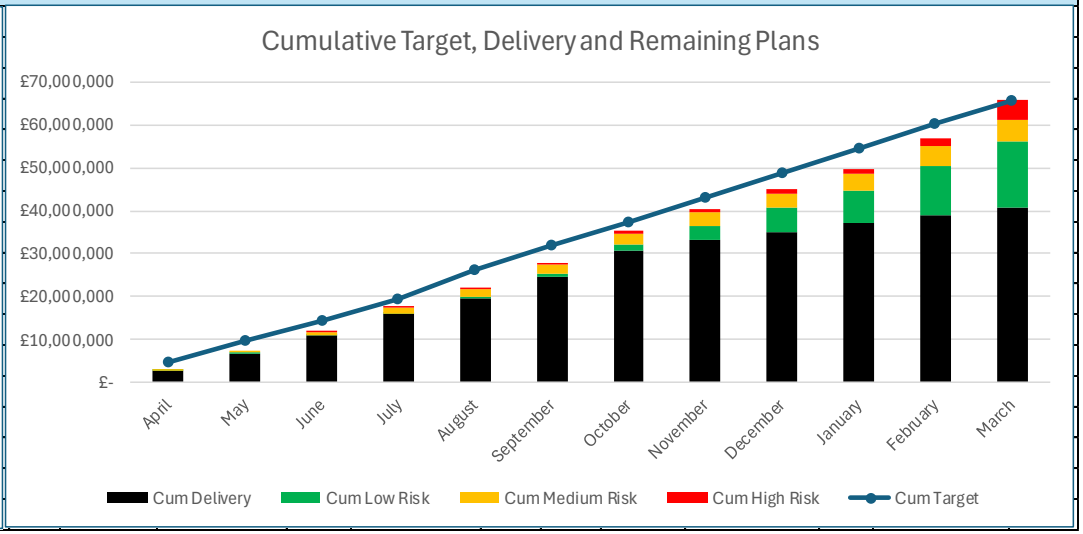
WTE Plan	256.07	**WTE Delivered**	79.11

Scheme Governance											
Total Number of Live Schemes	**154**										
EQIA Outstanding	53	34%									
Pre-Pipeline	10	6%									
Opportunity	31	20%									
Plan in Progress	6	4%									
Fully Developed	107	69%									
	Plans	**%**	**Delivered**	**%**		**Plans**	**%**	**Delivered**	**%**		
Recurrent	£37,754,355	57%	£23,846,573	36%	**Pay**	£28,604,952	43%	£17,821,947	27%		
Non Recurrent	£28,031,344	43%	£16,872,664	26%	**Non Pay**	£36,961,384	56%	£22,677,927	34%		
Total	**£65,785,699**	100%	**£40,719,237**	62%	**Income**	£219,363	0%	£219,363	0%		
					Total	**£65,785,699**		**£40,719,237**			

YTD Period Name: October 2026

In Year Plan Profile





WRAP Programme – 27/28 Planning

Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

27/28 Indicative Waste Reduction and Productivity Programme Position

Live planning position • checked 4 November 2026 | £ values shown in full-year terms

The 27/28 programme has £35.8m of plans against a £68.2m indicative Trust target, leaving a £32.3m planning gap and 53% coverage. Corporate Functions holds the largest Care Group plan value at £11.3m. Workforce & Pay is the largest TPR category at £15.4m.

TRUST ESTIMATED TARGET	PLANS IDENTIFIED	PLANNING GAP	TARGET COVERAGE
£68,153,072	£35,840,327	-£32,312,745	52.6%

CARE GROUP POSITIONS

Care Group	27/28 Target	Plans	Planning Gap	Coverage	Share of Plans
CSCS	£14,410,572	£3,285,970	-£11,124,602	22.8%	9.2%
Family Health	£8,415,110	£4,095,974	-£4,319,136	48.7%	11.4%
Medicine	£16,491,606	£9,672,408	-£6,819,198	58.7%	27.0%
Surgery	£16,783,834	£7,531,803	-£9,252,031	44.9%	21.0%
Corporate Functions	£12,051,950	£11,254,172	-£797,778	93.4%	31.4%
Trust Total	**£68,153,072**	**£35,840,327**	**-£32,312,745**	**52.6%**	**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	£15,415,885	43.0%
Procurement, Medicines & Non-Pay	£7,090,948	19.8%
Clinical Productivity & Pathways	£8,326,561	23.2%
Digital & Technology	£2,775,634	7.7%
Estates, Facilities & Energy	£1,286,582	3.6%
Income & Commercial	£181,000	0.5%
Corporate Services & Administration	£763,717	2.1%
Trust Total	**£35,840,327**	**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	33.5%
2	CIP203	ACUTE MODEL OF CARE	Clinical Productivity & Pathways	£4,818,000	13.4%
3	CIP2	NON RECURRENT NON PAY SAVINGS	Procurement, Medicines & Non-Pay	£4,422,863	12.3%
4	CIP240	MEA	Procurement, Medicines & Non-Pay	£1,800,000	5.0%
5	CIP174	RAMSEY REPATRIATION	Clinical Productivity & Pathways	£1,548,000	4.3%
Top 5 Total				**£24,589,293**	**68.6%**

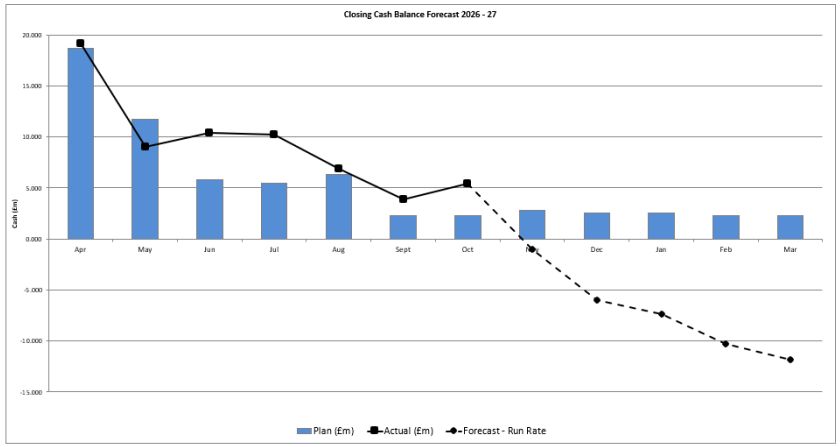
Current Cash Position and Better Payment Practice Code (BPPC)

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	5,476					



Closing cash was **£5.5m**, compared with a planned balance of **£2.3m**, resulting in a positive variance of **£3.2m**.

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 remained the same as prior month where £9m of payments at the end of the month were held.

The favourable variance is due to timing of supplier payments described above offset by the adverse I&E variance and other working capital movements. In October, £4.6m of DSF was received which has helped settle some aged creditors and maintain the cash position.

£7.7m of the £8m cash support requested has been approved and due to be received in November. This will allow partial settlement of aged creditors; however, the cash pressure remains with payments running approx. 2 weeks behind due dates.

The cash graph illustrates the impact on cashflow if supplier payments were settled on time. This will be mitigated by extending supplier payment dates through November & December; however, a further request for is required for submission in December for cash support in January.

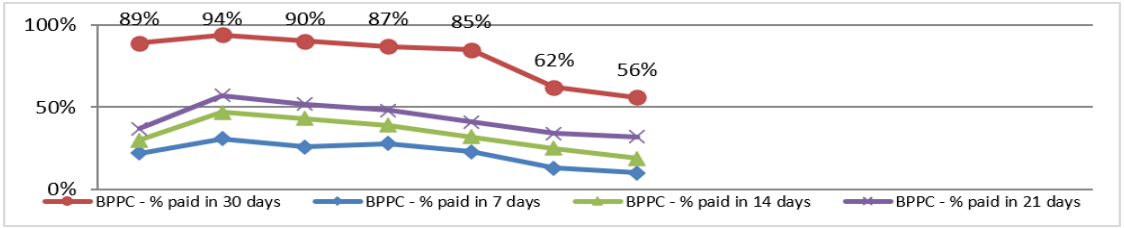
The run rate forecast, is based on continuation of cash receipts & payment run rates in line with current levels and any known adjustments. The run rates are extrapolated to give an indication of emerging cash pressures which continue to indicate a cash shortfall.

<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 October, the Group managed to pay 56% 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.



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 £8.2m to £55.2m. This is due to a £9.5m 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.

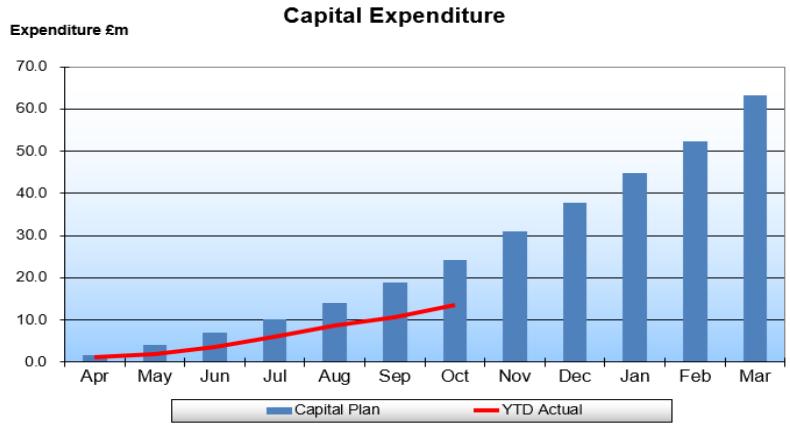
Capital Position	Plan	Forecast Outturn	YTD Plan	Actual YTD Expenditure	Variance to YTD Plan
	£000's	£000's	£000's	£000's	£000's
Internally Funded Schemes					
Electronic Patient Record (EPR)	7,200	7,200	1,547	1,146	- 401
York - PACU / Hybrid Theatre	2,850	1,700	1,500	1,605	105
Histopathology Refurb Completion	1,800	600	1,000	-	- 1,000
Salix Decarbonisation - Trust Contribution	1,459	1,459	-	-	-
Minor Works Schemes	559	559	125	135	10
Estates Backlog Maintenance & EDI	1,150	1,150	525	827	302
Y&S Digital Capital Projects	1,000	1,000	500	329	- 171
Medical Equipment Purchase/Lease	5,600	5,600	800	2,040	1,240
Capitalised Staff / Project Fees	2,100	2,100	1,045	1,243	198
Other Capital Projects	499	- 401	-	703	703
CIR - Refurb & Extension of SCBU York	-	1,450	-	171	171
Upgrade of CT (CT3) - York	-	700	-	432	432
Renal Ward York - Water ring upgrade	-	300	-	56	56
MRI 4 Relocatable	-	400	-	166	166
Ward 16 York	-	400	-	-	-
Total Internally Funding Schemes	**24,217**	**24,217**	**7,042**	**8,851**	**1,809**
PDC, Charitable and Grant Funded Schemes					
RAAC - Scarborough Pathology - PDC	16,458	14,604	12,098	-	- 12,098
RAAC - Scarborough Theatres - PDC	8,737	1,050	2,007	402	- 1,605
Constitutional Standards Schemes - PDC	6,150	6,150	500	-	- 500
Safer Estates Schemes - PDC	3,655	3,655	1,155	536	- 619
Charitable & Grant Schemes	4,160	5,460	1,510	3,823	2,313
Total Externally Funded Schemes	**39,160**	**30,919**	**17,270**	**4,761**	**- 12,509**
Total Capital Programme	**63,377**	**55,136**	**24,312**	**13,612**	**- 10,700**

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 M7 position is £11m behind plan.

This is mainly due to the RAAC schemes running behind the original planned phasing. RAAC expenditure was £13m below plan at M7, with the revised forecast now at £15m compared with the original £25m plan, 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.



M6 System position – Humber and North Yorkshire (inc. and excl. DSF)

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

			Surplus / (Deficit) including DSF			
			YTD			
Code	Name	Provider Type	Plan YTD £000s	Actual YTD £000s	Variance YTD £000s	Variance as a % of income %
Humber and North Yorkshire						
RCD	Harrogate and District NHS Foundation Trust	Acute	(2,553)	(22,177)	(19,624)	(9.9%)
RWA	Hull University Teaching Hospitals NHS Trust	Acute	(24,780)	(43,794)	(19,014)	(3.8%)
RV9	Humber Teaching NHS Foundation Trust	Mental Health	0	0	0	0.0%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Acute	(14,968)	(16,793)	(1,825)	(0.6%)
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Acute	82	(13,742)	(13,824)	(3.0%)
QOQ	NHS Humber and North Yorkshire ICB		0	0	0	0.0%
Humber and North Yorkshire Total			**(42,219)**	**(96,506)**	**(54,287)**	**(1.0%)**

			Surplus / (Deficit) excluding DSF			
			YTD			
Code	Name	Provider Type	Plan YTD £000s	Actual YTD £000s	Variance YTD £000s	Variance as a % of income %
Humber and North Yorkshire						
RCD	Harrogate and District NHS Foundation Trust	Acute	(9,303)	(22,177)	(12,874)	(6.5%)
RWA	Hull University Teaching Hospitals NHS Trust	Acute	(24,780)	(43,794)	(19,014)	(3.8%)
RV9	Humber Teaching NHS Foundation Trust	Mental Health	0	0	0	0.0%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Acute	(14,968)	(16,793)	(1,825)	(0.6%)
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Acute	(9,166)	(18,367)	(9,201)	(2.0%)
QOQ	NHS Humber and North Yorkshire ICB		(5,442)	(5,442)	0	0.0%
Humber and North Yorkshire Total			**(63,659)**	**(106,573)**	**(42,914)**	**(0.9%)**

M6 System Position (2)
Finance

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

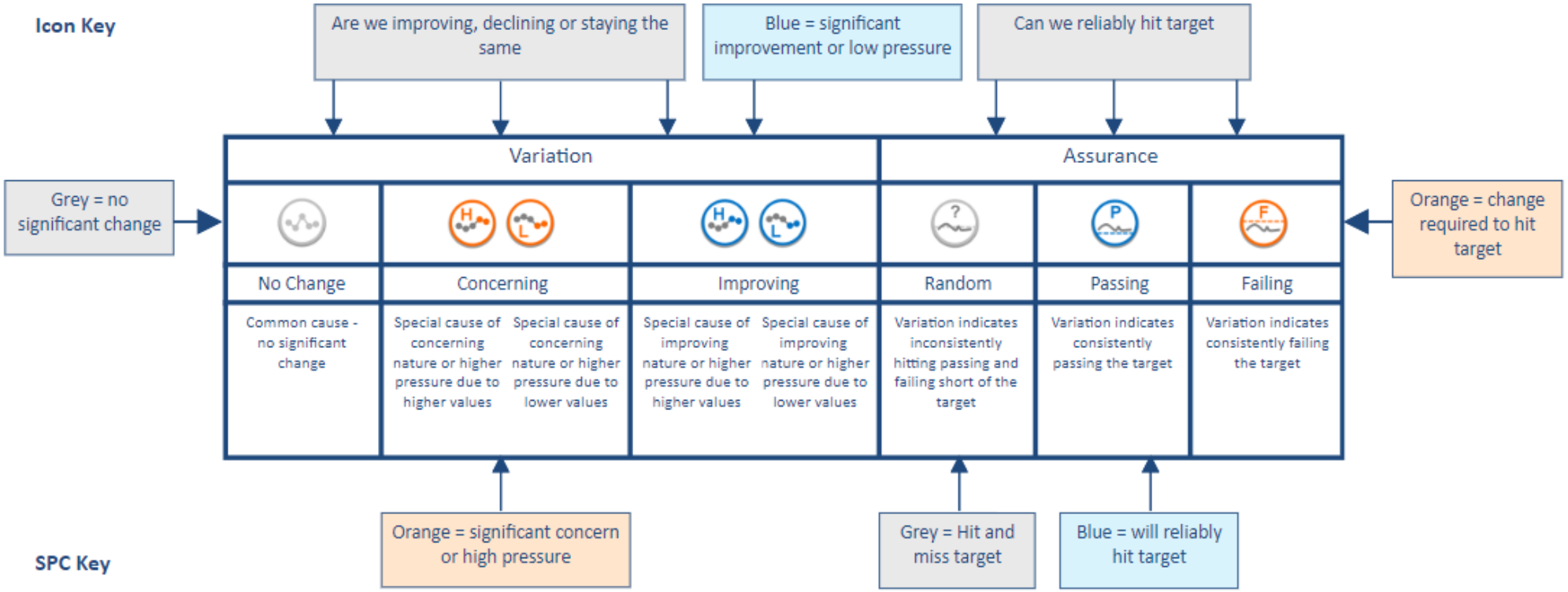
Efficiency

		YTD							FOT							
Code	Name	Plan YTD £000s	YTD Actual £000s	YTD Variance £000s	YTD Variance %	% of FOT %	% Recurrent %	% Pay %	Plan £000s	Forecast £000s	FOT Variance £000s	FOT Variance %	% Recurrent %	% High Risk %	% Unidentified %	% Pay %
Humber and North Yorkshire																
RCD	Harrogate and District NHS Foundation Trust	14,661	6,618	(8,043)	(54.9%)	20.7%	12.0%	39.9%	32,000	32,000	0	0.0%	40.2%	44.7%	32.6%	38.4%
RWA	Hull University Teaching Hospitals NHS Trust	31,883	13,887	(17,996)	(56.4%)	19.1%	86.9%	43.3%	72,881	72,881	(0)	(0.0%)	69.2%	55.8%	41.8%	49.9%
RV9	Humber Teaching NHS Foundation Trust	7,446	7,451	5	0.1%	51.9%	86.4%	67.9%	14,353	14,353	0	0.0%	86.8%	0.0%	0.0%	66.2%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	18,826	10,082	(8,744)	(46.4%)	21.8%	88.2%	60.8%	46,223	46,223	(0)	(0.0%)	58.0%	78.0%	37.2%	54.7%
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	31,796	24,748	(7,048)	(22.2%)	37.6%	45.9%	45.4%	65,787	65,786	(1)	(0.0%)	59.1%	15.8%	5.1%	45.0%
QOQ	NHS Humber and North Yorkshire ICB	36,795	36,768	(27)	(0.1%)	45.1%	69.0%		81,468	81,468	0	0.0%	71.9%	0.0%	0.0%	
Humber and North Yorkshire Total		**141,407**	**99,554**	**(41,853)**	**(29.6%)**	**31.8%**		**50.4%**	**312,712**	**312,710**	**(1)**	**(0.0%)**				

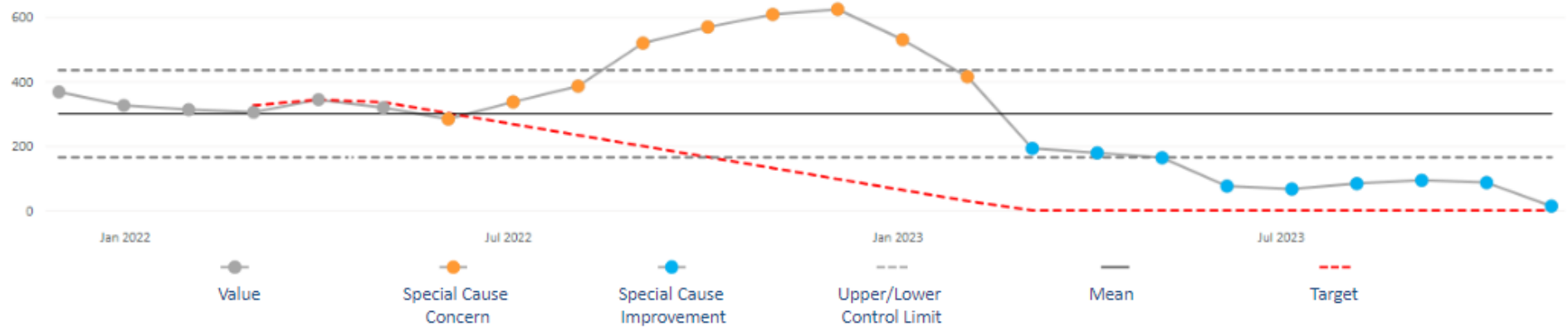
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3 are near the upper or lower control limit. The target can be either static or moving.

Icon Descriptions

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

			
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	25th November 2026
Subject:	Patient & Public Engagement
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

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☐ To create a great place to work, learn and thrive.
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Board Assurance Framework

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☐ Partnerships
☐ Transformative Services
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☐ Financial Balance
☒ Effective Governance

Equality Impact Assessment Concluded
(please document in report)

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The attached paper sets out broad proposals for new arrangements to strengthen patient and public involvement in the event of legislation being passed by Parliament that will remove the powers of Councils of Governors. The proposals add to the wide variety of existing arrangements.
The proposals have been informed by the discussion that took place at the joint Board/ Council of Governors meeting in September and a subsequent meeting of a joint task and finish group.

Recommendation:
The Board is requested to consider the proposals and whether they form an acceptable and appropriate basis for further work to develop operational arrangements and report back to the Board in January 2027.

Report History
Draft circulated to members of the task & finish group for comment. This version takes into account minor suggested amendments.

Meeting/Engagement	Date	Outcome/Recommendation

York and Scarborough Teaching Hospitals NHS Foundation Trust

Proposals for Enhancing Patient and Public Engagement if Councils of Governors Cease

Introduction

1. If the NHS legislation going through Parliament is enacted, it will result in Councils of Governors losing all its legal powers from April 2027 and requires NHS Foundation Trusts to establish new dynamic arrangements for patient and public engagement.

2. At a joint Trust Board and Council of Governors meeting held in September a wide-ranging discussion took place where various ideas and suggested principles and arrangements were shared. In October a joint task and finish group meeting was held to consider and refine those ideas and suggestions held that took place in October and agree a "position paper" for consideration by the Trust Board in November and Council of Governors in December to seek their views on the proposals developed by the task and finish group to date providing the basis for further work.

Principles

3. The new arrangements:

- must not duplicate or undermine the wide range of existing patient and public engagement activities and arrangements. A list of those is attached as annex1.
- should be locality based.
- should be open to anyone to attend
- should cover the performance and plans of the Trust as a whole and have a locality focus
- must be consistent with the five characteristics of good effective engagement:

  - ❖ Proactive: anticipates need and looks for issues before they emerge.
  - ❖ Representative: insight reflects the diversity of the local population and addresses inequalities.
  - ❖ Tangible: can demonstrate that local voice informs service improvement, left shift and digital transformation.

- ❖ Proportionate: uses public/staff/stakeholder insight in areas of greatest relevance.
- ❖ Dynamic: flexible and responsive in a timely fashion.

Suggested arrangements

4. Patient & Public Engagement (PPE) meetings take place in 5 localities: Bridlington & East Riding, Ryedale, Scarborough/Whitby, Selby, and York.

5. Meetings to take place twice a year in each locality.

6. To be open to any member of the public and patient to attend as well as community groups, local Councillors etc.

7. To be attended by a minimum of two members of the Trust Board, usually the Trust Chair and an Executive Director.

8. To build on the format that the Trust has adopted for the past 3 years with the annual Locality based Members Constituency meetings.

9. Issues arising at those meetings would usually be channelled to the appropriate Trust committee, but depending on the seriousness of the issue could be raised to the Board directly by the Board members who attended the meeting.

10. Given that existing Members of the Trust are implicitly interested in the work of the Trust to request their permission that they remain on our database so that they can be invited to the PPE meetings.

11. In addition, that awareness of the meetings is raised via social media, our website and press releases etc.

Staff

12. To date no discussion has taken place regarding what alternative arrangements, if any, should be established about the role of Staff Governors in the event of Councils of Governors ceasing.

13. Now that we have the Trust's new Chief Culture & People Officer in post consideration should be given to this issue.

Next Steps

14. For the Board and Council of Governors to consider and provide feedback on the proposals set out above.

15. Task and Finish Group to reconvene to develop operational arrangements to make whatever proposals are agreed a reality

16. To consider whether to retain the Council of Governors for a few months until the new arrangements can be enacted.

17. To consider having a panel of lay people from which a person would be part of the selection process for new NEDs and Executive Directors.

Martin Barkley

11th November 2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	25 November 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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

This report provides an update on CQC inspection activity, regulatory oversight and engagement.
Quarterly regulatory breach updates continue to be presented to the Trust Executive Committee and shared with the CQC.
Following the application to remove the Section 31 conditions relating to Emergency Department care for patients with mental health needs, additional evidence on risk assessment audits and the Mental Health Practitioner role is being collated for submission on 10 November 2026.

As at 30 October 2026, there were 12 open CQC cases; responses had been submitted for five, with CQC feedback awaited, and one further case had been partially responded to.
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.

2. CQC Activity - Ongoing

Inspection	Date inspected	Report	Rating
Scarborough Hospital Urgent and Emergency Care and Medical Care	October 2025	Report published 20 March 2026.	Urgent and Emergency Care: **Requires Improvement** Medical Care: **Good**
York Hospital Urgent and Emergency Care and Medical Care	January 2025	Report published 2 July 2025	Urgent and Emergency Care: **Requires Improvement** Medical Care: **Requires Improvement**
York and Scarborough Hospitals Maternity services	April 2026	Reports published 3 September 2026; York report; Scarborough report.	**Good**
Easingwold Renal Unit	May 2026	Report published 10 September 2026	**Good**
York Hospital Breast Screening Programme: Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)	June 2026	IRMER reports are not published. No enforcement action, three recommendations.	IRMER reports are not given a rating

Quarterly updates on all identified regulatory breaches are presented to the Trust Executive Committee and shared with the Care Quality Commission for routine monitoring and engagement.

2.1 Section 31: Care and Assessment of Patients with Mental Health Needs in the Emergency Department

Following the application to remove conditions, additional evidence on Emergency Department mental health risk assessment audits and the Mental Health Practitioner role is being collated for submission to the CQC on 10 November 2026.

3 Ongoing CQC Engagement

Quarterly engagement meetings are planned with CQC colleagues.

An on-site Surgery visit took place on 20 October 2026, focused on the fractured neck of femur pathway. Colleagues from the Surgery Care Group provided an update on the pathway, followed by a visit to Ward 39.

An engagement meeting was held on the same day, covering updates on Urgent and Emergency Care and the introduction of Nervecentre. The next Engagement is planned for 27 January 2027.

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 30th October 2026, there are 12 open CQC cases. Five cases have had responses submitted, and we are awaiting feedback from the CQC. One further case has been partly responded to.

5 CQC Updates / Inspections

5.1 Recent Inspections

Scarborough NHS Dialysis Unit, run by Fresenius Medical Care Renal Services Limited – Inadequate, published on 28 October 2026.

Background

The Scarborough dialysis service is delivered by Fresenius Medical Care under contractual arrangements held and managed by Humber Health Partnership/Hull University Teaching Hospitals. The unit is on the Scarborough Hospital site.

York and Scarborough Teaching Hospitals NHS Foundation Trust does not commission or directly provide the dialysis service. Under an SLA arrangement, Hull commissions consultant medical input from the Trust, meaning that Trust renal clinicians retain medical responsibility for patients while Fresenius employs the staff delivering dialysis and is responsible for the operational and technical aspects of the service.

The CQC has rated the service as Inadequate for being safe, effective and well-led. Responsive and caring are rated as requires improvement. Furthermore, the service has been placed in special measures and will be kept under close review to keep people safe and will be monitored to check sufficient improvements have been made.

The CQC have outlined that inspectors saw patients experiencing delays getting treatment and sometimes delays in being disconnected from dialysis machines.

Patients had advised that this was a regular occurrence which had been escalated to managers several times, but no action had been taken to prevent this from happening again. Inspectors brought this to the immediate attention of leaders and took enforcement action to ensure immediate improvements were made.

It was also identified that leaders had failed to ensure the service was clean. They found that the environment was visibly dirty, with broken flooring and examples of contamination which increased the risk of infection. The CQC further advised that they expect rapid improvements and will continue to monitor the service closely to keep people safe during this time.

Inspectors found:

- Leaders did not ensure lessons were learned from incidents.
- The environment was not always safe. For example, clinical areas were cluttered, restricting movement around the service and reducing staff ability to supervise people properly.
- Leaders did not ensure there were always enough qualified, skilled and experienced staff available to meet people's needs.
- Leaders were unable to access or provide assurance regarding staff training records or competency assessments.
- Staff did not ensure people received their medications safely.

The report can be found here: ***Scarborough NHS Dialysis Unit***

Well Led Inspection - Epsom and St Helier University Hospitals NHS Trust -Requires Improvement, published 22 October 2026.

The CQC outlined that during their inspection they found shortfalls in safety management and ensuring a consistent standard of care and strategic focus across its sites. The report outlined that the trust had inconsistent management structures and weaknesses in the timely management of safety risks, alongside ongoing concerns about staff experience, bullying and harassment, and workforce disparities. However, positive work included strong partnership working and information sharing, contributing to shorter waiting times and fewer hospital admissions, with improvement plans in place to address the concerns identified.

Key points found by inspectors included:

- The trust had embedded environmental sustainability within quality improvement and clinical transformation.
- The trust had introduced a health equity dashboard to identify and address inequalities.
- The trust had improved complaints management, with complaints reducing by 5%, although responses to staff concerns remained an issue.
- The trust had strengthened continuous improvement, although incident learning and feedback were not consistently shared.
- The trust had invested significantly in digital systems, although further staff training and information access improvements were needed.
- The trust had continued to manage ageing estate risks, which affected care, particularly in the emergency department.

The report can be found here: ***Epsom and St Helier University Hospitals NHS Trust***

Well Led Inspection - East Suffolk and North Essex NHS Foundation Trust – Requires Improvement, published 16 October 2026

The CQC have advised that they found that leaders understood the challenges facing their services, but they were not always quick enough to turn that understanding into action, putting people's safety at risk. Warning notices had been issued after identifying significant risks to people's safety, but the actions undertaken had not gone far enough to reduce the risk of avoidable harm to the people in their care.

Key findings from inspectors included:

- The trust had unclear accountability and management arrangements, resulting in weak oversight and decision-making.
- The trust had inconsistent audit and management systems, limiting sustained improvement and creating potential safety risks.
- The trust had strong partnership arrangements, but these did not always deliver timely and effective care, particularly for people with mental health needs.
- The trust had promoted openness and transparency, although staff experiences were inconsistent.
- The trust had inconsistent approaches to continuous learning and innovation, including improving equity of care and outcomes.
- The trust understood their duty of collaborate and was an active partner.
- The trust had taken steps to improve environmental sustainability and reduce its carbon footprint.

The report can be found here: ***East Suffolk and North Essex NHS Foundation Trust***

5.2 Updates from the CQC

The state of health care and adult social care in England 2025/26

On Friday 23 October 2026 the CQC published this year's State of Care, their annual assessment of health and social care in England. This involved a launch event which can be watched on YouTube at this link: State of Care 2025/26.

The full document can be found here: ***State of Care - Care Quality Commission***

The CQC have advised that their 2025/26 report presents a mixed picture across health and adult social care services in England. It is reported that the demand on health and adult social care services in England continues to grow and, in some areas, including community mental health services, people who need care have increasingly complex or advanced needs. They have seen improvements in how the system responds to demand, for example, a better experience of contacting GPs, benefits of digital solutions, and shorter waits for elective care.

Furthermore, increasing demand is outpacing improvements in care, with persistent inequalities, particularly in deprived areas. Key concerns include longer waits for children and young people, workforce shortages across primary, community and social care, delayed hospital discharges, and challenges in shifting care towards community and prevention.

IR(ME)R annual report 2025/26

The CQC have published their annual report looking at their work to enforce the Ionising Radiation (Medical Exposure) Regulations 2017 - IR(ME)R. The report can be found here: ***Report: IR(ME)R annual report 2025/26***

The report presents an overview of the statutory notifications received in 2025/26 and summarises the key findings from our inspection and enforcement activity during the year.

In 2025/26, the CQC received 996 notifications relating to significant accidental and unintended exposures, compared with 842 notifications in 2024/25. The increase was reported to reflect rising demand for services, increasing complexity of patient pathways and technologies, and continued positive engagement with reporting incidents and learning processes.

For the first time they have also included a national analysis of the outcomes of 1,220 investigations by providers following significant accidental and unintended exposures and the corrective measures they identified. This important analysis provides a baseline for comparing future investigations and helps employers to translate learning from incidents into practical improvement activity.

Date: 2 November 2026

Report to:	Trust Board of Directors
Date of Meeting:	25 November 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 ☐

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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, performance and improvement activity for September/October 2026, including October workforce, unit diverts and homebirth provision. It describes areas of assurance, alongside delivery risks and the actions underway to address them. Daily incident monitoring, weekly triage monitoring and maternity and neonatal governance provide ongoing oversight; improvement work remains in progress and assurance is

qualified where evidence is incomplete. The Perinatal Quality Oversight Model supports monthly Board reporting and quarterly reporting to NHS England. The November 2026 national return is presented separately as an appendix to the Board papers.

Key Assurance

- No neonatal deaths were reported in October 2026, including babies born at York or Scarborough and subsequently transferred elsewhere. No MOSS safety signals have been reported since January 2025. Five perinatal mortality reviews were completed in October; all parents were informed and their views sought. All five reviews were published within seven months, four within six months. There were no new MNSI referrals in October; one investigation remains ongoing.
- Recruitment continues following the April 2026 workforce investment. An additional 4% headroom was added in October, increasing the establishment by 5.50 WTE, with a further 7.00 WTE due to commence in February 2027. This supports the planned strengthening of service resilience, although the benefits depend on staff taking up post. Appointed recruits who have not yet started are excluded from reported workforce figures.
- MIS Year 8 safety actions are reported as in progress and on track, with a neonatal medical staffing compliance risk being assessed as outlined below. Training is reported as on track against the minimum 90% requirement at the first checkpoint. Outstanding staff are booked to attend, with monthly training opportunities across both sites. The final November training position will be reported to the Board in January 2027.
- Saving Babies' Lives Care Bundle compliance is reported at 87% overall. Fetal growth restriction, reduced fetal movement and fetal monitoring in labour are each self-assessed as fully implemented. The remaining delivery priorities are identified, with a completed quality impact assessment and a draft cross-care-group business case progressing.
- The new triage telephone system is live, in time to be confirmed this will enable access monitoring, call recording and oversight of response times. Assessment and waiting times are monitored weekly. A dedicated triage OPEL score and action plans addressing partial compliance with the national specification are being developed. These measures strengthen monitoring and escalation arrangements; further evidence is needed to demonstrate sustained improvement in timely assessment.

Key Risks

- Maternal Care Bundle implementation is reported at 7%, and delivery by March 2027 remains at risk. The action plan identifies dependencies on digital developments and system suppliers, and the absence of a dedicated obstetric physician as an epilepsy-related constraint. National MEWS implementation is progressing following an MDT walk-through, and specialist support is available through the Maternal Medicine Network. These arrangements support ongoing delivery and specialist input, but do not yet remove the implementation risk.
- The remaining Saving Babies' Lives Care Bundle priorities are the in-house maternity tobacco dependency service, audit and monitoring of preterm birth pathways and multidisciplinary clinic capacity, and the pre-existing diabetes service model. A quality impact assessment is complete and a cross-care-group business case is progressing in draft. Midwifery specialist and diabetes specialist nurse capacity risks are recorded on the risk register, supporting visibility and ongoing management of the outstanding constraints.
- The identified MIS Year 8 compliance risk relates to neonatal medical staffing. The medical staffing position and plan are being benchmarked against the

required standard, with the risk retained until the position and mitigations are confirmed. The report states that a clear plan for a fully funded neonatal nursing and medical establishment aligned with relevant BAPM standards is required before submission, rather than full medical staffing compliance. The service expects the plan to be in place before submission; assurance remains conditional on its confirmation.

Key Concerns

- Service resilience remains a focus while recruitment is completed. There were four diverts in October: three at Scarborough, affecting no women, and one at York, affecting three women. All affected women were followed up to confirm outcomes and appropriate ongoing care plans. Recruitment is progressing, but staffing gaps and redeployment from triage to other clinical areas continue to affect timely assessment.
- Timely triage assessment requires continued attention. Women not assessed by a midwife within 15 minutes increased to 5.5% at Scarborough, from 2.2%, and to 10.1% at York, from 6.6%. Medical attendance times at York in September were recorded for only 177 of 731 attendances (24.2%); among recorded cases, 6.2% waited over four hours and one person self-discharged following an extended wait. Missing times do not establish delays, but limit service-wide assurance. Weekly monitoring, consistent recording and repeat audit are the stated priorities for assessing performance and demonstrating improvement.
- There were 26 incidents classified as Moderate Harm or Severe Harm/Death in October, compared with a mean of 19.3 over the previous seven months. Seven NICE Safer Staffing Red Flags were reported: six at Scarborough and one at York, involving delays to ARM, induction of labour, elective caesarean sections or a time-critical action. Incidents are monitored daily, Monday to Friday, by the Quality and Governance Team, Ward Managers and Matrons. This provides ongoing oversight of reported concerns; the increased incident position remains an area for continued scrutiny.
- Perinatal mortality learning focuses on resuscitation, stabilisation, airway management and family engagement. An ongoing thematic review will identify recurring issues and proposed improvement priorities, with intended governance arrangements including named leads, timescales and measurable outcomes for agreed actions. These are not yet completed improvements and do not establish that care contributed to a death. Actions have been taken in response to the concluded MNSI report's recommendation on testing general anaesthetic equipment and prompts on triage call documentation and neonatal resuscitation equipment availability; the report does not yet provide evidence of their effectiveness.
- Following Board agreement, the Single Improvement Plan remains paused, with oversight focused on the 10-Point Plan, Saving Babies' Lives Care Bundle version 3.2, the Maternal Care Bundle, MIS Year 8 and Thirwall Inquiry immediate actions. The 10-Point Plan is reported as 54% compliant overall, with partially compliant areas progressing. The next position statement is planned for December Quality Committee and Board Development Workshop review, and a progress update is due to NHS England on 31 December 2026. The Board is asked to formalise joint accountability for maternity and neonatal services and support Clinical Director attendance and contribution alongside the Director of Midwifery.

Recommendation:
The Board is asked to receive the updates from the Maternity and Neonatal Service.

The Trust board is requested to establish clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility, documenting this within approved Board terms of reference, a role/accountability statement or Board paper explicitly confirming joint responsibility and delegated authority via the Maternity and Neonatal Assurance Group.

The Trust board is also asked to support Clinical Directors for maternity and neonatal services attendance at future Board meetings alongside the Director of Midwifery and that this attendance and active contribution is evidenced within Board minutes consistently.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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 (November 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 September/October 2026, and data for October 2026 for workforce, unit diverts and homebirth service provision.

Annex 1 provides the current delivery position for the service against the core national safety metrics.

Perinatal Quality Oversight Model

The introduction of the Perinatal Quality Oversight Model (PQOM) provides enhanced oversight of key performance indicators, patient outcomes, safety concerns, and improvement actions, enabling earlier identification of risks and more robust escalation processes. In line with PQOM, the Service is required to report the information outlined in the data measures monthly to the Trust Board and to NHS England quarterly (a national return was submitted to NHSE in November 2026 and is presented as an appendix to the Board Papers rather than reproduced in this report since it covers many of the same areas.

Perinatal Deaths

There were no Trust reported neonatal deaths in October 2026. There were no neonatal deaths in October 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 five completed Trust reviews of perinatal deaths undertaken at the perinatal mortality meeting in October 2026.

- Three cases at Scarborough and two at York.
- All parents were informed and their views sought.
- All five reviews were published within seven months, four within six months.
- Median gestation was 26 weeks (range 23–39); birthweights ranged from 500g to 3,780g.
- External reviewers were involved in four out of five cases (80%).

Learning focuses on neonatal resuscitation, stabilisation, airway management and family engagement during resuscitation incidents. These themes do not imply concerns in every case or that care contributed to a death.

An ongoing thematic review (additional paper) brings together finding and families' experiences to identify recurring issues and proposed improvement priorities in resuscitation, stabilisation, airway management, and family communication and support. These priorities are not completed improvements. For agreed actions, the intended governance arrangements comprise named leads, timescales and measurable outcomes, with monitoring through maternity and neonatal governance.

Good practice was identified in CTG analysis, escalation and MDT communication. The thematic review will consider how to share and sustain this practice, without implying assurance about all care in every case.

Maternity and Newborn Safety Investigations (MNSI)

There were no cases referred to MNSI in October 2026. There is currently one ongoing MNSI case being investigated.

A concluded MNSI report has been received. There was one safety recommendation in relation to testing of general anaesthetic equipment and two safety prompts regarding triage call documentation and availability of neonatal resuscitation equipment. Actions have been taken against each of these recommendations.

Moderate Harm Incidents and above

There were 26 incidents classified as Moderate Harm or Severe Harm/Death during October, representing a sustained increase compared with a mean of 19.3 over the previous seven months. Daily monitoring of the incidents takes place Monday to Friday by the Quality and Governance Team, Ward Managers and Matrons.

Red flags

During October 2026, seven reports in the maternity and neonatal incident extract were classified as NICE Safer Staffing Red Flags. Six related to Scarborough (85.7%) and one to York (14.3%).

The most common category was a delay of more than 24 hours in artificial rupture of membranes (ARM), accounting for three reports (42.9%). Two reports involved elective caesarean sections postponed until the following day (28.6%). One report involved induction of labour delayed by more than 24 hours, and one involved the delay or cancellation of a time-critical action (14.3% each). The six Scarborough reports related to delays in ARM, induction of labour or elective caesarean sections; the York report related to a time-critical action.

TOTAL REPORTED RED FLAGS	SCARBOROUGH	YORK
7	6	1

Reported red-flag category	No.	% of reports	Rank
Delay in artificial rupture of membranes (ARM) of more than 24 hours	3	42.9%	1
Elective caesarean section delayed until next day	2	28.6%	2
Induction of labour delayed more than 24 hours	1	14.3%	3=
Delay or cancellation of a time-critical action	1	14.3%	3=

Seven distinct incident reports. Percentages use the supplied reports as the denominator.

Site	No.	%
Scarborough	6	85.7%
York	1	14.3%



Maternity Unit diverts/ closures and suspension of services

In October, there were four diverts in total; three from Scarborough and one from York. In the Scarborough diverts no women were impacted. 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.

Provision of the homebirth service is shown in the table below:

October 2026	East Coast	York and Selby
24hrs Homebirth Service Partial night cover either Team A or Team B Day service	0 12 18	4 6 14
Homebirth	0	2
Attendances at home in labour and transfer in (with reason)	0	0
Homebirths not supported due to staffing	0	3
Attended by independent midwives	0	0
Born Before Arrival (booked homebirth only)	0	1
Free Labour/Birth due to Homebirth services not available	0	0

Triage Audit Compliance

Triage assessment and wait times are monitored weekly. 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, strengthen documentation through call recording capabilities and enable oversight of call response times.

Action plans are being developed to address areas of partial compliance against the benchmarking exercise that has taken place using the new National Maternity Triage Specification and NHS England assessment tool.

Women not seen within 15 minutes of arrival by the midwife at SGH have increased to 5.5% from 2.2% on the previous month, and to 10.1% from 6.6% at York. This is due to full staffing investment not fully in place due to ongoing recruitment and awaiting new starters to commence in post. In addition, there has been an increase in activity of 54 attendances

on previous month at York. Midwives have been redeployed from triage to support other clinical areas resulting in the increased delays from admission to assessment.

The Board can take limited assurance regarding the timeliness of medical review at York in September 2026. Medical practitioner attendance times were documented for only 177 of 731 attendances (24.2%), preventing a reliable assessment of performance across the service. Among the recorded cases, 51% had a reported wait of less than one hour, 6.2% waited over four hours, and one person self-discharged due to an extended wait for review. These findings warrant attention with further improvements required to show medical attendance times against required screening for urgency of assessment.

Missing attendance times do not, in themselves, establish that care was delayed. However, the incomplete evidence prevents stronger assurance about timely medical review. Improvement actions will prioritise consistent recording of medical practitioner attendance times, followed by repeat audit and reporting of data completeness alongside waiting-time performance.

Midwifery Workforce

The midwifery and maternity support worker 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. A negative figure shows an over-establishment to the current budget.

October 2026 Band 6 to 3 midwifery vacancy and recruitment position:

	Band 5/6		Band 3/4	
	York	Scarborough	York	Scarborough
Establishment budget	**114.82**	**63.69**	**30.64**	**13.73**
Staff in post	121.42	53.14	22.64	18.22
Substantive Vacancy	-6.60	10.55	8.00	-4.49
Maternity Leave	3.96	3.32	0.59	1.00
Recruitment vacancy	-2.64	13.87	8.59	-3.49
Supernumerary	6.83	4.37	0.00	0.30
Sickness	9.36	1.96	2.06	1.46
Roster vacancy	**13.56**	**20.21**	**10.65**	**-1.72**

An additional 4% headroom has been added in October, which has increased the establishment by 5.50 WTE. These figures do not include recruits who are appointed but yet to commence in post. 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 October 2026. A final November 2026 position will be reported in January 2027 to the Board. This demonstrates strong assurance around MIS training requirements.

Fetal Monitoring

Staff Group	Oct-26
Midwives (194)	92% (179/194)
Obstetric Consultants/SAS Doctors (17)	94% (16/17)
Obstetric Tier 2 (Reg/ST) (7)	100% (7/7)

MDT Emergency Training

Staff Group	Oct-26
Midwives (194)	96% (186/194)
Obstetric Consultants/SAS Doctors (17)	100% (17/17)
Obstetric Tier 2 (Reg/ST) (7)	100% (7/7)
Obstetric Tier 1 (F2/GP Trainees/SHO) (1)	100% (1/1)
Anaesthetic Consultants/ SAS Doctors (16)	94% (15/16)
Obstetric Anaesthetic Doctors (10)	90% (9/10)
MSWs (36)	89% (32/36)

Neonatal Resuscitation Training

Staff Group	Oct-26
Midwives (194)	92% (178/194)
Neonatal/Paediatric Consultants/SAS Doctors (11)	91% (10/11)
Neonatal Tier 2 (Resident Doctors who attend any births)	100% (11/11)
Neonatal Tier 1 (who attend any births)	100% (13/13)
Neonatal Nurses (Band 5+)	92% (28/30)

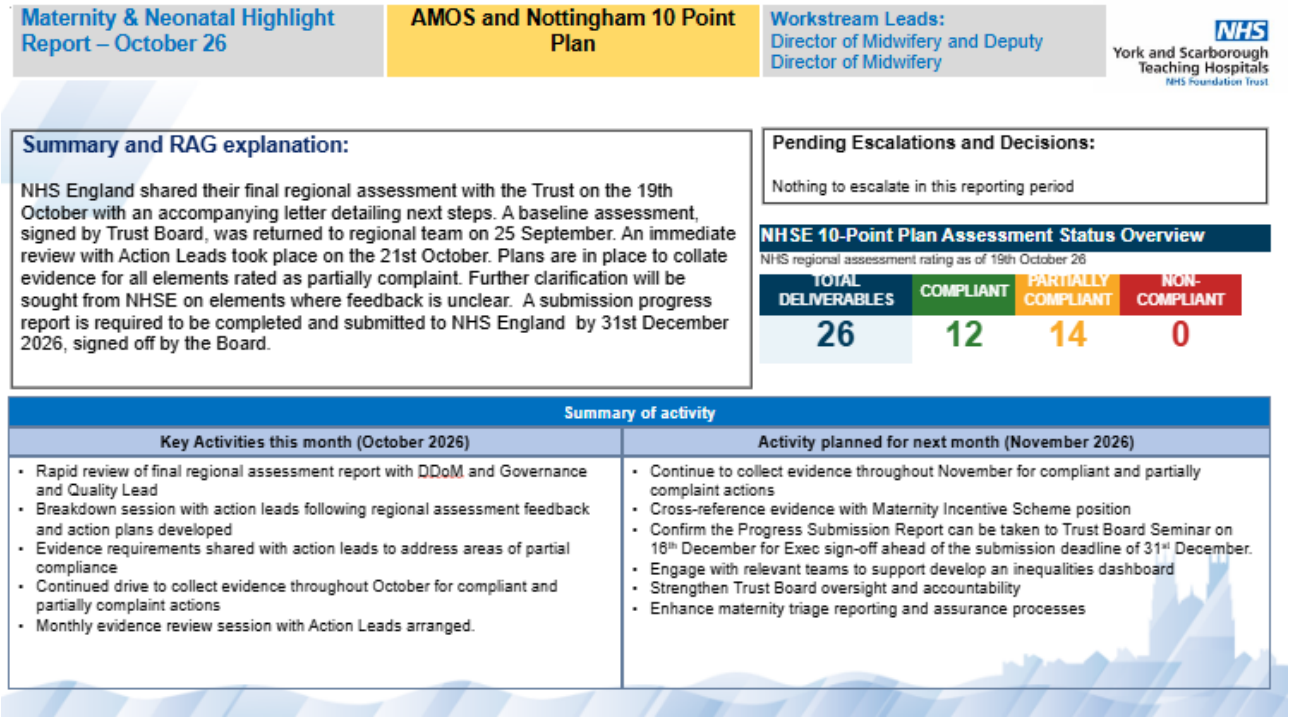
Improvement and Transformation

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
- Thirwall Inquiry immediate actions

10-point plan – 54% compliant overall. Feedback from NHSE regarding the September baseline position has been received and partially compliant areas are progressing. Dedicated time will be allocated to December Quality Committee to review the next position statement, prior to its review at the Board Development Workshop with agreement of the Board. Progress update due to NHS England on 31st December 2026.

The Trust board must establish clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility. This needs documenting within approved Board terms of reference, a role/accountability statement or Board paper explicitly confirming joint responsibility and delegated authority via the Maternity and Neonatal Assurance Group. Directors of Midwifery and Clinical Directors leading maternity and neonatal services must also attend boards and take part in discussions when maternity and neonatal matters are on the agenda. Agreement of the Board to invite the Clinical Directors for maternity and neonatal services alongside the Director of Midwifery must be demonstrated consistently and their attendance and active contribution evidenced within Board minutes.



Maternity & Neonatal Highlight Report – October 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

Summary and RAG explanation:

NHS England shared their final regional assessment with the Trust on the 19th October with an accompanying letter detailing next steps. A baseline assessment, signed by Trust Board, was returned to regional team on 25 September. An immediate review with Action Leads took place on the 21st October. Plans are in place to collate evidence for all elements rated as partially complaint. Further clarification will be sought from NHSE on elements where feedback is unclear. A submission progress report is required to be completed and submitted to NHS England by 31st December 2026, signed off by the Board.

Pending Escalations and Decisions:

Nothing to escalate in this reporting period

NHSE 10-Point Plan Assessment Status Overview

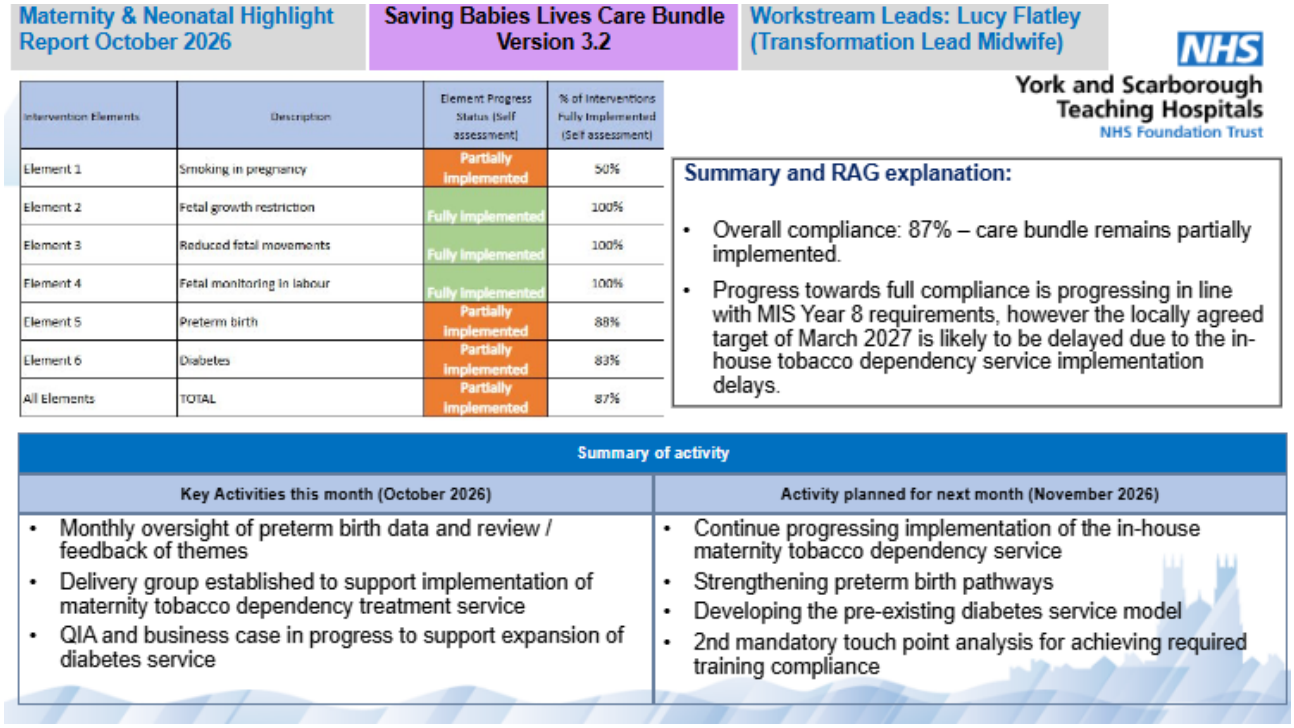
NHS regional assessment rating as of 19th October 26

TOTAL DELIVERABLES	COMPLIANT	PARTIALLY COMPLIANT	NON-COMPLIANT
26	12	14	0

Summary of activity

Key Activities this month (October 2026)	Activity planned for next month (November 2026)
• Rapid review of final regional assessment report with DDoM and Governance and Quality Lead • Breakdown session with action leads following regional assessment feedback and action plans developed • Evidence requirements shared with action leads to address areas of partial compliance • Continued drive to collect evidence throughout October for compliant and partially complaint actions • Monthly evidence review session with Action Leads arranged.	• Continue to collect evidence throughout November for compliant and partially complaint actions • Cross-reference evidence with Maternity Incentive Scheme position • Confirm the Progress Submission Report can be taken to Trust Board Seminar on 16th December for Exec sign-off ahead of the submission deadline of 31st December. • Engage with relevant teams to support develop an inequalities dashboard • Strengthen Trust Board oversight and accountability • Enhance maternity triage reporting and assurance processes

Paper attached on SBLCB Q2 progress update. Currently 87% compliant overall. Fetal growth restriction, reduced fetal movement and fetal monitoring in labour are each self-assessed as fully implemented (100%). Three main areas of focus continue around in house maternity tobacco dependency service, audit and monitoring of preterm birth pathways and multidisciplinary clinic capacity and the pre-existing diabetes service model. The quality impact assessment is complete, and a cross-care-group business case is in draft and progressing. Directorate is managing some additional challenges with midwifery specialist capacity and some new risk around DSN capacity alongside Medicine care group and the risk register has been updated to reflect this.



Maternity & Neonatal Highlight Report October 2026 | **Saving Babies Lives Care Bundle Version 3.2** | **Workstream Leads: Lucy Flatley (Transformation Lead Midwife)**

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

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	Fully Implemented	100%
Element 5	Preterm birth	Partially Implemented	88%
Element 6	Diabetes	Partially Implemented	83%
All Elements	TOTAL	Partially Implemented	87%

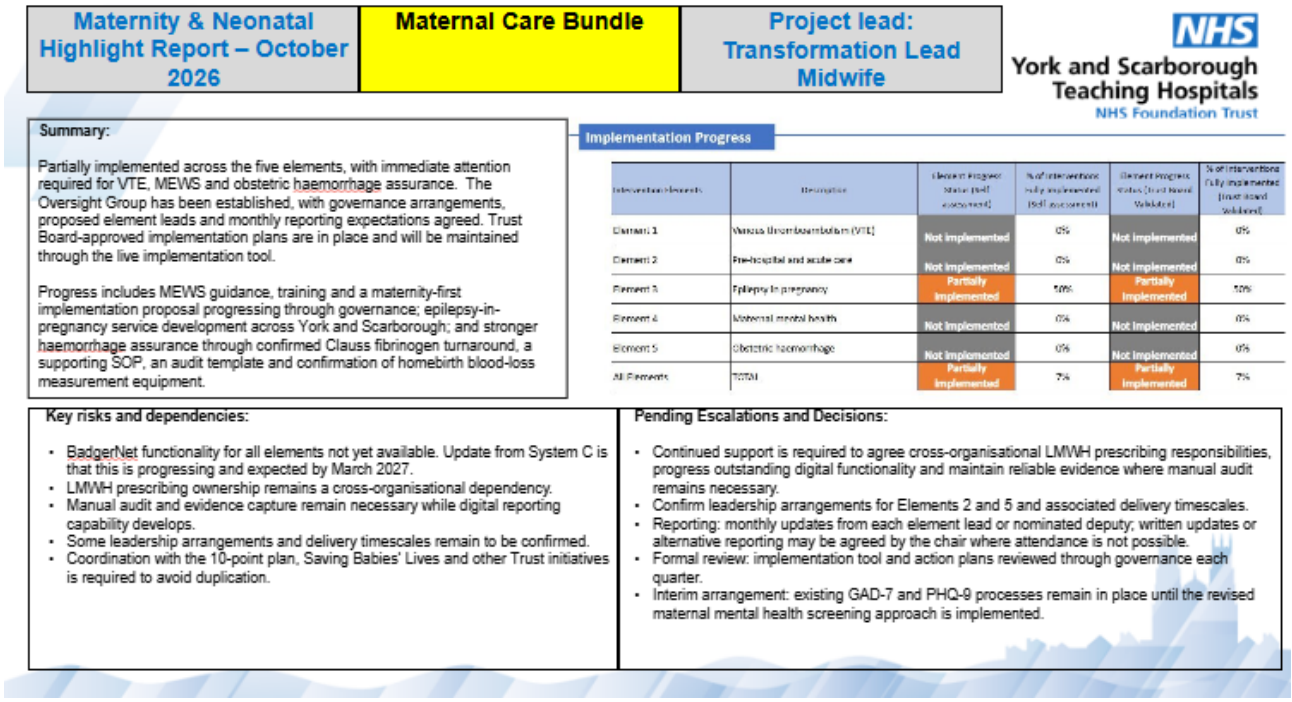
Summary and RAG explanation:

- Overall compliance: 87% – care bundle remains partially implemented.
- Progress towards full compliance is progressing in line with MIS Year 8 requirements, however the locally agreed target of March 2027 is likely to be delayed due to the in-house tobacco dependency service implementation delays.

Summary of activity

Key Activities this month (October 2026)	Activity planned for next month (November 2026)
• Monthly oversight of preterm birth data and review / feedback of themes • Delivery group established to support implementation of maternity tobacco dependency treatment service • QIA and business case in progress to support expansion of diabetes service	• Continue progressing implementation of the in-house maternity tobacco dependency service • Strengthening preterm birth pathways • Developing the pre-existing diabetes service model • 2nd mandatory touch point analysis for achieving required training compliance

Overall implementation at 7% recognising the MCB was only published in January 2026. Delivery by March 2027 is at risk. National MEWS implementation is progressing, and an MDT walk-through has taken place. Some elements at risk are reliant on digital developments and System Suppliers. The absence of a dedicated obstetric physician is an identified epilepsy constraint for the service. This forms part of the action plan and the small number of referrals are overseen via the Maternal Medicine Network for specialist support.



Maternity & Neonatal Highlight Report – October 2026 | **Maternal Care Bundle** | **Project lead: Transformation Lead Midwife**

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Summary:

Partially implemented across the five elements, with immediate attention required for VTE, MEWS and obstetric haemorrhage assurance. The Oversight Group has been established, with governance arrangements, proposed element leads and monthly reporting expectations agreed. Trust Board-approved implementation plans are in place and will be maintained through the live implementation tool.

Progress includes MEWS guidance, training and a maternity-first implementation proposal progressing through governance; epilepsy-in-pregnancy service development across York and Scarborough; and stronger haemorrhage assurance through confirmed Clauss fibrinogen turnaround, a supporting SOP, an audit template and confirmation of homebirth blood-loss measurement equipment.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented (Trust Board Validated)
Element 1	Venous thromboembolism (VTE)	Not Implemented	0%	Not Implemented	0%
Element 2	Pre-hospital and acute care	Not Implemented	0%	Not Implemented	0%
Element 3	Epilepsy in pregnancy	Partially Implemented	50%	Partially Implemented	50%
Element 4	Maternal mental health	Not Implemented	0%	Not Implemented	0%
Element 5	Obstetric haemorrhage	Not Implemented	0%	Not Implemented	0%
All Elements	TOTAL	Partially Implemented	7%	Partially Implemented	7%

Key risks and dependencies:

- BadgerNet functionality for all elements not yet available. Update from System C is that this is progressing and expected by March 2027.
- LMWH prescribing ownership remains a cross-organisational dependency.
- Manual audit and evidence capture remain necessary while digital reporting capability develops.
- Some leadership arrangements and delivery timescales remain to be confirmed.
- Coordination with the 10-point plan, Saving Babies' Lives and other Trust initiatives is required to avoid duplication.

Pending Escalations and Decisions:

- Continued support is required to agree cross-organisational LMWH prescribing responsibilities, progress outstanding digital functionality and maintain reliable evidence where manual audit remains necessary.
- Confirm leadership arrangements for Elements 2 and 5 and associated delivery timescales.
- Reporting: monthly updates from each element lead or nominated deputy; written updates or alternative reporting may be agreed by the chair where attendance is not possible.
- Formal review: implementation tool and action plans reviewed through governance each quarter.
- Interim arrangement: existing GAD-7 and PHQ-9 processes remain in place until the revised maternal mental health screening approach is implemented.

Maternity Incentive Scheme Year 8 has seen improved position with all safety actions in progress and on track. There is one compliance risk around neonatal medical staffing and we are currently benchmarking the medical staffing position and plan against the required

standard. As a caution this is marked as a risk until the position and mitigations are confirmed. MIS standards state that Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation, rather than demonstrate full medical staffing compliance, therefore this plan will be in place prior to submission and is not expected to remain a risk.

Maternity & Neonatal Highlight Report October 2026 | **Maternity Incentive Scheme Year 8** | Workstream Leads: Jamie Broadbent – Quality and Governance Lead

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Summary and RAG explanation:

Progress continues to be made.

- One additional element has been marked as "meets compliance" following confirmation that no short-term locums are employed across the service.
- One element has been marked as "compliance risk" due to non-compliance with neonatal BAPM medical staffing requirements at York. Engagement work with the relevant teams has commenced and a review of rota compliance will commence if required.

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	1	5	1	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
Total	0	1	24	2	0	27

Summary of activity

Key Activities this month (October 2026)	Activity planned for next month (November 2026)
• A review of the locally adapted MIS Y8 audit tool was complete; the tool has been adopted to support a robust governance process • Mid-point check-in review session scheduled • Further evidence review sessions scheduled • Work with named Leads to develop action plans to support an improved compliance position	• An evidence review with Leads to take place on 5th November • All Evidence Review meetings scheduled • Training compliance final assessment end November 2026 • Work with Operational teams to describe identified neonatal medical staffing gaps • Agreement Declaration Form will be taken through governance in February 27 in line with reporting requirements. • A full review of neonatal resuscitation compliance at Scarborough to commence • Neonatal pulse oximetry testing guideline to be drafted and ratified in December

Key Risks to Delivery of the Single Improvement Plan

The Single Improvement Plan continues to be paused. Some work continues outside of the 5 national requirements, particular the Perinatal Culture Programme and MNVP engagement work referred to in the attached papers.

Recommendations to Trust Board

To note the contents of this report

Date: November 2026

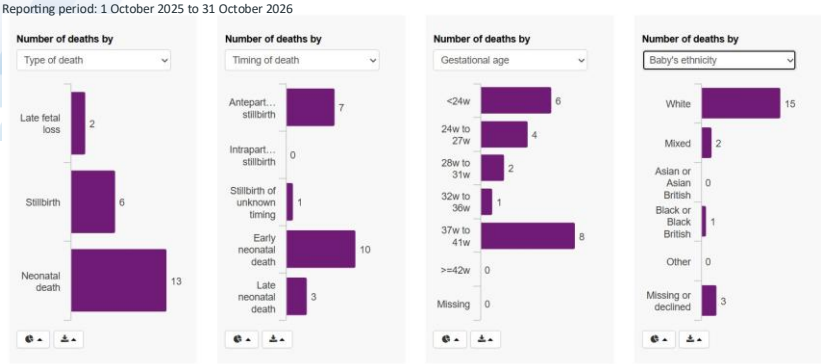
York and Scarborough Teaching Hospitals NHS Foundation Trust

Maternity Quality and Safety Metrics

(Local trust data is reported for September 2026; MBRRACE data – October 2026)

Perinatal Deaths – to 31 October 2026

Reporting period: 1 October 2025 to 31 October 2026



York and Scarborough Teaching Hospitals NHS Foundation Trust

Data: MBRRACE Register, National Perinatal Epidemiology Unit, University of Oxford

KEY MESSAGE

- Rolling 12 months - 21 deaths: 2 late fetal losses, 6 stillbirths and 13 neonatal deaths.
- No intrapartum stillbirths.
- The chart shows 13 preterm perinatal deaths and 8 term babies.
- Three deaths occurred outside the Trust following birth at YSTH.

ACTION

Continue work towards full implementation of Saving Babies Lives Care Bundle v3.2.

Continue monthly monitoring of perinatal deaths and the gestational-age breakdown.

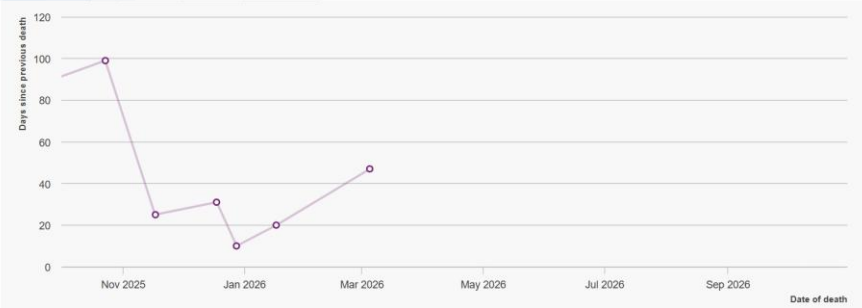
Review missing ethnicity data.

ASSURANCE

- No MOSS safety signals since January 2025.
- PMRT reviews and monthly Perinatal Mortality Meetings support case review. Eligible cases go to MNSI.
- Quarterly PMRT reports and action plans provide Directorate, CG and Private Trust Board oversight.

Stillbirths – October 2026

Reporting period: 1 October 2025 to 31 October 2026 (6 deaths)



NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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.

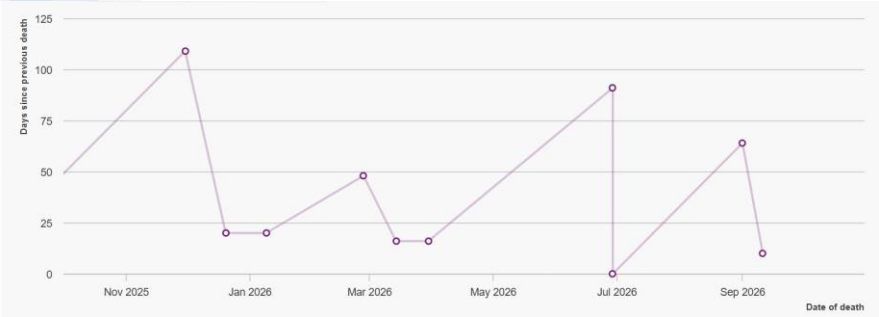
Continue routine monthly monitoring

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 – October 2026

Reporting period: 1 October 2025 to 31 October 2026 (10 deaths)



NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Data: MBRRACE Register, National Perinatal Epidemiology Unit, University of Oxford

KEY MESSAGE

- No neonatal deaths meeting MBRRACE-UK reporting criteria were recorded in October 2026. The chart shows 10 deaths from 1 October 2025 to 31 October 2026, with the most recent in September.

ACTION

Continue work towards full implementation of Saving Babies Lives Care Bundle v3.2.

Continue monthly monitoring of deaths and the intervals between them.

ASSURANCE

- All neonatal deaths undergo PMRT review at the monthly Perinatal Mortality Meeting, with MNSI referral where criteria apply.
- Quarterly PMRT reports and action plans provide oversight through the Directorate, CG Board and Private Trust Board.

Birth Mode Summary – York (September 2026)

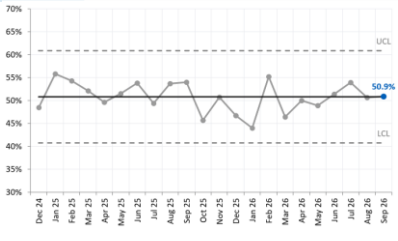
Birth mode measures | Main SPC charts

York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal Births

LATEST

50.9%



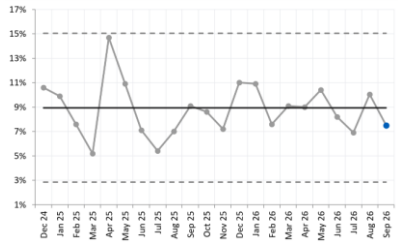
Mean 51.0

Within Expected Variation

Assisted Vaginal Births

LATEST

7.5%



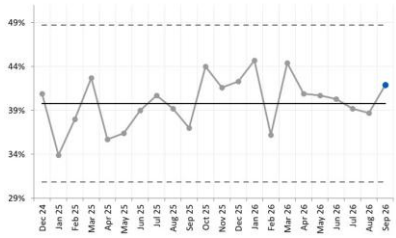
Mean 9.0%

Within Expected Variation

Caesarean Births

LATEST

41.9%



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 (September 2026)

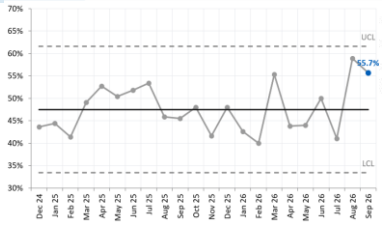
Birth mode measures | Main SPC charts

York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal Births

LATEST

55.7%



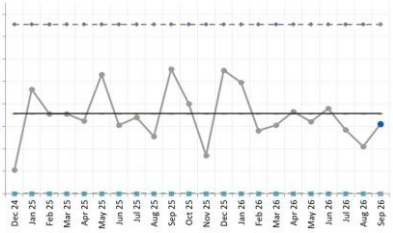
Mean 47.1%

Within Expected Variation

Assisted Vaginal Births

LATEST

6.2%



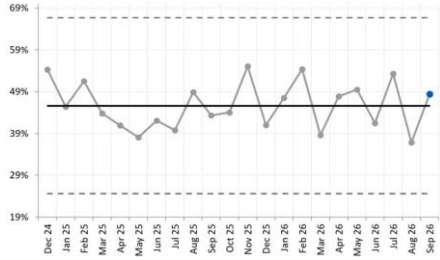
Mean 7.2%

Within Expected Variation

Caesarean Births

LATEST

48.5%



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

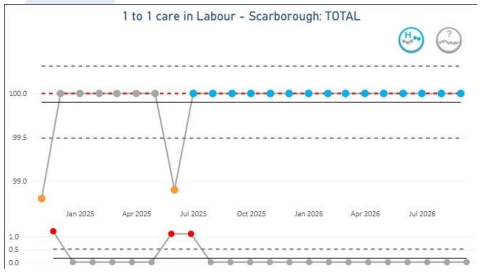
Local SPC indicates stable processes across the three birth mode measures. Continue to review national benchmarking alongside local performance.

1:1 Care in Labour – September 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust

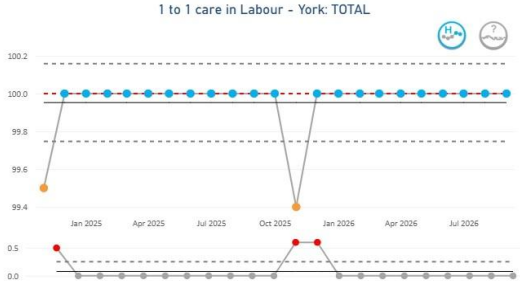
Scarborough

LATEST
100%



York

LATEST
100%



Data: Signal RCB DPI All Metrics V1.1 - Power BI

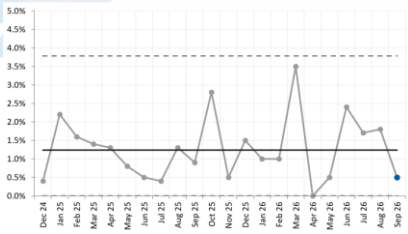
Summary:	Action:	Assurance:
Sustained special cause for improvement for 1:1 care in labour is seen across both sites.	Daily weekday huddles continue to monitor staff acuity and outcomes, alongside BirthRate + Acuity Tool. Specialist Midwives, Managers and Matrons are deployed to work clinically when 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 (September 2026)

Severe perineal trauma | Main SPC charts

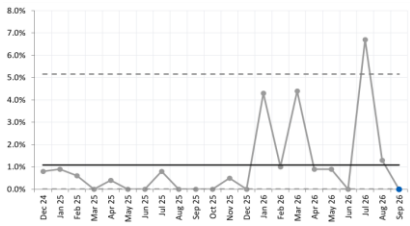
York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal births



LATEST
0.5%
Mean 1.2%

Assisted births



LATEST
0%
Mean 1.1%

KEY MESSAGE

Normal-birth tears remain within expected variation at 0.5%. Assisted-birth tears increased to 6.7% in July 2026, above the upper process limit and indicating special-cause concern. There were no reported 3rd and 4th degree tears in September.

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

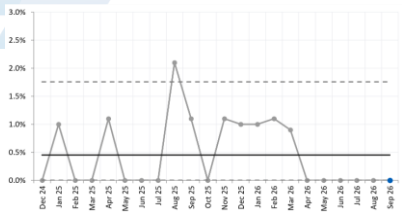
Normal-birth performance remains statistically stable. Existing case-review arrangements remain in place and continued monthly SPC monitoring determines the July assisted-birth result is isolated.

3rd/4th Degree Tears – Scarborough (September 2026)

Severe perineal trauma | Main SPC charts

York and Scarborough Teaching Hospitals NHS Foundation Trust

Normal births

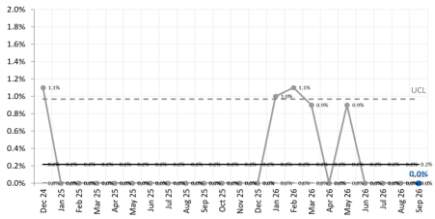


LATEST

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. The latest National Maternity Dashboard identifies trust rate of 24/1000 births, against a national and MBRACE rate of 27/1000 births, showing that the trust is not an outlier for 3rd/4th degree tears.

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.

PPH ≥1500mls (October 2026)

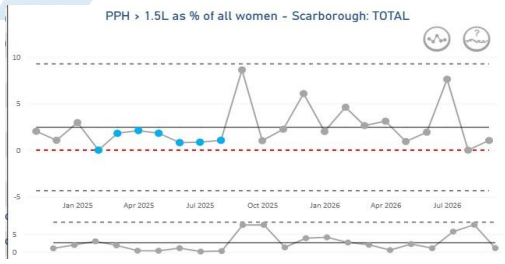
Postpartum haemorrhage over 1.5 litres | Main SPC charts

York and Scarborough Teaching Hospitals NHS Foundation Trust

Scarborough

LATEST

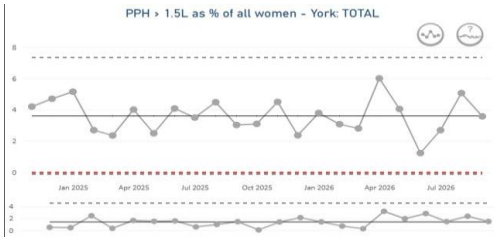
0.5%



York

LATEST

3.6%



Data: Intro - BI&REF 10192 - PPH insights dashboard - Power BI

KEY MESSAGE

Latest PPH >1500ml rates are within expected variation at both sites: 0.5% in Scarborough and .6% in York (4.6% cross site). Results are within expected limits overall with isolated variation.

ACTION

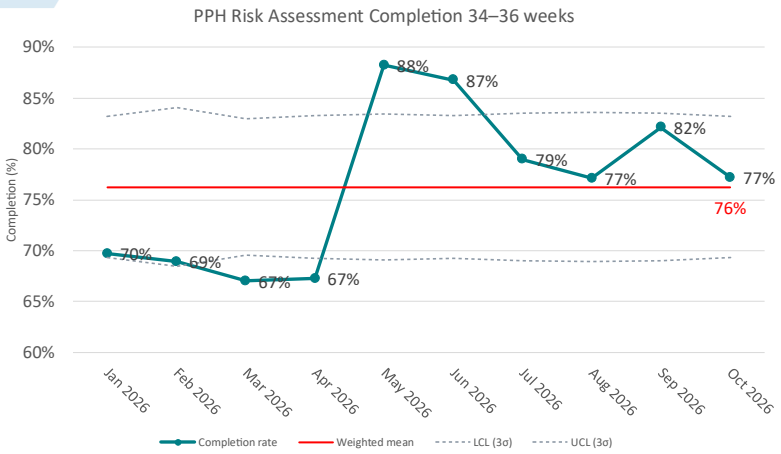
- Continue routine monthly monitoring and reporting
- Continue review of all PPH >1500ml cases
- Review if a further unusual pattern emerges

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 (October 2026)

York and Scarborough Teaching Hospitals NHS Foundation Trust



Overview:

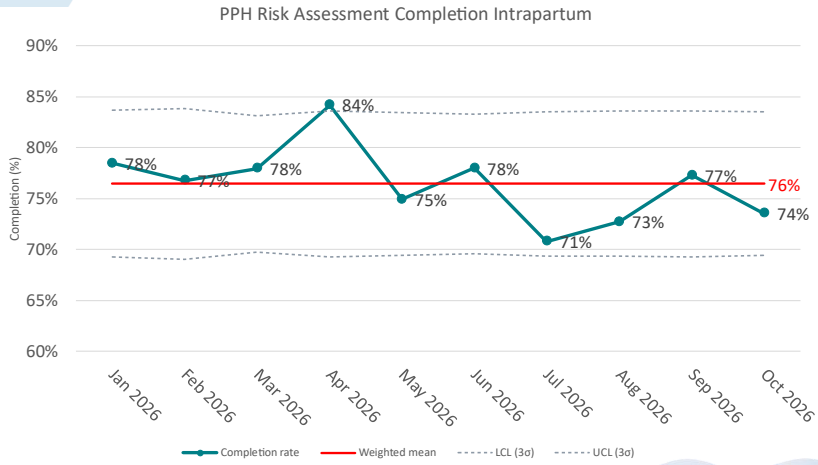
Since March 2026, team leaders have assessed compliance data monthly, identified themes and taken action to increase compliance.

Actions:

Weekly audits continue when acuity allows, with immediate actions and learning from themes fed back to staff.

PPH risk assessment compliance - Intrapartum (October 2026)

York and Scarborough Teaching Hospitals NHS Foundation Trust



Overview:

The LW Management team have been asked to monitor compliance rates for the intrapartum PPH Risk Assessment and identify improvements

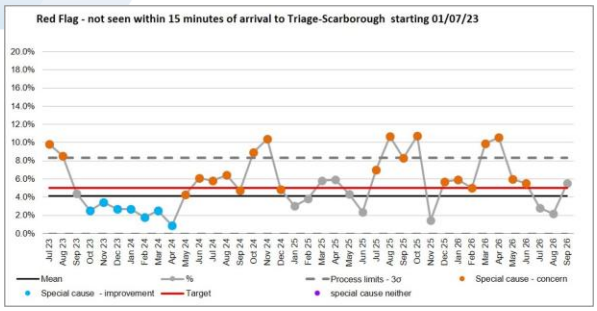
Actions:

This will be incorporated into the ward manager audits to maintain oversight, review themes and action plan any non-compliance

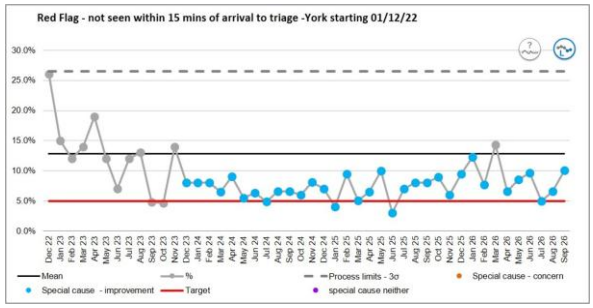
Maternity Triage (September 2026)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Scarborough



York



Summary:	Actions:	Assurance:
• Red Flags at SGH have increased to 5.5% from 2.2% on the previous month due to high vacancy rate. • Red Flags at York have increased to 10.1% from 6.6% - due to an increase in short term sickness and an increase in activity of 54 attendances on previous month.	• Considering the introduction of a Triage specific OPEL score to allow timely and appropriate escalation • Telephone line now upgraded • Benchmarking exercise has taken place to review and action new National Recommendations. - Action plan to follow • 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 (September 2026)

York and Scarborough Teaching Hospitals NHS Foundation Trust

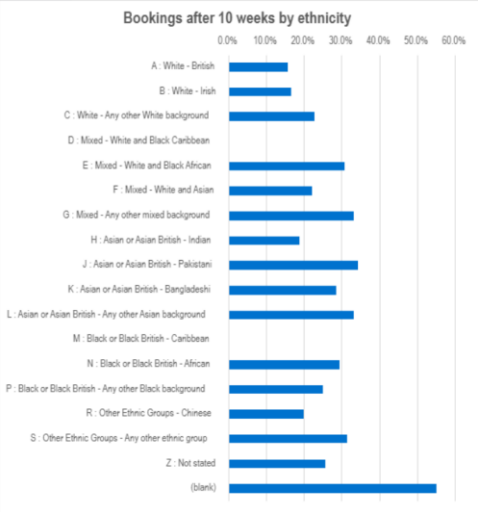
DR Wait times	August n (%)	September n (%)
< 1 hour	108 (52%)	90 (51%)
> 1 hour	52 (24.80%)	41 (23.10%)
> 2 hours	32 (15.30%)	25 (14.10%)
> 3 hours	10 (4.70%)	9 (5.08%)
> 4 hours	7 (3.30%)	11 (6.20%)
Self-discharged due to extended wait time for review	**N/A**	**1 (0.56%)**
Total recorded	**209**	**177**

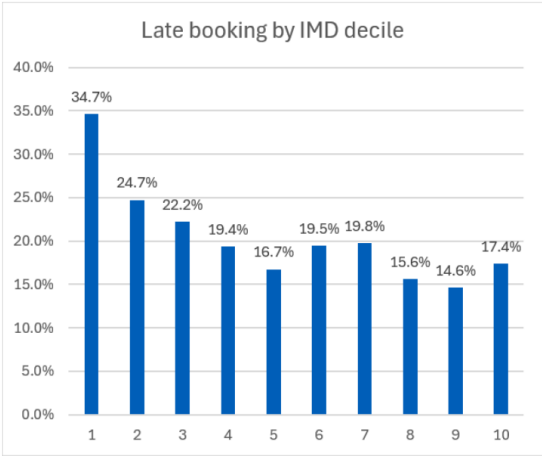
Lack of data means analysis difficult. Time documented on only 177 cases, where there were 731 attendances.

Maternity equity: timely booking

19.4% booked after 10 weeks (892 of 4,598 bookings)

The 2025 dashboard data reported that 78.4% of booking appointments at the Trust occurred within the first 10 weeks of pregnancy, compared with 64.8% for England.



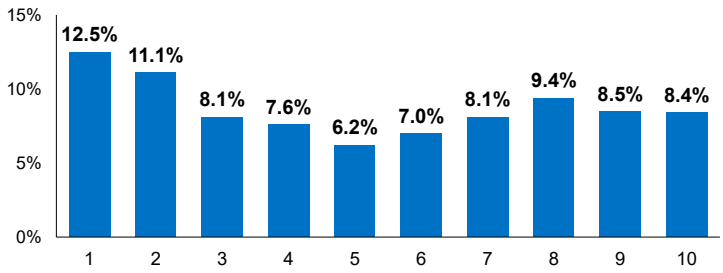


Both associations: p<0.001

Preterm birth: variation by deprivation

8.5% preterm births (330 of 3,884 deliveries)

Birth before 37 completed weeks, by IMD decile



IMD 1 = most deprived, IMD 10 = least deprived. P = 0.254

Source: Maternity Equity and Outcomes Paper, 26 October 2026 (Analysis: 1 Sep 2025 to 31 Aug 2026)

NEY Region: Sector-based Perinatal Quality Oversight Meetings

Trust Report

ICB: Humber & North Yorkshire

Trust name and site: YSTHFT

Quarter/months reporting on: Q2 2026-27

Name of person completing form:

Executive summary

Summarise key risks, good practice and recent improvements.. Highlight priority areas with significant impact on quality, safety, equity and experience.

Areas of Risk, Concern and good practice	Actions, learning and demonstrated impact
Medical assessment within 15 mins for Orange clinical urgency within Triage.	Sep: YH 34.8%, SGH 60.7%. Cover prioritised, OPEL planned.
York neonatal Tier 2 medical cover: overnight gap	Cover improved to 09:00–00:00. Overnight gap remains.
24-hour parental consultation: York alert, SGH alarm	Video calls at both sites. Audit to assess impact planned.
Quality Improvements	**Actions, learning and demonstrated impact**
PPH >1500 ml: 4.3% in July to 2.8% in September	MDT reviews, PPH risk-assessment QI and PROMPT learning.
Family contact and personalised care plans (PCP)	Named contact in place. Positive PCP feedback, review due.
ATAIN: 5.3%, rolling yearly rate 5.6%	Transitioning infant flowchart approved in October. Rollout in November 2026.
Escalations to Regional Maternity Team	**Actions, learning and demonstrated impact**
Regional priority: sustainable triage medical cover	Benchmarking complete. Further triage investment required.
Regional priority: neonatal staffing and transitional care	Staffing and transitional-care business cases in development.
Regional priority: York SCBU build delayed and isolation capacity	Return Jan/Feb 2027. Water checks and dedicated bay.

Perinatal quality overview

While the majority of PQOM minimum measures will be sourced from MSDS, Trust-validated figures are requested for a small number of selected metrics to ensure timely oversight of current performance.

Measure	Jul 2026	Aug 2026	Sep 2026	Rolling yearly rate	Trend/Insight	Actions & Impact
Triage – initial assessment with a midwife within 15 minutes (%)	96.8% (YH) / 98.5% (SGH)	95% (YH) / 97.2% (SGH)	89.4% (YH) / 94.9% (SGH)	90.3%(YH) / 93.7% (SGH)	Downward trend at both sites; YH below yearly rate.	Additional workforce investment into headroom, staffing numbers and leadership posts. Some posts recruited but not yet filled so further impact to improve is expected.
Triage – medical assessment for orange rated within 15 mins of midwifery initial assessment (%)	33.3%(YH) / 67.6% (SGH)	23.2% (YH) / 51.9%(SGH)	34.8% (YH) / 60.7% (SGH)	36.9%(YH) / 53.8% (SGH)	September rebound following August fall; YH remains below yearly rolling rate.	Dedicated medical staffing prioritised where possible. Identified as an area of investment required as part of the National Triage Specification and RCOG Medical Staffing for maternity triage. Regularly monitoring and plans in place to escalate a clear OPEL triage framework.
PPH >= 1500ml (rate per 1000)	4.3% (SGH 7.6%/YH 2.7%)	3.4% (SGH 0%/YH 4.9%)	2.8% (SGH 1.1%/YH 3.6%)	3.4% (SGH 3.2%/YH 3.5%)	Positive third consecutive monthly fall; now below yearly rolling rate.	OASI care bundle implemented. All PPH >1500ml cases are reviewed through the multidisciplinary Maternity Case Review process and learning shared. PPH risk assessment compliance is part of a quality improvement project across multiple phases of the pregnancy.

Measure	Number in last 12 months	Insight: For any maternal deaths reported in the last 12 months, please provide a summary of demographic characteristics (age, ethnicity, deprivation, parity and identified vulnerabilities), together with any themes, health inequalities identified, and actions arising from local review.
Number of Maternal deaths	None	

Neonatal: Data Outcomes

Measure	Quarter 2 (Jul-Sep 2026)	Rolling yearly: Nov 25 – Sep 26	QI Workstreams/actions
PMRT C&D Totals (reviewed)	**6**		PMRT processes are being strengthened through increased MDT engagement, regional collaboration to support external attendance at reviews, and enhanced leadership through the recruitment of a 0.6 WTE PMRT Specialist Midwife and the appointment of a new PMRT Lead Obstetrician. Learning from reviews is embedded through directorate meetings, thematic reviews, and shared learning forums, helping drive continuous improvement in care and outcomes.
NNAP Outliers Positive	**2025 data – York:** **Non-invasive breathing**	**N/A**	NNAP data provided and reviewed by ODN. Data cleansing to be completed monthly.
NNAP Outliers Negative (alert level amber, red)	**2025 data** **Parental Consultation in 24 hours** **Alert (York) / Alarm (SGH)**	**N/A**	NNAP data provided and reviewed by ODN. Data cleansing to be completed monthly. Digital technology used to support parental consultation via video call, where unit presence not able. Commenced in Scarborough in October 2026, to provide equity of service across whole Trust. Audit to be implemented to monitor current position.
PSIIs reported	**1**		PSII launched, SEIPS analysis ongoing. Family engagement been undertaken to a high level.
Governance structures	**8a Care Group Quality and Governance Lead (1WTE)** **B7 Neonatal Governance Specialist Nurse (0.56WTE)** **B5 Clinical Governance Coordinators (0.5WTE)**		Appropriate governance and patient safety structures are in place within the directorate and are embedded within the wider Trust governance framework. Reporting is escalated through the Care Group Board, Patient Safety and Experience Sub-Committee, and Quality Committee, providing assurance to the Trust Board.
ATAIN %	**5.3%**	**5.6%**	Transitional care provided via the SCBU/LNU at present. Business case in development to implement TC in maternity. Some cases identified as avoidable as they were suitable for TC care.
Risk register – Neonates specific	**Active Risks 10** **6 scored at 12** **2 scored at 9** **1 scored at 8** **1 scored at 6**	**N/A**	A revised risk management approach has been implemented, with all risks reviewed and supported by clear "if…then" statements to better articulate impacts and improve clinical engagement. Controls and mitigations are regularly reviewed and updated, supported by ongoing risk management training. Risks are reviewed in line with their scores and are reported through directorate governance, the Care Group Board, and the Risk Committee to ensure effective oversight.
Infections on Unit/IPC	**0**		

Neonatal Workforce:
Medical, Nursing & AHPP staff BAPM Compliance

BAPM Standard	Compliance
Medical Workforce	
Airways – Training and Supervision	Neonatal/ Paediatric Consultants/ SAS Doctors 100% Neonatal Tier 2 Resident Doctors 100% Neonatal Tier 1 100% Neonatal Nurses 90%
Appropriate skill and grade cover depending on Level of unit	Scarbrough Unit – Appropriate skill and grade cover for level 1 unit York Unit - Neonatal medical staffing does not currently meet LNU requirements due to the lack of dedicated 24/7 Tier 2 cover. Provision has improved, with two Tier 2 doctors available from 09:00 to 00:00; however, a gap remains between 00:00 and 09:00 7 days a week.
Activity Matched	Activity is matched appropriately in relation to staffing.
Named lead for PMRT, NNAP, Network audits	PMRT Lead – Hayley Edwards (Obstetrician) / Medhat Ezzat (Neonatologist), Audit Lead – Medhat Ezzat (Neonatologist), NNAP – Sundeep Sandhu (Consultant)

Nursing workforce	Funded establishment	WTE In post	**Unavailability (Vacancy/Sickness/Unfunded)**
BAPM compliance: Direct Patient Care Workforce	Band 7 1.0 Band 6 5.71 Band 5 15.11 Band 4 2.15 Band 3 7.47	Band 7 1.0 Band 6 4.74 Band 5 13.5 Band 4 1.3 Band 3 5.5	Overall staff sickness YDH 4.33% SGH 2.67% Vacancy YDH 1.6 WTE Band 5 SGH 0.6 WTE Band 3
Supernumerary and leadership roles	Band 8a 0.5 Band 7 1.0	Band 8a 0.5 Band 7 1.0	
Quality roles (Governance, FiCare, Education)	Band 7 1.36	Band 7 1.36	
QIS	% compliance of total workforce - York 76% Scarborough 78%		

Learning from Incidents and safety reviews (Maternity & Neonatal)

Please summarise key themes from patient safety incident reviews, PSIRF thematic learning, MNSI findings, complaints, coroner Regulation 28 reports, and prevention of future death notices. Include actions taken and evidence of impact to support regional assurance of learning systems. Please also describe how learning has been shared with staff and embedded in practice (teaching, feedback loops, changes to pathways).

Top 3 Maternity and Neonatal themes (last quarter)	Actions, learning and impact
1. Patient and family engagement	Triangulated learning from complaints, concerns, PMRT and PSII reviews shows recurring issues in communication, timeliness of updates, clarity of information, and support during escalation. Complaint themes include delays, poor communication, lack of support, and referral issues. A single point of contact (Ward Manager or Matron) has been established for maternity and neonatal families following involvement within a patient safety event. This ensures timely engagement, consistent communication, and improved responsiveness. Staff have been briefed on the new communication pathway to ensure families receive clear updates during learning responses. A monitoring process is being developed to track responsiveness and communication quality.
2. Clinical Decision making and neonatal resuscitation and stabilisation	MSNI, PSII, PMRT, and ODN feedback highlight variation in clinical decision-making, resuscitation readiness, equipment availability, and team coordination. Issues include inconsistent escalation, variation in stabilisation practice, workforce availability, commissioning of appropriate services and equipment not always being immediately accessible. A thematic review is underway to analyse decision-making, stabilisation processes, escalation pathways, and team coordination. A round-table has been convened focusing on: Resuscitation equipment; Equipment location and accessibility; Staff familiarity and competency; and Cross-disciplinary engagement. Collaboration with the ODN is ongoing to ensure alignment with regional standards, opportunities for development and benchmarking our workforce and service. Simulation-based training and regular opportunities for clinical exposure in tertiary centres is being reviewed to strengthen decision-making, clinical exposure and team leadership.
3. Post-Partum Haemorrhage	PPH remains a consistent theme across AARs and incident clinical reviews. Issues relate to early recognition, escalation, documentation, and variation in use of PPH bundles. A thematic review is underway, focusing on early recognition, escalation, team coordination, documentation, and bundle compliance. Findings will be presented to the PSI Group in November 2026. Work is ongoing to strengthen multidisciplinary response and ensure consistent use of PPH bundles. Learning is being incorporated into PROMPT training, simulation, and audit cycles.

Learning from service user feedback (Maternity & Neonatal)

Please summarise key themes from service user feedback. Include actions taken and evidence of impact to support regional assurance of learning systems. Please also describe how learning has been shared with staff and embedded in practice (teaching, feedback loops, changes to pathways).

Top service user themes (last quarter)	Actions, learning & impact
1. Pain relief	Service users reporting delays in postnatal pain relief and lack of general awareness of options available for intrapartum pain relief. Working with Acute Matron to create patient information posters for the unit, as well as reviewing antenatal education. Also linking with anaesthetic research fellow to gather feedback around potential implementation of alternative PCA. Collaborating with In-patient Matron to look at ongoing impact of medication rounds postnatally, and continue with launch of self-administration of medication (SAM). Impact not yet knows as recently introduced but largely service users views on SAM are positive.
2. Feeding support	Service users reporting lack of feeding support both on the unit and in the community, this affects feeding outcomes for women and birthing people. Feedback includes inconsistencies in information given, delays in referrals and limited one to one input. MNVP working with trust to highlight these challenges, trust review of feeding service and business case ongoing. MNVP re-structure has allocated the postnatal and community workstreams to the former Scarbrough engagement lead who is highly qualified and experienced in these areas. She will support the trust in planning and development going forward.
3. Informed Choice	Mixed feedback from all geographical areas on feeling informed, feeling that they have received balanced, unbiased information. Some service users report feeling well informed however some feel that explanations were rushed and decisions weren't theirs to make. Personalised care plan was launched in Feb and has been well received; this will aid with informed decision making. Birthing outside of guidance focus group was held to inform the newly approved birthing out of guidance guideline that has been rolled out to all staff to support them in supporting women and birthing people to make the choices that are right for them and still receive the right care that fits around those choices. Antenatal education planning will also support service users with understanding the B.R.A.I.N acronym. The shift in feedback on this area to mixed is a positive indication that work around informed choice is filtering through and having an impact. Formal review of PCP due to take place in next quarter.

Above areas are all mapped into the MNVP 26-27 workplan for ongoing development

Safety Champions meetings and walk rounds
Maternity and Neonatal themes

Feedback raised by staff, last three months	Response
Neonatal Capacity and Winter planning	**Action:** Confirm recruitment progress for the additional registrar post and review contingency plans for winter capacity. **Assurance:** Recruitment remains active and the risk has been identified and escalated through appropriate operational discussions. **Attention to the Board:** Potential workforce and service resilience risks associated with winter neonatal demand
Maternity Theatre capacity at SGH	**Action:** Multi-speciality round table to review all delays and potential impact on outcomes for women and families. Review impacts on other specialties **Assurance:** impact increasing and multi-speciality teams working to develop a BC for additional staff required on the SGH site, linked with moving Planned C/S to main theatres **Attention to the board**: Additional staffing investment to be required
Feedback raised by service users, last three months	**Response**
Delays to receiving Epidurals within 30 mins of request	**Action,** audit underway to review the number of delays and reasons for delay **Assurance:** reporting findings through care group governance and to QC once complete to agree determine required actions. Is articulated within the MNSIP **Attention to the Board.** All red flags reported to the board monthly
Additional safety champions intelligence, last three months	**Response**
Staff feeling positive with new starters coming and feeling supported in the workplace.	Continue to undertake walkarounds and support escalations from staff, feeding back actions taken and outcomes where appropriate.

Follow-up evidence required from previous PQOM

Please provide a summary of progress against the themes below, including evidence of impact.

Theme	Evidence requested	Summary of Evidence
Triage and medical cover	Updated compliance data by site, category and time of day; medical-review waiting times; evaluation of the twilight shift and interim medical-cover arrangements; findings from benchmarking against the national specification; and the proposed model and implementation timetable for sustainable medical support within triage.	• Wait times included on slide 3 with actions taken. • 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.
Workforce and vacancy controls	Recruitment and workforce trajectory against the funded establishment and Birthrate Plus position; impact of vacancy controls and sickness absence; current mitigations; and evidence that staffing arrangements support safe, sustainable care and delivery of national maternity and neonatal requirements.	Midwifery was not subject to vacancy control restrictions and active recruitment aligned to phase 1 of the midwifery workforce business case to meet BR+ requirements is underway reflected in the increase in vacancy. Overall slight upwards trend for sickness throughout August and September; though this remains an improved position across a 12m period.
Neonatal standards and service gaps	Current BAPM direct-care and QIS compliance; progress and Board decisions on business cases for psychology, speech and language therapy, dietetics, neonatal pharmacy, transitional care and outreach; confirmation that replacement CPAP equipment is operational; clarification of commissioned services; and progress in reducing avoidable term admissions and managing the impact of the decant on safety, flow and family experience.	• Both sites meet minimum QIS compliance. • A business case to align neonatal nurse staffing to BAPM requirements in development. Ongoing discussions with commissioners are underway and will inform the final cot case proposals. • Replacement CPAP equipment is in active use at York site and will go-live in Scarborough next. • In response to a key theme identified in ATAIN, a flowchart for Managing Transitioning Infants was developed and approved through internal governance routes in October and will be rolled out throughout November 26. • Any impacts from the decant at York is actively managed by the Ward Manager and Matron; service user engagement and feedback is continuously shared via MNVP.
Estates and neonatal decant	Progress against the planned York neonatal-unit occupation date and the Scarborough decant programme; current position and mitigation of bed-access, water-safety and capacity risks; and subsequent evaluation of the impact on safety, service-user experience and staff working arrangements. Risk highlighted with repatriations to York that require isolation as no isolation cubicle available.	York neonatal-unit renovation is slightly delayed. Plans to move back on 8/12/26 have been delayed until Jan/Feb 2027. Water testing will commence for 8 weeks once renovation works complete. Water safety checks in place in current location and is monitored via Estates. A dedicated estates project team is overseeing the renovation work at Scarborough; with planned decant in Q3 2027 with planned return date by 28 March 2028. Operational and Project impact monitored via regular oversight group. Any repatriations requiring isolation are cared for in a dedicated bay when required.
Home-birth and community services	Updated frequency of home-birth service suspension and the number of women affected; implementation of revised working arrangements and guidance; support and informed-choice arrangements where requests cannot be met; and development of the future community-midwifery model, followed by evaluation of access and experience.	Ongoing engagement with community teams is underway to inform community-midwifery model.

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	MNVP Engagement with Diverse Communities
Director Sponsor:	Sascha Wells-Munro, Director of Midwifery
Author:	Helen McConnell, MNVP Chair

Status of the Report
Approve ☐ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives
☒ To provide timely, responsive, safe, accessible and 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)
☒ Yes
☐ No
☐ Not Applicable

Executive Summary

This paper outlines the MNVP's engagement with diverse communities to bring the experiences of women, birthing people, partners and families into maternity and neonatal service improvement. Engagement includes people with English as an Additional Language, LGBTQ+ and neurodivergent service users, families experiencing pregnancy after loss, refugee, Traveller and international communities, women in prison and shelter settings, and people with specific communication, health

seek to reduce language, communication, accessibility and trust barriers, broadening the voices heard beyond routine feedback mechanisms and informing understanding of care experiences, reasonable adjustments

The paper provides assurance on the breadth and inclusivity of engagement, while recognising that individual or small-scale feedback does not represent a whole community. Sustained relationships, transparent reporting of reach and triangulation with wider feedback remain important; future updates should demonstrate
Recommendation: Note the range of communities engaged and take assurance from the varied methods used to support accessible and inclusive participation, while recognising the limitations of individual and small-scale feedback. The Board is asked to support continued targeted and sustained engagement with underrepresented communities, including exploration of viable remuneration for service users participating in focus groups and targeted feedback, and to receive future updates on engagement reach, themes, resulting actions and evidence of impact.

Report Exempt from Public Disclosure
No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Data presented for discussion; proposed actions and governance route to be agreed.
Maternity and Neonatal Assurance Group	10th November 2026	Minor changes recommended and made prior to submission to QC.
Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	

1. Introduction

The MNVP works to ensure that the experiences of women, birthing people, partners and families inform maternity and neonatal service improvement. This report outlines the breadth of communities engaged and the range of methods used to gather feedback.

The engagement described includes feedback received through face-to-face conversations, email, focus groups and surveys. Different approaches have been used to reduce barriers to participation and enable people to contribute in ways that are accessible and appropriate to them.

2. Communities and Groups Engaged

People with English as an Additional Language (EAL)	Experiences where language may affect communication, information, informed decision-making or access to services.
Partners	Partner and family perspectives alongside those of women and birthing people.
LGBTQ+ community	Experiences of LGBTQ+ parents and families, including inclusive language, communication and respectful care.
Neurodivergent service users	Communication, sensory needs, environment, information and individualised support.
Pregnancy after loss	The needs of families whose previous experience of pregnancy or baby loss may shape a subsequent pregnancy.
Refugee community	Experiences where language, culture, unfamiliarity with NHS systems or access barriers may affect care.
Askham Grange	Perspectives from women in the prison setting about maternity care and access to support.
Traveller community	Experiences of accessing, navigating and maintaining continuity with maternity and neonatal services.
St Giles Women's Shelter	Feedback from women who may experience significant vulnerability and whose voices may be less visible through routine mechanisms.
Deaf partner	Lived experience relating to accessible communication and involvement in maternity care.
People living with Ehlers-Danlos syndrome	Experiences where a long-term health condition may influence pregnancy, birth, care planning and communication.
International community	Perspectives from families from a range of countries, cultures and backgrounds.
RAY	Engagement supporting inclusion of people reached through Refugee Action York.

People affected by domestic abuse	Feedback to help services understand safety, confidentiality, access and support needs.

3. Engagement Approach

A strength of the MNVP model is its ability to use multiple engagement methods rather than relying solely on formal surveys. The approach recognises that some individuals and communities may be less likely to take part through standard NHS feedback mechanisms and therefore a variety of engagement methods are utilised as follows:

- Face-to-face conversations and community engagement
- Focus groups and facilitated discussions
- Surveys
- Email and written feedback
- Individual lived-experience conversations
- Engagement through community organisations and established networks
- Partner and family feedback

This flexible approach supports participation by people who may experience language, communication, accessibility, trust or other barriers. It also enables the MNVP to hear from people in settings where they may feel more comfortable contributing.

4. Impact and Added Value

The breadth of engagement demonstrates that the MNVP is actively seeking to broaden whose voices are heard, rather than relying only on feedback from people who independently come forward. This provides an important additional perspective alongside wider maternity and neonatal feedback.

- A richer understanding of different experiences of maternity and neonatal care
- Identification of barriers that may not emerge through routine feedback
- Greater consideration of accessibility and reasonable adjustments
- Increased understanding of partner and family experiences
- Stronger representation of underserved and potentially marginalised communities
- Better use of lived experience in service improvement and decision-making

5. Key Risks and Limitations

Engagement with an individual or a small number of people must not be interpreted as representing the views of a whole community. The MNVP will continue to describe the source and scale of feedback transparently and will triangulate findings with wider feedback where possible.

One-off contact can identify important issues, but sustained relationships are more likely to build trust and demonstrate whether improvement activity has changed people's experiences. Continued support from community and voluntary-sector partners will therefore be important.

6. Next Steps

1. Continue targeted engagement alongside universal feedback opportunities.
2. Strengthen relationships with voluntary, community and specialist organisations.

3. Develop repeat engagement where relationships have already been established, moving from one-off contact towards sustained involvement where possible.
4. Continue to offer different ways to participate, recognising that one approach will not work for everyone.
5. Use themes from engagement to inform MNVP priorities and discussions with maternity and neonatal service leadership.
6. Identify gaps in representation and proactively seek opportunities to hear from communities whose experiences are less visible.
7. Where feasible, record the engagement method, approximate reach, themes identified, actions agreed and evidence of subsequent impact.

7. Conclusion and Assurance

The Committee and Board can take assurance that the MNVP is using a varied and inclusive approach to engagement, with evidence of reach beyond traditional feedback routes into a diverse range of communities. This supports the MNVP's role in bringing a broader range of lived experience into maternity and neonatal service improvement and decision-making.

8. Recommendations to the Trust Board

- Note the range of communities and groups engaged by the MNVP.
- Take assurance from the varied engagement methods used to increase accessibility and inclusion.
- Support continued targeted and sustained engagement with communities whose experiences may be underrepresented, including through exploring viable remuneration for service users participating in focus groups and targeted feedback.
- Receive future updates on themes, resulting actions and evidence of impact.

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Maternity Feedback Survey Update
Director Sponsor:	Joe Hague, Chief Nurse
Author:	Lucy Flatley, Transformation Lead Midwife

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

The small, self-selected sample provides early insight across the maternity pathway but cannot establish the prevalence of concerns or provide general clinical safety assurance. The survey has received nine responses, including three since the previous report, since its launch in April 2026. Positive feedback highlights continuity with known midwives, personalised support and supported decision making. Respondents described feeling listened to, reassured and involved in choices about their care. Eight of nine

respondents rated decision-making support during labour and birth positively, and eight of nine rated their own feeling of safety positively.

The additional responses reinforce concerns about accessible community postnatal appointments, timely specialist feeding referrals, consistent feeding advice, digital information and overnight partner access. They also identify perceived staffing-related restrictions on home birth, limited postnatal preparation in antenatal education and a need for greater postnatal privacy.

Improvement work is already underway: the community review includes the homebirth service and antenatal education offer, with the aim of expanding provision. The infant feeding team is currently being expanded and partner access to the ward is being reviewed with the aim of increasing access. These developments respond to themes in the feedback, with their impact to be monitored as changes progress.

Recommendation:

The Board is asked to:

1. Receive the updated report for information and discussion, noting the limited assurance possible from nine self-selected responses.
2. Note positive feedback alongside variation in experience and reported safety-related concerns requiring review.
3. Endorse a joint review with the Maternity and Neonatal Voices Partnership (MNVP) of the survey format and approach to collecting feedback, given the limited number of responses. A new approach will be agreed with the MNVP, including alternative, accessible ways for women to share their experiences.
4. Endorse review of communication, informed choice and home birth access, antenatal education, postnatal pathways and specialist feeding referrals through existing improvement workstreams.
5. Request confirmation that reported safety concerns will be reviewed with named action owners where appropriate.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Data presented for discussion; proposed actions and governance route to be agreed.
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Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	

Maternity Feedback Survey

1. Introduction and Background

The Maternity Feedback Survey has been developed jointly by York and Scarborough Teaching Hospitals NHS Foundation Trust and the Maternity and Neonatal Voices Partnership (MNVP) to capture women's experiences across the antenatal, intrapartum and postnatal pathway. This is in addition to other feedback mechanisms including the National Annual CQC maternity survey, feedback from MNVP engagement and complaints, compliments and concerns.

The survey is intended to:

- Support ongoing quality improvement.
- Provide assurance regarding women's experiences of care.
- Identify emerging themes and opportunities for improvement.
- Inform maternity safety, quality and equity workstreams.

2. Approach and methodology

Survey Development and Design

The Maternity Feedback Survey was co-produced by York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) and the Maternity and Neonatal Voices Partnership (MNVP) to capture the experiences of women and birthing people across the maternity pathway. The survey was designed to gather feedback relating to antenatal, intrapartum and postnatal care, with a particular focus on personalised care, decision making, safety, communication, continuity of care and postnatal support.

The survey consists of a combination of quantitative and qualitative questions, enabling respondents to rate their experiences using structured response scales whilst also providing free-text comments describing what worked well and where improvements could be made. This mixed-methods approach allows both measurable trends and detailed patient narratives to be captured.

Respondents provided feedback across the whole maternity journey including:

- Access to maternity services and booking processes.
- Antenatal care and continuity of care.
- Shared decision making and personalised care planning.
- Labour and birth experiences.
- Postnatal inpatient and community care.
- Infant feeding support.
- Digital services and information provision.
- Overall experiences and suggestions for improvement.

Data Collection

The survey was launched April 2026 and has been running now for just over 6 months. It is hosted on Microsoft Forms and there is a QR code that links to the survey in the personalised care plan which all women receive, and it is discussed by the community midwife at the postnatal discharge appointment. Responses are submitted anonymously to

encourage openness. Results are presented as numbers of responses and rounded percentages. For questions rated on a scale from 1 to 5, scores of 4 or 5 are counted as positive. Responses marked “not applicable” are left out when calculating percentages for that question.

This summary is based on nine responses received between April 2026 and October 2026 and should therefore be interpreted with caution. The findings reflect the experiences of a small, self-selected group and cannot be assumed to represent the wider maternity population. They provide early insight into lived experiences, but do not establish how widespread these experiences are or whether the service is improving or worsening. A shortened survey will be produced to encourage wider completion, given the small number of responses received since launch and concerns that the current survey may be too long. The questions to retain will be agreed, focusing on the key themes identified so far and findings from the national CQC maternity survey.

The proposed approach is to compare the original and shortened Maternity Feedback Surveys using questions retained in both versions, keeping their wording and response scales consistent wherever possible. Results will be presented separately for each version, with the collection period and number of valid responses shown for each question and the same approach used to define positive ratings and exclude “not applicable” responses. Free-text feedback will be reviewed against common themes to identify recurring concerns and new issues. Questions that are new or substantially changed will be reported separately rather than treated as directly comparable. Interpretation will take account of differences in participation, respondent characteristics and how feedback is collected; given the small initial sample, any differences will be descriptive and will not, on their own, demonstrate improvement or deterioration in care.

Demographic Profile

Birth Location

- York: 6 responses (67%).
- Scarborough: 3 responses (33%).

Year of Birth

- 2025 births: 2 (22%).
- 2026 births: 7 (78%).

Mode of Birth

- Planned caesarean birth: 3 (33%).
- Unplanned caesarean birth: 1 (11%).
- Spontaneous vaginal birth: 4 (44%).
- Forceps birth: 1 (11%).

Age Profile

Age information was provided in eight of the nine responses; one response did not include age information. The recorded age bands are listed below.

- 18–25 years
- 26–30 years
- 31–35 years
- 41–45 years

Ethnicity

- Eight of the nine respondents selected the White ethnic-background category, which includes British, Irish, Gypsy or Irish Traveller and other White backgrounds. One respondent did not provide ethnicity information.

- The small sample and limited range of ethnic backgrounds mean these responses cannot be assumed to represent the wider maternity population. The survey needs to be promoted in accessible formats and through a range of community routes to encourage broader participation and capture experiences that may currently be missing.

Governance

Findings will be reviewed alongside complaints, compliments, incidents, other service-user feedback and local quality metrics. Reported safety-related concerns require review to understand if actions are required or have already been completed. Anonymous survey accounts do not establish verified clinical findings or completed investigations.

3. Key findings

Continuity of care remains a significant strength
The strongest positive theme identified was continuity of care. Women consistently described:

- Seeing the same midwife throughout pregnancy.
- Feeling known as an individual.
- Receiving reassurance and personalised support.
- Developing trusting relationships with staff.

Several respondents linked positive experiences to relationships with known midwives. An additional response described seeing the same two midwives and feeling listened to, while also reporting that a preferred home birth could not be supported because of staffing limitations.

Positive experiences during labour and birth
Feedback regarding labour and birth was predominantly positive. Women described:

- Feeling safe during labour.
- Being supported to make decisions.
- Compassionate and calm care during complex situations.
- Positive involvement of birth partners

Eight of nine respondents (89%) rated support for their own decision-making during labour and birth positively. Eight of nine (89%) rated their own feeling of safety positively. One reported feeling unsupported and unsafe. Of the eight respondents who answered the questions about their partner or companion, all rated the support for their involvement in decisions positively. Seven of the eight also gave a positive rating for their partner's or companion's perception of safety during labour and birth.

Communication identified as primary improvement theme
Communication remains a recurring improvement theme across the nine responses, alongside access to postnatal care and feeding support. The additional responses include both positive accounts of clear explanations and empowered choices, and concerns about inconsistent advice and incomplete referral pathways.

Examples included:

- Receiving conflicting information from different professionals.
- Uncertainty regarding induction pathways.
- Variable explanations from consultants and clinicians.

- Confusion regarding appointments, results and next steps.

Women particularly highlighted induction discussions as an area where information was inconsistent and personal preferences were not always perceived to be fully explored. The maternity service recognises the ongoing challenges with consistency of information and continues to monitor this through service-user feedback and ongoing improvement work. The personalised care plan, alongside the new Supporting Maternity Choices guideline, aims to support clearer, more consistent information, individualised discussions and shared decision making. These measures are intended to help address the concerns identified and their impact will need to be monitored.

The small number of responses means we cannot determine how widespread these concerns are. However, reports of delays in acting on blood results, difficulties accessing requested pain relief and unclear information about blood-clot prevention need further review.

Place-of-birth choice and antenatal preparation
Seven of nine respondents reported discussion of place-of-birth options, while two reported no discussion. Eight reported a birth-preference discussion at 36 weeks and one did not. One additional response described wanting a home birth but perceiving that staffing prevented this being supported. Of the two respondents who gave applicable antenatal-class preparedness ratings, both rated postnatal preparation negatively; one also described limited detail in infant feeding education. Five respondents reported not being offered classes in at.

The maternity service is aware of the issues affecting home birth provision. A community review is currently underway and is working to address these challenges. The feedback reinforces the importance of this ongoing work and of clear discussions with women about service availability and their place-of-birth preferences.

The antenatal education offer is also included within the ongoing community review, with the aim of expanding provision. Feedback on access to classes and preparation for the postnatal period and infant feeding will inform this work.

Variable experiences of postnatal care
Many women reported highly positive postnatal experiences, particularly where compassionate staff support was provided.

However, respondents also identified:
- Delayed discharge and late-evening departures, including one additional report of leaving after 11 pm.
- Variable communication about checks, medicines and discharge arrangements.
- Preferences for overnight partner presence, particularly soon after birth or during induction.
- A request for greater postnatal privacy and more private rooms.

Seven of nine respondents rated inpatient postnatal care positively, one gave a neutral rating and one a negative rating. Discharge ratings were positive in six responses, neutral in one and negative in two. The additional responses reinforce the importance of privacy, partner access and timely discharge communication. Partner access to the ward is currently under review, with the aim of increasing access. This work will consider feedback about the importance of partner presence, particularly in the immediate postnatal period, alongside the privacy and rest needs of everyone receiving care on the ward.

Community postnatal support
Community postnatal care received generally positive feedback, with women valuing home visits, follow-up support and continuity from known midwives.

Several respondents reported:

- Limited home visits.
- Attendance at clinics shortly after operative birth.
- Reduced continuity following discharge.
- Logistical difficulties accessing appointments

Six of nine respondents rated community postnatal care positively, one gave a neutral rating and two gave negative ratings. Three respondents described only one home visit followed by clinic attendance. The new feedback reinforces travel difficulties when recovering from birth and caring for a baby and toddler, including parking costs and repeated appointments for feeding or weight concerns. One requested more choice of appointment locations.

Feeding Support
Women generally reported feeling supported in their infant feeding choices and appreciated non-judgemental approaches to feeding discussions.

Some respondents identified:

- Variable practical feeding support.
- Delays within specialist feeding pathways.
- Limited information regarding formula feeding.
- Issues with follow-up feeding referrals.

All nine respondents rated support for their feeding choice positively, but satisfaction with feeding support was positive in six responses and neutral in three. Free-text feedback highlights a distinction between respecting feeding choice and providing practical, timely help. Feedback also highlighted unclear referral pathways and difficulties accessing specialist feeding support. Another respondent reported advice perceived as outdated or inconsistent and limited antenatal feeding preparation.

The infant feeding team is currently being expanded. This work is intended to strengthen the support available to women and families. The feedback also highlights the need to continue reviewing consistency of advice, specialist referral routes and follow-up arrangements alongside team expansion.

Digital experience – BadgerNotes
Women valued having access to their maternity information electronically however, several respondents highlighted concerns relating to:

- Difficulty understanding appointment purpose.
- Limited notification functionality.
- Confusion regarding appointment locations and timing.
- Inconsistent information across communication systems.

Five of nine respondents rated satisfaction with BadgerNotes positively, two gave neutral ratings and two negative ratings. One additional response described difficulty locating information and results not always being visible; the other two additional responses rated the information positively. Existing concerns about appointment purpose, notifications and

inconsistent information therefore remain relevant. Digital review should distinguish system functionality from the completeness and clarity of information entered or shared through it.

4. Next steps

- Review the survey format, length, accessibility and timing of invitations with the MNVP in response to limited participation. Develop alternative options for women to provide feedback and agree a new approach jointly with the MNVP, including how participation and feedback will be monitored.
- Review reported safety-related concerns and establish whether relevant incidents or investigations already exist.
- Continue the community review currently working to address known home birth service issues, including how service availability, alternatives and constraints are discussed with women.
- Continue to monitor consistency of information and use the personalised care plan alongside the new Supporting Maternity Choices guideline to support individualised discussions and shared decision making. Review subsequent feedback to assess whether these measures improve women's experiences.
- Review and develop the antenatal education offer as part of the ongoing community review, with the aim of expanding provision and using feedback on postnatal recovery and infant feeding preparation to inform development.
- Review community postnatal appointment locations and home-visit planning in relation to recovery, transport and caring responsibilities.
- Continue the current expansion of the infant feeding team alongside review of specialist feeding referral routes, responsibility for follow-up and access when initial referrals are unsuccessful.
- Continue the current review of partner access to the ward, with the aim of increasing access while considering the privacy and rest needs of everyone receiving care.
- Review consistency of feeding advice, digital information, privacy and discharge communication.
- Review findings monthly, assign action owners through the improvement plan and report progress through maternity governance.
- Share anonymised positive service-user feedback with relevant teams.

5. Summary

The updated nine-response survey identifies positive experiences of continuity of care, personalised support and labour decision making alongside variation in postnatal care, feeding support and information provision. The three additional responses reinforce access barriers and introduce further feedback on home birth availability, antenatal preparation and privacy. The small sample does not provide broad clinical safety assurance, and reported safety-related concerns require governance review. Findings should inform prioritised actions and be triangulated with other evidence as participation increases.

Date: 29 October 2026

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Maternal Care Bundle Implementation Update
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 ☐

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☐ To use resources to deliver healthcare today without compromising the health of future generations.
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Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

The Trust Board-approved Maternal Care Bundle implementation tool records 14 interventions across five elements: one fully implemented, six partially implemented and seven not implemented. Overall implementation is assessed as partial, with 7% of interventions fully implemented and no individual element fully completed.

Progress includes full implementation of the complex-care referral pathway, approval of the National MEWS maternity guideline, completion of the Trust-wide Quality Impact

Assessment and implementation paper, ICB engagement on the early-pregnancy LMWH pathway, receipt of the Maternal Medicine Network acute referral pathway, and confirmation of home-birth equipment and pathology arrangements for Clauss fibrinogen testing.

The report provides assurance that a comprehensive baseline and coordinated action plan are in place, but not yet assurance of full or sustained implementation. Delivery by March 2027 remains at risk, with 13 of 14 interventions not yet fully implemented. Critical dependencies include digital development, cross-organisational pathways, guideline and SOP updates, workforce and training, accessible information and audit capacity. Current escalations concern VTE, epilepsy in pregnancy and maternal mental health; specific constraints include the absence of an obstetric physician for epilepsy in pregancy, the vacant audit midwife post and BadgerNet self-administration functionality not expected until March 2027. An interim paper process for maternal mental health is being scoped.

SMART actions and named owners underpin delivery, with monthly oversight, milestone review and escalation, monthly highlight reporting to maternity governance groups, and quarterly implementation-tool updates and Board reports. Senior support is required for unresolved cross-organisational and digital dependencies; assurance of compliance will depend on completed actions and audit evidence.

Recommendation:

- Note progress update of the national implementation tool and the current position.
- Support escalation of cross-organisational and digital dependencies that cannot be resolved within maternity services.
- Recognise that delivery of all interventions by March 2027 is currently at risk and support timely senior escalation where milestones or critical dependencies are not being achieved.
- Receive quarterly progress reports which will include updated implementation status, delivery against SMART actions, exceptions, and assurance from completed audits.

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

No ☒ Yes ☐

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Data presented for discussion; proposed actions and governance route to be agreed.
Maternity and Neonatal Assurance Group	10th November 2026	
Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	

Maternal Care Bundle Implementation Update

1. Introduction and Background

The NHS England Maternal Care Bundle (MCB) was published in January 2026 and establishes a national baseline of best practice across five clinical areas consistently associated with higher rates of maternal mortality and severe maternal morbidity. The care bundle has been developed in response to repeated findings from MBRRACE-UK that a significant proportion of maternal deaths involve missed opportunities for earlier identification, escalation, senior input, and coordinated multidisciplinary care.

The overarching aims of the Maternal Care Bundle are to:

- Reduce preventable maternal deaths and severe morbidity
- Improve early recognition and response to clinical deterioration
- Reduce unwarranted variation in care across services and settings
- Address persistent inequalities in maternal outcomes related to ethnicity, deprivation and access to care
- Support consistent, system-wide approaches to safety across maternity, emergency, primary and specialist services

The five elements of the Maternal Care Bundle are:

1. Venous thromboembolism (VTE)
2. Pre-hospital and acute care
3. Epilepsy in pregnancy
4. Maternal mental health
5. Obstetric haemorrhage

The care bundle is intended to be implemented by all NHS maternity providers in England by March 2027. This will be achieved by working in partnership with wider Trust services (including emergency care, ambulance services, neurology, maternal medicine, mental health and primary care). While the Maternal Care Bundle establishes minimum standards, it is expected these interventions will be embedded into routine practice, supported by governance, audit and continuous improvement.

2. Current implementation position

The updated implementation position confirms that no element is fully implemented. Across the 14 interventions, one is fully implemented, six are partially implemented and seven are not implemented. Overall implementation is therefore assessed as partially implemented, with 7% of interventions fully implemented.

Element	Clinical area	Interventions	Board-validated status	Fully implemented
1	Venous thromboembolism	3	Not implemented	0 of 3

2	Pre-hospital and acute care	3	Not implemented	0 of 3
3	Epilepsy in pregnancy	2	Partially implemented	1 of 2
4	Maternal mental health	3	Not implemented	0 of 3
5	Obstetric haemorrhage	3	Not implemented	0 of 3
Overall	All elements	14	Partially implemented	1 of 14 (7%)

3. Action plan by element

Element 1: VTE
Current position: Not implemented
The current maternity VTE risk assessment form has been reviewed and is aligned to the national questionnaire. A Trust-wide process, supporting SOP, digital workflow and monitoring arrangements remain to be implemented. Following engagement with the ICB, pharmacy and clinical effectiveness colleagues, the ICB is establishing a working group to agree the early-pregnancy LMWH pathway; a local prescribing process is also required while this system work progresses. The target remains implementation by 31 January 2027, with quarterly audit thereafter.

Element 2: Pre-hospital and acute care
Current position: Not implemented
National MEWS implementation is progressing. The maternity guideline is approved and a Trust-wide Quality Impact Assessment and implementation paper were completed in October. These identify significant risk in retaining different maternal deterioration tools across settings. The proposed approach is National MEWS within maternity, wider Trust implementation according to risk and readiness, digital deployment where available and interim paper MEWS where required. A multidisciplinary pathway walk-through with Yorkshire Ambulance Service and MNVP representatives is planned for both sites on 13 November 2026. The Maternal Medicine Network acute referral pathway has been received with a plan for yearly review and will be presented to the Maternity Guideline and Audit Group in November.

Element 3: Epilepsy in pregnancy
Current position: Partially implemented
The complex-care referral pathway is fully implemented. Remaining actions are to establish the Scarborough epilepsy service and co-produce an SOP and service specification covering staffing, clinic schedule and referral pathways by December 2026. Further work is required to ensure case review and risk stratification within 14 days of first NHS contact and timely medication review for women assessed as high risk. The absence of an obstetric physician with a speciality interest in epilepsy within the Trust remains an identified escalation.

Element 4: Maternal mental health
Current position: Not implemented
Once available in BadgerNet, the maternal mental health guideline requires revision to incorporate self-administration of the Whooley questions at all required antenatal and postnatal timepoints, use of EPDS when indicated, and onward referral arrangements. Accessible, paper and translated routes, staff communication and training, and quarterly audit are required. BadgerNet does not currently support the required self-administration functionality however this is expected by March 2027. A local paper process is therefore being scoped as an interim control.

Element 5: Obstetric haemorrhage
Current position: Not implemented
Assurance has been received that the required equipment is available for all planned home births, completing that action. Audits of cumulative blood-loss measurement, timely escalation and multidisciplinary review for significant haemorrhage are in development. Progress is constrained by the absence of an audit midwife. Pathology has confirmed, with a supporting SOP, arrangements relating to timely Clauss fibrinogen testing; the remaining requirement is to complete and evidence the planned audits.

4. Key risks and dependencies

Risk/dependency	Required control
March 2027 delivery trajectory	Only one of 14 interventions is fully implemented. Monthly milestone review, early escalation and senior support are required to recover the trajectory.
Digital capability	All elements require digital development. Interim paper processes must be governed, monitored and replaced by sustainable digital solutions.
Cross-organisational delivery	VTE prescribing, ambulance pathways, acute referral and specialist care require active participation from the ICB, primary and acute care, YAS, pharmacy, neurology, pathology and the Maternal Medicine Network.
Workforce and training	Implementation requires training and compliance monitoring across maternity and non-maternity settings; the absence of an obstetric physician is an identified epilepsy service constraint.
Evidence and audit capacity	The vacant audit midwife post limits completion of haemorrhage audits and assurance of reliable implementation. Prioritisation and alternative audit support are required.
Equity and accessibility	Paper and digital routes, translated information and accessible formats must be embedded so implementation does not widen inequalities.

5. Governance and monitoring

- The Maternal Care Bundle oversight group will monitor delivery and risks monthly.

- Progress will be reported monthly to the Maternity and Neonatal Assurance Group and Maternity Directorate Group through a highlight report.
- The implementation tool will be updated each quarter with current evidence, action progress, revised implementation status and escalations, and submitted with an accompanying report to the Trust Board in accordance with MIS requirements.

6. Conclusion

The Trust Board-approved implementation tool provides a comprehensive baseline and action plan. The validated position is that one of 14 interventions is fully implemented, six are partially implemented and seven are not implemented; no element is fully implemented.

Delivery by March 2027 remains at risk because of the scale of work outstanding and dependence on digital development, cross-organisational pathways, workforce and training, accessible information and audit capacity. Progress has been made through approval of the National MEWS guideline, completion of the Quality Impact Assessment and implementation paper, establishment of ICB engagement on the VTE pathway, receipt of the Maternal Medicine Network pathway, completion of the community haemorrhage equipment review and confirmation of pathology arrangements.

The proposed monthly oversight and quarterly Board reporting arrangements will support active management of milestones, exceptions and escalations. The Trust can take assurance that a structured implementation programme is in place, while recognising that assurance of full and sustained compliance will depend on delivery of the actions and demonstrable evidence through audit.

Date: 28 October 2026

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Saving Babies' Lives Care Bundle
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.
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Implications for Equality, Diversity and Inclusion (EDI) *(please document in report)*

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This report provides an update on implementation of the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2) across the Trust for Quarter 2 2026/27 (July–September 2026), for the Board meeting in November 2026. The updated NHS England implementation tool records 60 of 69 interventions as fully implemented (87%), with overall delivery self-assessed as partially implemented. These figures represent self-assessment.

Fetal growth restriction, reduced fetal movement and fetal monitoring in labour are each self-assessed as fully implemented (100%). Fetal monitoring training and competency compliance now exceeds the minimum 90% requirement in the staff groups reported.

Key areas for improvement include:

- Smoking in pregnancy (50%) – face-to-face training, referral reliability, treatment and quit-outcome evidence, and feedback processes; delivery remains dependent on implementing the in-house maternity tobacco dependency service.
- Preterm birth (88%) – audit and quality improvement pathways, right place of birth and delayed cord clamping remain partially implemented. Normothermia is now fully implemented; monthly monitoring of optimisation measures continues.
- Diabetes in pregnancy (83%) – multidisciplinary clinic capacity and the pre-existing diabetes service model. The quality impact assessment is complete and a cross-care-group business case is in draft.

Cross-element challenges include smoking training compliance below the minimum 90% requirement in several staff groups. Some audit evidence has not yet been received for Q2 25/26 due to the report being presented in November, one month earlier than planned due to no Trust Board meeting in December. Targeted improvement actions are in place, including implementation of a maternity tobacco dependency service, optimisation of preterm pathways, and development of the pre-existing diabetes in pregnancy service provision. Progress is monitored through the Single Improvement Plan, with quarterly reporting aligned to MIS Year 8 requirements.

Based on the current level of partial implementation and the dependencies associated with service redesign, workforce training, data quality and pathway reliability, there is a risk that the Trust will not achieve full compliance with SBLCBv3.2 by March 2027. Close monitoring, timely escalation and delivery of the agreed improvement actions will be required to mitigate this risk.

Recommendation:

The Board is asked to:

- Note the current level of compliance and variation across SBLCBv3.2 elements
- Receive assurance on the governance, monitoring and improvement plans, while noting the evidence gaps and audit exceptions identified in the updated Q2 implementation tool
- Support the prioritisation of key improvement areas, specifically:
    - Smoking cessation pathways and tobacco dependency service implementation
    - Preterm birth pathway optimisation and reduction of unwarranted variation
    - Development of the diabetes in pregnancy service model
- Support a continued focus on equity, addressing identified inequalities in outcomes

- Note the risk that full compliance may not be achieved by March 2027 and support timely escalation where delivery is off trajectory
- Agree ongoing quarterly oversight and reporting to ensure delivery of full compliance

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

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Data presented for discussion; proposed actions and governance route to be agreed.
Maternity and Neonatal Assurance Group	10th November 2026	
Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	

Saving Babies' Lives Care Bundle

1. Introduction and Background

This report provides an overview of progress at York and Scarborough Teaching Hospitals NHS Foundation Trust in implementing the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2). It summarises current levels of compliance across all six elements of the care bundle, highlights key areas of achievement and improvement, and outlines the actions required to achieve full implementation.

The Trust has undertaken a comprehensive self-assessment against SBLCBv3.2 using the NHS England implementation tool, supported by local audit data for Quarter 2 2026/27 (July–September 2026), guideline review and quality improvement activity. This report presents that quarter's position to the Board in November 2026. Where Q2 results are missing or evidence is inconsistent, the limitation is identified rather than assumed to demonstrate compliance.

The Saving Babies' Lives Care Bundle is a national programme developed by NHS England to reduce perinatal mortality and improve outcomes for babies and families. It sets out a series of evidence-based interventions and best practice standards across the maternity pathway.

Version 3.2, published in April 2025, builds on previous iterations by incorporating:

- Updated implementation guidance to reflect MIS requirements
- Updated NICE and RCOG guidance where available
- A stronger focus on reducing unwarranted variation and improving equity of outcomes

The six elements of SBLCBv3.2 are:

1. Reducing smoking in pregnancy
2. Risk assessment and management of fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring in labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

These elements collectively address key contributors to avoidable perinatal mortality.

2. Approach and methodology

The Trust has completed a self-assessment across all six elements, supported by evidence including:

- Clinical audits
- Guidelines and policies
- Training compliance data
- Quality improvement programmes
- MSDS and BadgerNet audit data

The overall position indicates:

- 60 of 69 interventions fully implemented (87%, self-assessed)
- Overall status: Partially implemented across the care bundle.

The remaining areas requiring focused improvement are:

- Smoking cessation pathways and workforce training (Element 1)
- Preterm optimisation reliability (Element 5)
- Pre-existing diabetes pathway development and clinic model (Element 6)

3. Governance

Since the launch of SBLV3 the national implementation tool has been completed on a quarterly basis. Previously this was reviewed by the LMNS and a quarterly assurance meeting to discuss progress with implementation. The Humber and North Yorkshire LMNS are no longer operational and as per MIS year 8 requirements we will provide quarterly updates on implementation progress to the trust board and regional team via the Perinatal Quality Oversight Model.

We will continue to complete the national implementation tool and map identified improvement work into the single improvement plan to ensure progress with identified improvements.

4. Current position for each element

Element 1: Reducing smoking in pregnancy

50% of interventions fully implemented: 5 of 10 are fully implemented and 5 are partially implemented. The outstanding interventions are opt-out referrals (1.4), treatment and quit outcomes (1.6), feedback to maternity services (1.7), CO-monitor training (1.8) and Very Brief Advice/pathway training (1.9).

September 2026 rolling face-to-face training compliance is 86% for midwives, 84% for maternity support workers, 70% for obstetric consultants, 88% for tier 2 doctors and 100% for tier 1 doctors. Several groups remain below the minimum 90% requirement. NCSCT e-learning compliance is 99% for midwives, 100% for obstetric consultants and 95% for both tier 2 and tier 1 doctors. Figures are reported and escalated monthly through the Maternity Directorate and overseen by practice development midwives.

Treatment and quit-outcome evidence, and feedback arrangements, remain partially implemented. Transition to an in-house maternity tobacco dependency service is progressing and will ensure accurate oversight of quit data and associated feedback arrangements.

Q2 recorded referral rates are 77.4% at York and 59.1% at Scarborough, both below the minimum 90% ambition. Referrals to North Yorkshire and City of York local authorities have been affected since July 2026 which is evident in the audit results. Once the in-house service is implementing, opt out referrals will be reinstated. Q2 CO measurement recording is 94.5% at booking and 82.5% at 36 weeks at York, and 96.9% and 91.4% respectively at Scarborough. Monthly review of exceptions by the community matron and team leaders continues.

Element 2: Risk assessment and management of fetal growth restriction

100% of interventions self-assessed as fully implemented: all 20 interventions are recorded as fully implemented in Q2 2026/27. This status is retained from the tool, but the audit exception below requires clarification and follow-up.

For intervention 2.18, the Q2 proportion of babies below the 3rd birthweight centile born after 37+6 weeks is 47.1% at York and 54.5% at Scarborough. Scarborough's result is above the national GAP average and exceeds the threshold of less than 48% recorded in the implementation tool. Quarterly reviews with fetal medicine lead obstetricians and Datix incident reporting support oversight and learning.

Element 2 remains self-assessed as fully implemented: local guidance aligns with national standards for timing of birth in fetal growth restriction, and quarterly case-review arrangements are established. The initial review has identified no issues with adherence to national standards. A multidisciplinary team (MDT) review will be completed for each case to confirm the findings and identify any learning or improvement actions. Data will continue to be monitored.

The updated tool records fetal growth guidelines, surveillance pathways and quarterly audit evidence as supporting full implementation

Element 3: Raising awareness of reduced fetal movement

100% of interventions fully implemented: both interventions in the updated tool are recorded as fully implemented.

Q2 cross-site audit records computerised CTG use in 96.3% of clinically eligible women attending with reduced fetal movement. For recurrent reduced fetal movement, the ultrasound measure is 87% for July and August 2026; this is not a complete three-month Q2 result and this data will follow in the next quarterly updates. These measures exceed the respective 90% and 80% thresholds recorded in the tool. Local guidelines and information provision remain recorded as evidence of implementation.

Element 4: Effective fetal monitoring in labour

100% of interventions fully implemented: all 5 interventions are recorded as fully implemented. September 2026 rolling training and annual competency assessment compliance is 93% for midwives, 95% for obstetric consultants and 92% for tier 2 doctors, meeting the minimum 90% requirement in all reported groups. Compliance with fetal monitoring training is monitored each month by the practice development midwives and presented at maternity and neonatal assurance meetings.

The tool records structured risk assessment, escalation and holistic review guidelines, and evidence for dedicated fetal monitoring lead roles.

Element 5: Reducing preterm birth

88% of interventions fully implemented: 23 of 26 are fully implemented and 3 are partially implemented. The outstanding interventions are audit and quality improvement pathways (5.2), right place of birth (5.18) and delayed cord clamping (5.22). Normothermia (5.23) is now fully implemented. Improvement activity and monthly monitoring continue.

Q2 singleton preterm birth rates are 6.2% at York and 5.5% at Scarborough, against the less-than-6% ambition recorded in the tool. York remains above this ambition; Scarborough is below it.

For right place of birth, the tool records a Q1 regional result of 76% against a minimum ambition of 85%, and one off-pathway delivery in Q1 that has been reviewed. The Q2 neonatal Operational Delivery Network report is awaited.

Q2 delayed cord clamping audit results are 73.3% at York and 0% at Scarborough. This intervention remains partially implemented, with further optimal cord-management actions and education to be agreed using the BAPM quality improvement toolkit. Normothermia results are 93.3% at York and 75% at Scarborough: both meet the minimum 70% ambition, while York meets the 85% stretch ambition. Monthly monitoring and feedback continue, including attention to babies being too warm.

Other Q2 optimisation and outcome results require continued oversight. A full course of antenatal corticosteroids within one week of birth is recorded for 53% at York and 33% at Scarborough; the intervention remains self-assessed as fully implemented. Magnesium sulphate is recorded at 100% at York and there were no applicable cases at Scarborough. Mother's milk within the first two days is recorded at 67% at York and 75% at Scarborough. Mortality to discharge in very preterm babies is recorded at 12.5% at York and 50% at Scarborough, against the tool's less-than-6.5% benchmark.

Element 6: Management of diabetes in pregnancy

83% of interventions fully implemented: 5 of 6 are fully implemented and 1 is partially implemented. Intervention 6.1, the multidisciplinary one-stop clinic model for women with pre-existing diabetes, remains partially implemented.

The HbA1c intervention (6.4) remains self-assessed as fully implemented. The tool records Q1 audit results of 100% at both sites, but the Q2 audit data is pending. The hybrid closed-loop intervention (6.2) is also recorded as fully implemented, with 100% at both sites in Q1 and Q2 data is pending. Q2 results are therefore required to support updated assurance.

For the pre-existing diabetes clinic model, the quality impact assessment is complete, and a business case is in draft across care groups. Guidance and clinic development are being prioritised, with a focused quality improvement project underway. The other interventions remain self-assessed as fully implemented, supported by the guidelines recorded in the tool.

5. Summary

For Quarter 2 2026/27 (July–September 2026), the Trust has self-assessed 60 of 69 Saving Babies' Lives Care Bundle interventions as fully implemented (87%). Overall implementation remains partial. This report is presented to the Board in November, one month earlier than planned because there is no December Trust Board meeting. Outstanding Q2 audit results will be included in the next update.

Fetal growth restriction, reduced fetal movement and fetal monitoring in labour are each self-assessed as fully implemented (100%). Fetal monitoring training and competency assessment meet the minimum 90% requirement in all reported staff groups. Full implementation is supported by the guidance and multidisciplinary review of all cases, with continued monitoring of results.

The principal implementation gaps remain smoking in pregnancy (50%), preterm birth (88%) and diabetes in pregnancy (83%). Priorities are improving smoking training and referral pathways, implementing the in-house maternity tobacco dependency service, strengthening preterm audit and quality improvement pathways, improving right place of birth and delayed cord clamping, and developing the multidisciplinary pre-existing diabetes clinic model.

Targeted improvement work is underway, including progression of the maternity tobacco dependency service, education and quality improvement for optimal cord management, and development of the pre-existing diabetes clinic model, supported by a completed quality impact assessment and a draft business case. Progress will continue to be monitored through the Single Improvement Plan and quarterly Board reporting. The awaited Q2 right-place-of-birth report and diabetes audit results will provide further assurance when available.

There remains a risk that full compliance will not be achieved by March 2027 if the required service, workforce, data and pathway improvements are not delivered within the agreed timescales. Close oversight and timely escalation through established governance arrangements will be required to support delivery and mitigate this risk.

The continued focus is on reducing unwarranted variation, sustaining training compliance and improving equity of access and outcomes. Assurance will draw on implementation status, clinical audit findings and multidisciplinary case-review learning, with follow-up of outstanding evidence and validation of neonatal outcome data.

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Perinatal Culture Improvement Plan
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 ☐

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Implications for Equality, Diversity and Inclusion (EDI)

☒ Yes
☐ No
☐ Not Applicable

The report describes work intended to promote equitable care and an inclusive workplace but does not yet demonstrate its impact on inequalities.

Executive Summary:

This report provides the Board with an update on the development and delivery of perinatal culture improvement actions within the Maternity and Neonatal Single Improvement Plan (MNSIP). The wider Maternity and Neonatal Single Improvement Plan programme has been paused from July 2026 – December 2026 to focus improvement activity on four key priority areas which are the 10-point plan following the AMOS and Nottingham reports, Saving Babies Lives Care Bundle Version 3.2, The

Maternal Care Bundle and Maternity Incentive Scheme (year 8). This provides important context for the delivery position presented below.

MNSIP actions are informed by staff surveys, focus groups and Culture Conversations, leadership walkarounds, service-user feedback including MNVP, incident and audit findings, workforce data and safety intelligence. They are managed through the MNSIP's existing improvement and governance arrangements.

Progress has been reported across multidisciplinary engagement, staff and service-user co-production, leadership visibility, workforce support and safety learning. 41 of the 67 Culture score milestone actions are recorded as complete, while 26 still need progressing. These figures relate only to the Culture score component and do not represent delivery of the wider perinatal culture improvement work.

Outstanding workforce capacity decisions, delays to estates and digital improvements, and formal approval of the behavioural charter remain key risks. Evaluation of leadership visibility, communication and escalation arrangements are to be completed.

The plan must be reviewed by the Trust Board at least every six months in line with the requirements of NHS Resolutions Maternity Incentive Scheme.

Recommendation:

The Board is asked to:

- Note progress in the wider perinatal culture improvement work.
- Agree prioritisation of outstanding actions when the MNSIP resumes including workforce, behavioural, estates, digital and evaluation actions, with clear accountability and agreed recovery dates.
- Agree to review the perinatal culture improvement plan at least every six months, with material risks escalated through the agreed governance route.

Report Exempt from Public Disclosure

No ☒ Yes ☐

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Scheduled discussion and contents noted; with agreement for onward oversight via governance route.
Maternity and Neonatal Assurance Group	10th November 2026	
Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	

Perinatal Culture Improvement Plan

1. Introduction and Background

This report provides the Trust Board with an update on perinatal culture improvement and supports its oversight of this work. The improvement actions sit within the Maternity and Neonatal Single Improvement Plan (MNSIP), bringing together staff and service-user experience, workforce support and safety learning through existing improvement and governance arrangements. NHS Resolution MIS Year 8 Safety Action F, covering Board oversight, governance, culture and leadership, requires a plan informed by triangulated evidence and recognised improvement methodology, with evidence of progress and impact. The plan must be reviewed by the Trust Board at least every six months. This report serves to meet that reporting and oversight requirement.

2. Considerations

Perinatal culture improvement actions are embedded in the Maternity and Neonatal Single Improvement Plan (MNSIP), developed with staff and service users. Quality improvement centres on women, birthing people and families, empowering multidisciplinary staff to improve the Trust's maternity and neonatal services together. The Maternity and Neonatal Strategic Approach to Improvement (Appendix 1) sets out the service-wide approach. Teams use quality improvement methodology, including Plan–Do–Study–Act (PDSA), supported by Trust QI and QSIR training. Workstream leads and senior responsible owners attend monthly programme oversight groups to review actions and delivery timeframes. A two-step RAG approach distinguishes progress in completing actions from the evidence needed to demonstrate sustained improvement.

The improvement journey was supported by four service-wide events:

1. MNSIP development in November 2023 with MNSIP launch and exploration of communication preferences in April 2024;
2. Completion of the Culture Score Survey in April 2024 which received 264 staff responses.
3. Culture Conversations in October 2024 which explored the survey findings, followed by an engagement day involving 80 staff to develop the Culture Score Survey action-plan in March 2025. Six improvement themes, resulting in 76 MNSIP high level and milestone actions, were identified; and
4. "Kindness is our culture, what does this mean to you? Day" in February 2026 where anonymous feedback shared was used to create a Behavioural Charter representing our collective commitment to kindness, respect and compassionate care.

This work sits alongside other staff engagement including annual staff survey, walkaround feedback, service-user co-production and feedback, workforce intelligence and safety learning. Differences in scope and reporting periods require consideration when these sources are reviewed together.

3. Current Position/Issues

Culture SCORE delivery position: there are 76 actions in the improvement plan related to the culture score survey, this comprises 9 high level actions and 67 milestone actions. 41 actions are complete, 19 are off track, 2 are in progress and 5 are not started following the pause of the MNSIP. A summary of actions relating to the six themes is provided below:

- **Burnout and poor behaviours:** kindness engagement and staff co-design of the Maternity & Neonatal behavioural charter have progressed. This has been socialised with colleagues for final feedback and is being taken through governance routes for approval in December 2026 and then will be launched with a communication plan. The Lead PMA recruitment is complete, and the candidate has started in post. There is a weekly rota and cover across the PMA team, with next steps to work towards full 12-hour/seven-day coverage.
- **Estates and equipment**: capital equipment and estates work confirmed for 2026/27 is being progressed and a baseline review of estates in all clinical areas has been completed. The 2025/26 estates and equipment requests via the capital schemes were cross referenced with staff feedback from the engagement day to ensure equipment requested was in line with feedback from clinical teams. Outstanding actions are to develop a long- and medium-term estates plan to be developed to inform future capital planning and an easy guide to support staff with the current capital processes. A full review of the maternity and neonatal services equipment linked to the asset register is to be completed to inform future capital equipment planning. The York Neonatal Unit has been decanted whilst the refurbishment is being completed, and this is due to be finished in January 2027. A decent plan for Scarborough maternity and neonatal services will be agreed to support the required roof repairs from March 2027.
- **IT/digital infrastructure:** digital training actions are ongoing. 'BadgerBites' training sessions on specific topics for all staff and students to attend have been launched and all IT equipment has been received in each clinical area. The outstanding action to develop a BadgerNet audit tool for clinical documentation in line with clinical guidance and national best practice standards is delayed and will be progressed via the Digital Authority Group meeting which was re-established in September 2026.
- **Leadership and management**: maternity leadership visibility arrangements have progressed. This includes manager and matron presence on each site and midwifery operational leadership team posters. Wider leadership posters, the leadership commitment pledge and on-call arrangements will progress once the wider improvement plan is recommenced.
- **Communication:** a '5 times 5 ways' approach to communicate has been established to ensure information in communicated to staff in multiple formats, these formats have been agreed following staff feedback on one of the engagement days. Established formats comprise SLT walkarounds, email newsletters, posters, weekly safety briefings such as SNAaK bites (Safety, News, Action and Knowledge) and a closed Facebook group. Leaders review preferences through walkarounds, team meetings and engagement events. Awareness testing, effectiveness evaluation and post-implementation reviews remain incomplete due to pausing the wider improvement plan to focus on the national priorities.

- **Cross-site working:** a cross-site escalation policy is established and embedded. A formal evaluation of this is to be completed to review accountability, multidisciplinary participation and consistency between sites.

Staff engagement: Culture Conversations and engagement events explored findings and developed solutions. The Kindness is our culture event took place in February 2026 which supported the development of the co-produced behaviour charter. It focused on fostering positive behaviours and addressing poor behaviours confidently. The charter is planned to be launched formally following approval in December 2026.

Culture SCORE actions have been cross-referenced with staff survey feedback to ensure all relevant actions are articulated and progressed through the MNSIP.

Leadership walkarounds provide an established engagement route. Perinatal Leadership Drop-Ins were identified for Scarborough on 23 July 2026 and virtually on 29 July 2026. Meeting structures have been reviewed in response to staff feedback and there are now established meetings for staff engagement and listening. This includes, ward level meetings led by ward managers, a meeting between ward managers and the matron teams and a monthly senior midwifery forum, including the specialist midwives' team and MNVP attendance.

Service-user feedback, including MNVP: listening to women, parents and families and co-producing services are MNSIP commitments. The MNVP annual overview 2025 describes contributions to communication, antenatal education, feeding support, regional work and QI. Examples include 15 Steps, MDT/MNVP website improvement and birth-partner work combining patient and staff feedback to develop the proposed behavioural charter.

The maternity feedback survey was launched in 2026, and October feedback describes compassionate care and good MDT working alongside issues raised on conflicting advice and inconsistent explanations. This is limited feedback rather than a service-wide outcome measure. The MNVP do a broad range of engagement work across the trust and feed this back via a number of established methods including attending monthly senior midwifery leadership meetings, maternity and neonatal assurance group and directorate group meetings and having a weekly meeting with the transformation lead midwife and monthly with the Director of Midwifery to discuss any urgent or arising matters. Response to service user feedback follows the process of improvement outlined in appendix 1 depending on the feedback provided. The CQC maternity service survey results from 2025 were reviewed in partnership with the MNVP, and actions were co-produced and embedded into the MNSIP. The same approach for the 2026 results will be taken.

Equality, diversity and inclusion: York and Scarborough have joined the National Perinatal Equity and Anti-Discrimination Programme (PEADP) in July 2026 which addresses racism and discrimination in care and staff experience. Preparatory work includes leadership involvement, the identification of local challenges through data and staff/service-user insights, and proposed equity actions agreed for inclusion in the MNSIP. This work is supported by equity dashboards, national initiatives and staff survey/WRES information. Proposed training covers stereotyping, culturally sensitive risk communication, allyship, speaking up and outcome inequalities; its approval, delivery and evaluation are not yet established.

Perinatal Culture Improvement Plan

Incidents, audits and safety intelligence: The MNSIP workstream "Developing and Sustaining a Culture of Safety, Learning and Support" covers multidisciplinary participation in governance, Safety-II and learning from good practice, a positive safety culture, and the maternity and neonatal governance framework. Proposed measures for this workstream use evidence from Datix, the perinatal dashboard, MNSI recommendations, learning-from-action reports, PMRT, ATAIN, attendance, audits, guideline changes and MIS safety actions. The outstanding task is to bring current findings from these sources together with anonymised Freedom to Speak Up Guardian and safety champion themes and review them alongside the other evidence sources described in this report.

A thematic PPH audit and action plan has been completed for presentation to PSII Group. Clinical documentation QI, a refreshed Quality and Patient Safety Governance Framework, an improved complaints and guideline position, PMRT Board reporting and a ward-to-board schedule of business are all in place demonstrating reported improvement activity. Recruitment to a guideline and audit lead midwife is currently in progress to support this agenda.

Workforce data: The "Growing, Retaining and Supporting our Workforce" workstream of the MNSIP covers education time, workforce review, appraisal, escalation and 12/7 Professional Midwifery Advocate (PMA) support. Funding towards closing the midwifery establishment gap over three years has been agreed and progress with this recruitment is progressing and continues to be reported via established governance routes. Flexible-working processes are complete and embedding through the workforce panel. The neonatal nursing staffing business case is currently being completed, and the review of obstetric and neonatal medical staffing remains ongoing.

4. Summary

Perinatal culture improvement remains embedded within the Maternity and Neonatal Single Improvement Plan (MNSIP). Progress includes multidisciplinary engagement, co-production with staff and service users, leadership visibility, communication and workforce support. Delivery of all the Culture Score actions are ongoing with completed actions requiring evaluation to demonstrate sustained improvement in staff and family experience. The pause in the wider MNSIP from July to December 2026 provides context for the delivery position while services focus on the four national priority areas.

Outstanding work includes behavioural charter approval, full PMA coverage, workforce capacity reviews, estates and digital developments, and evaluation of leadership, communication and cross-site escalation arrangements. Further triangulation of staff, service-user, workforce and safety evidence is needed to assess impact and inform future priorities. The report therefore provides grounded assurance on improvement activity and engagement, while recognising that sustained cultural improvement is not yet fully demonstrated.

5. Next Steps

The Board is asked to note the breadth of ongoing perinatal culture improvement work and the progress reported across staff and service-user engagement, leadership, communication and workforce support. In doing so, the Board is asked to recognise that

completion of actions does not, on its own, demonstrate sustained cultural improvement; further evaluation and triangulation of evidence are required.

The Board is asked to support the reprioritisation of outstanding culture improvement work when the MNSIP resumes, taking account of the four national priorities and current staff and service-user feedback.

The Board's support is sought for clear accountability of the agreed recovery dates, with delivery and impact measures informed by staff survey, engagement, MNVP and service-user feedback, workforce, incident, audit, speaking-up and equity evidence.

The Board is asked to agree to review the perinatal culture improvement plan at least every six months, with progress and material risks reported through the agreed governance route. Future reports should distinguish delivery of improvement actions from evidence of sustained improvement in staff and family experience, enabling the Board to assess impact and consider whether further support or escalation is required.

Date: 5 November 2026

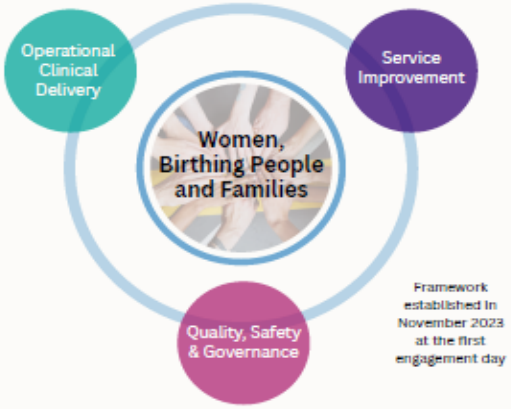
Appendix 1: The Maternity and Neonatal Strategic Approach to Improvement

The Maternity and Neonatal Strategic Approach to Improvement

Maternity & Neonatal Services York & Scarborough

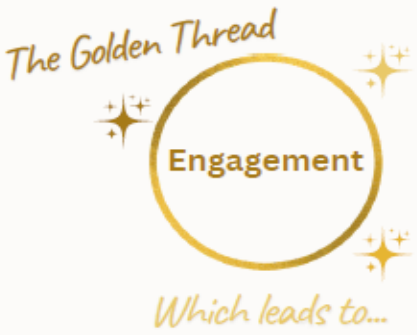
NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Maternity and Neonatal Services Delivery Framework: Empowering staff and service users to work together to improve outcomes in maternity and neonatal care



Framework established in November 2023 at the first engagement day

- The framework ensures all work is centred around the service user experience
- An MDT approach is taken in all discussions with early engagement from the Maternity and Neonatal Voices Partnership (MNVP)



- Collective ownership of the aim and actions to achieve it
- Clear understanding of roles and responsibilities in the improvement journey
- Consistent communication and awareness of where the actions will be held and progress & impact monitored
- Visibility of progress and celebration of successes

How it works in everyday practice

A problem arises or an issue is identified which requires addressing

Key stakeholders have initial discussions to agree how the problem or issue can be addressed

Key questions which help frame the discussions:
- Is this something that needs to be put on the risk register and actions and mitigations monitored this way?
- Is this something that can be picked up operationally through agreed actions and ward audits to monitor?
- Is this something that requires unpicking and a quality improvement project launching as a result?

Collective agreement on next steps and where the actions will be held and progress & impact monitored

(1) Quality, Safety & Governance

It is added to the risk register and mitigating actions and impact monitored with oversight from the Care Group Governance Lead

(2) Operational Clinical Delivery

Actions agreed to address the issues and impact operationally monitored through tendable ward rounds with oversight from the Matrons

(3) Service Improvement

1. Key stakeholders are identified to support identified quality improvement project to address the problem/issues.
2. A project brief is developed and submitted to the Maternity and Neonatal Single Improvement Plan Oversight Group for review and approval
3. Actions are incorporated into the Maternity and Neonatal Single Improvement Plan and monitored through Smartsheets with oversight from the programme team

Reporting and Communications

Reports on Progress and Impact are incorporated into the care group governance structure with the initial reports being discussed at the Maternity Directorate and/or the Child Health Directorate through:
1. Quality, Safety and Governance reports and risk register reports (Communications: Weekly SNAaK briefing)
2. Matron operational reports (Communciations: updates at team meetings)
3. Maternity and Neonatal Single Improvement Plan Highlight Reports (Communications: Maternity and Neonatal Single Improvement Plan monthly Key Messages)

Why it works

- Teams work within a psychologically safe space, everybody has an equal voice, respects each others thoughts, ideas and opinions
- Teams work collectively and cohesively which avoids duplication of work
- We actively listen, hear and act to meet individual needs of our service users and wider community
- We engage and collaborate with our Maternity and Neonatal Voices Partnership (MNVP)
- Teams work flexibly to solve a problem. Following the Plan, Do, Study, Act cycle (PDSA) to support a continuous improvement approach
- Staff are supported to attend Trust QI and QSIR training
- Early engagement, good professional relationships and open and honest conversations supports collective ownership and delivery of actions
- Compassionate leadership, engagement and oversight from the SLT
- The single improvement plan is dynamic with realistic timeframes and deliverables, developed and agreed with colleagues and service users
- Dedicated programme support is provided and good working relationships between the directorate and programme team
- The programme team support action owners to progress the deliverables but are not action owners themselves. This enables the programme team to effectively monitor, report and provide oversight of the large scale improvement projects.
- Organisation processes are followed for all projects
- Good governance and simple application of project management principles
- 2-step RAG rating used to support and demonstrate sustained improvements

Appendix 2 Behavioural Charter

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Maternity Equity: Analysis by Deprivation and Ethnicity
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)

☒ Yes
☐ No
☐ Not Applicable

The analysis identifies statistically significant inequalities in timely access to maternity care by deprivation and recorded ethnicity. It also identifies ethnicity-recording completeness as an equity and assurance issue.

Executive Summary:

This paper presents an analysis of maternity antenatal booking and preterm birth outcomes by Index of Multiple Deprivation (IMD) and recorded ethnicity for the period 1 September 2025 to 31 August 2026. The analysis was undertaken in response to the maternity 10-point plan and its focus on equity and inequalities through the Maternity and Neonatal Equalities Dashboard.

The 2025 dashboard data reported that 78.4% of booking appointments at the Trust occurred within the first 10 weeks of pregnancy, compared with 64.8% for England. It also reported a Trust preterm birth rate before 37 weeks' gestation of 76.2 per 1,000 births, compared with 77.2 per 1,000 for England, while highlighting higher rates among women living in deprivation quintiles 1 and 2. The Trust therefore undertook a more detailed review by recorded ethnicity and deprivation.

The booking cohort comprised 4,598 records and the delivery cohort 3,884 records. Overall, 892 of 4,598 bookings (19.4%) occurred after 10 weeks. Late booking was significantly associated with deprivation and recorded ethnicity (both $p<0.001$). The rate was 34.7% in IMD decile 1, compared with 17.4% in IMD decile 10, and 25.4% among patients with a recorded non-White-British ethnicity, compared with 15.8% among White British patients.

There were 330 preterm births among 3,884 deliveries (8.5%). Rates varied by IMD, but the pattern was inconsistent and the association was not statistically significant ($p=0.254$), this should not be interpreted as evidence that inequality is absent. Ethnicity was blank or recorded as not stated in 6.7% of booking and delivery records. This group had higher recorded rates of late booking (46.0%) and preterm birth (17.2%), requiring investigation of pathway, recording-practice and patient factors. The findings support targeted pathway review, co-production with the Maternity and Neonatal Voices Partnership, improved ethnicity-data completeness and ongoing monitoring by site, deprivation and ethnicity.

Recommendation:
The Trust Board is asked to:

1. Note the statistically significant inequalities in timely maternity booking associated with deprivation and recorded ethnicity.
2. Receive oversight of a deep dive into late-booking pathways for people living in IMD deciles 1-3.
3. Support co-production with affected communities through the Maternity and Neonatal Voices Partnership.
4. Require improvement in ethnicity-recording completeness, with review by site.
5. Support monthly monitoring of late booking by site, IMD and ethnicity, using counts and percentages.
6. Support repeat review of preterm birth outcomes when a larger dataset is available.

Report Exempt from Public Disclosure

☒ No ☐ Yes

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

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Data presented for discussion; proposed actions and governance route to be agreed.
Maternity and Neonatal Assurance Group	10th November 2026	

Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	
Health Inequalities Delivery Group	17th December 2026	

Maternity Equity and Outcomes: Analysis by Deprivation and Ethnicity

1. Introduction and Background

This paper presents an analysis of access to maternity care and preterm birth outcomes by Index of Multiple Deprivation (IMD) and recorded ethnicity. The analysis covers bookings and deliveries recorded between 1 September 2025 and 31 August 2026. It is intended to inform service improvement to reduce inequalities, improve equity and does not establish causation.

This data was drawn in response to the maternity 10-point plan and its focus on equity and inequalities. Access to maternity care and preterm birth outcomes had been identified as areas for further focus through the Maternity and Neonatal Equalities Dashboard, and this analysis was undertaken to drill down into the data by deprivation and recorded ethnicity. The findings are intended to support targeted improvement, inform co-production with the Maternity and Neonatal Voices Partnership (MNVP), and strengthen ongoing assurance that maternity services respond proportionately to identified need.

The booking cohort contains 4,598 records and the delivery cohort 3,884 records. The cohorts relate to different maternity events and should not be treated as identical populations. Late booking is defined in this analysis as booking after 10 weeks, and preterm birth as birth before 37 completed weeks gestation.

2. Considerations

The principal issue is unequal timely access to maternity care. The data supports focused improvement work and co-production on access into maternity care for those identified as booking later, as well as improving ethnicity data quality.

Proposed priorities are:

- Deep-dive late-booking pathways, initially focusing on IMD deciles 1-3 and identifying delay at referral, initial contact and completion of booking.
- Co-design improvement work with affected communities through the Maternity and Neonatal Voices Partnership.
- Improve ethnicity-recording completeness, including review of missing data by site and feedback to clinical teams.
- Introduce monthly monitoring by site, IMD and ethnicity, reporting both counts and percentages.
- Review preterm birth outcomes again using a larger sample with the preterm birth leadership team.

3. Current Position/Issues

Timely booking

The Maternity and Neonatal Equalities Dashboard reported that, during the 2025 reporting period, 78.4% of booking appointments at the Trust took place within the first 10 weeks of pregnancy, compared with 64.8% for England. Although the Trust-level position was above the England proportion, further analysis was undertaken to understand variation by recorded ethnicity and deprivation decile and to identify whether the overall figure concealed inequalities between groups. In the analysed cohort, 892 of 4,598 patients booked after 10

weeks, a rate of 19.4%. There was a statistically significant association between late booking and deprivation ($p<0.001$). The highest rate was in IMD decile 1 at 34.7% (105 of 303), compared with 17.4% (116 of 668) in IMD decile 10. The pattern is strongest at the most deprived end and is not a smooth gradient across every adjacent deprivation decile.

There was also a statistically significant association between late booking and recorded ethnicity ($p<0.001$). White British patients had a late-booking rate of 15.8% (557 of 3,528), compared with 25.4% (193 of 761) for patients with a recorded non-White-British ethnicity. The grouped comparison provides a stable headline but may conceal differences between individual communities.

Preterm birth

The Maternity and Neonatal Equalities Dashboard reported that, during the 2025 reporting period, the Trust rate of babies born preterm before 37 weeks' gestation was 76.2 per 1,000 births, compared with 77.2 per 1,000 for England. Although the overall Trust rate was similar to the England rate, the dashboard highlighted higher rates among women living in deprivation quintiles 1 and 2. Further analysis was therefore undertaken to examine preterm birth by recorded ethnicity and deprivation in greater detail and to identify whether the overall position concealed inequalities between groups. In the analysed cohort, there were 330 preterm births among 3,884 deliveries, an overall rate of 8.5%. Rates varied by IMD, including 12.5% in IMD decile 1 (31 of 248) and 8.4% in IMD decile 10 (48 of 570). However, variation was inconsistent and the association was not statistically significant ($p=0.254$). The finding should be described as insufficient evidence of a consistent association in this dataset, rather than evidence that inequality is absent.

Data quality and equality implications

Ethnicity was blank or recorded as not stated for 6.7% of bookings and 6.7% of deliveries. Within this group, 46.0% of bookings occurred after 10 weeks (142 of 309) and 17.2% of deliveries were preterm (45 of 262). Missing ethnicity data can have equity implications, and this data indicates that women and birthing people whose ethnicity is not recorded may experience later access to maternity care. Work will begin with the digital midwives to review the causes of missing and blank ethnicity data and monitor data completeness.

4. Summary

- Late booking affected 19.4% of the booking cohort and is the clearest equity signal in the data received.
- Late booking was significantly associated with deprivation and recorded ethnicity (both $p<0.001$).
- Preterm birth was 8.5% overall in the reporting period and this dataset did not show a statistically significant or consistent IMD gradient.
- Missing ethnicity data is an equity and assurance issue and requires investigation.

5. Next Steps

The following actions will be taken:

1. Meet with the Community Midwifery Leadership Team in November 2026 to review the findings, identify priority areas for improvement and agree initial actions.

2. Collaborate with the Maternity and Neonatal Voices Partnership (MNVP) to incorporate service-user perspectives and co-design actions that will have an impact on access, experience and outcomes.

3. Introduce a monthly review of maternity booking data by site, ethnicity and deprivation, including counts, percentages, trends and agreed follow-up actions.

4. Review the preterm birth data with the Preterm Birth Leadership Team and agree any further analysis, improvement priorities and next steps.

5.Work to establish maternity equity dashboard to be progressed

6. Work with the Digital Midwife to review the causes of missing and blank ethnicity data and monitor data completeness.

7. Update to be provided on the above actions through Directorate in December.

Date: 26th October 2026

Appendix

Figure 1: Antenatal booking appointments >10 weeks' gestation by IMD decile (September 2025-September 2026 data)

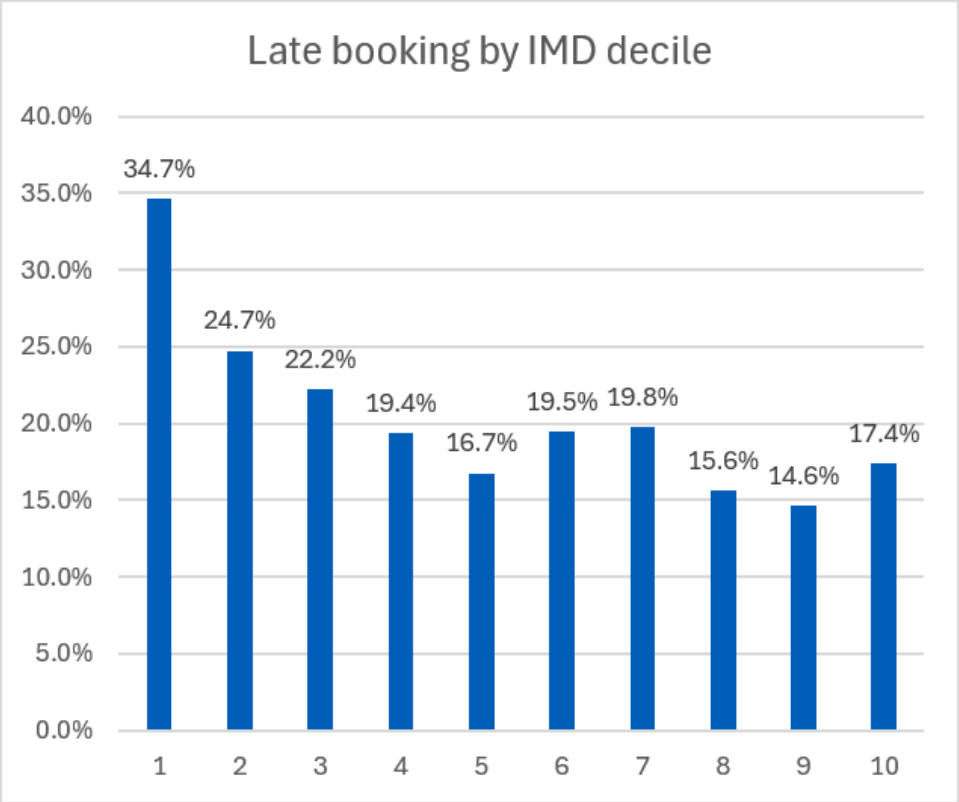


Figure 2: Preterm births by IMD decile (September 2025-September 2026 data)

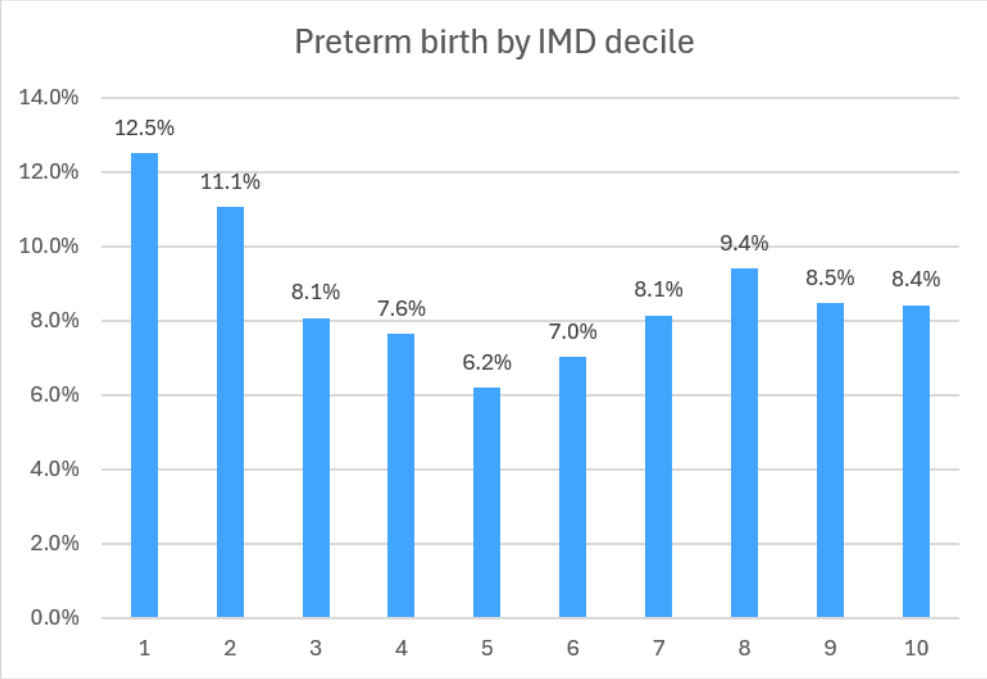


Figure 3: Antenatal booking appointments >10 weeks' gestation ethnicity comparison (September 2025-September 2026 data)

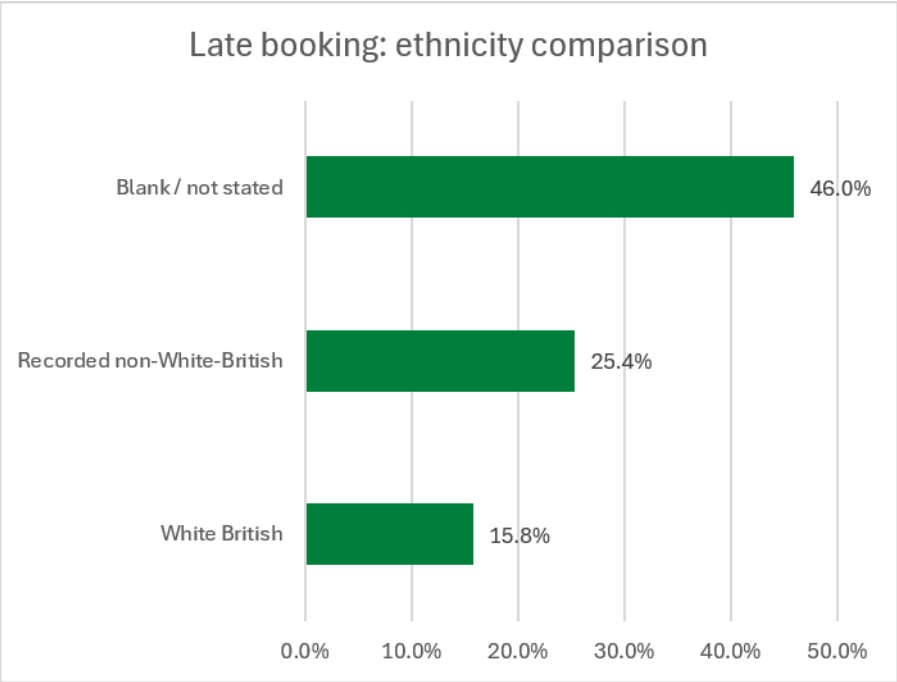
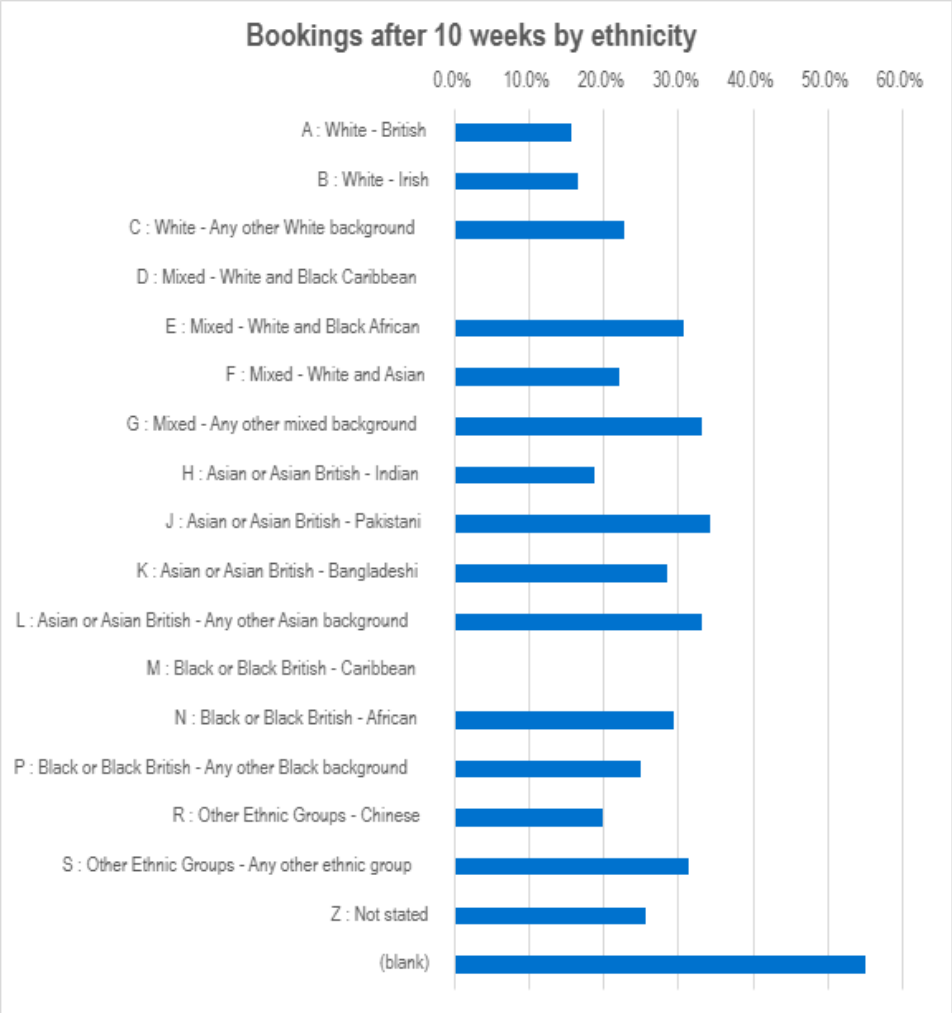


Figure 4: Antenatal booking appointments >10 weeks gestation by ethnicity (September 2025-September 2026 data)



Report to:	Board of Directors
Date of Meeting:	26 November 2026
Subject:	Care Group Learning from Deaths and Perinatal Mortality Review Tool (PMRT) Report Quarter 2 2026/2027
Director Sponsor:	Sascha Wells-Munro, Director of Midwifery
Author:	Jamie Broadbent, Family Health Care Group Quality & Governance 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:

The NHS Resolution Maternity (Perinatal) Incentive Scheme (MIS) Year 8 (2026/27) continues to support the delivery of safer maternity and neonatal services through compliance with six core Safety Actions: workforce and capacity; training; learning from reviews and investigations; service-user voice and equity; care bundles; and board oversight, governance, culture and leadership. The scheme is designed to strengthen local accountability, support learning and improvement, and improve outcomes for

women, babies and families. The MIS Year 8 framework continues to require regular Board oversight and assurance regarding perinatal mortality reviews, associated learning, and the implementation of improvement actions arising from local and national reviews.

A key requirement of Safety Action C is that all eligible perinatal deaths are notified to MBRRACE-UK and reviewed using the Perinatal Mortality Review Tool (PMRT). Trusts are required to ensure robust multidisciplinary review processes, meaningful parental engagement, timely completion of reviews, and evidence that learning is translated into service improvement.

This report provides the Trust Board with an overview of all eligible perinatal deaths reported to MBRRACE-UK during Quarter 2 2026/27. It summarises compliance with PMRT requirements, emerging themes and learning identified through the review process, actions taken to improve patient safety, and assurance regarding adherence to the requirements of the NHS Resolution Maternity (Perinatal) Incentive Scheme Year 8.

This report forms part of the Trust's ongoing governance arrangements to ensure transparency, organisational learning, and continued oversight of maternity and neonatal safety performance.

Recommendation:

The Trust Board is asked to receive this report, note the findings and learning from Quarter 2 2026/27 perinatal mortality reviews, and take assurance regarding compliance with the NHS Resolution Maternity (Perinatal) Incentive Scheme (MIS) Year 8 requirements and the ongoing monitoring of associated improvement actions.

Report Exempt from Public Disclosure

No ☒ Yes ☐

Report History

This report is submitted to the Trust Board on a quarterly basis to provide assurance regarding compliance with the NHS Resolution Maternity (Perinatal) Incentive Scheme (MIS) Year 8 requirements, including oversight of perinatal mortality reviews, key learning, and associated improvement actions.

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Data presented for discussion; proposed actions and governance route agreed to public board following removal of PID.
Maternity and Neonatal Assurance Group	10th November 2026	
Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	

Perinatal Mortality Review Tool (PMRT) Report Quarter 2 2026/2027

1. Purpose

The purpose of this report is to provide assurance to the Trust Board, including the Maternity Safety Champion and Board-level Safety Champion, that all eligible perinatal deaths are reported to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and reviewed using the Perinatal Mortality Review Tool (PMRT) in accordance with national requirements.

The report provides oversight of perinatal mortality activity within York and Scarborough Teaching Hospitals NHS Foundation Trust, including compliance with reporting and review standards, the quality and timeliness of the review process, parental involvement, key learning identified, and the actions taken to improve the safety and quality of maternity and neonatal care.

This report contributes to the Trust's assurance framework for NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) Year 8, supporting effective governance, organisational learning, and Board oversight of maternity and neonatal safety. The findings will also be shared with the Trust Learning from Deaths Oversight Group.

1.1 Definitions

The following definitions are used by MBRRACE-UK to identify reportable perinatal deaths:

- Late miscarriage (late fetal loss): A baby delivered between 22+0 and 23+6 weeks' gestation showing no signs of life, irrespective of when the death occurred.
- Stillbirth: A baby delivered from 24+0 weeks' gestation (or weighing 400g or more where gestation is unknown) showing no signs of life, irrespective of when the death occurred.
- Neonatal death: The death of a liveborn baby from 22 completed weeks' gestation (or weighing 400g or more where gestation is unknown) occurring before 28 completed days of life.

2. Context

As part of the requirements of NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) Year 8, Trusts must demonstrate that all eligible perinatal deaths are notified to MBRRACE-UK and reviewed through the Perinatal Mortality Review Tool (PMRT) in accordance with national standards. This includes evidence of multidisciplinary review,

parental engagement, identification of learning, and implementation of quality improvement actions.

This quarterly report provides the Trust Board with an overview of all eligible perinatal deaths reported to MBRRACE-UK during Quarter 2 2026/27, together with compliance against PMRT requirements, key themes arising from reviews, identified learning, and progress against improvement actions. The report enables the Board to gain assurance regarding the effectiveness of local governance arrangements and the Trust's continued commitment to improving outcomes for women, babies and families.

1. Current Position/Issues

1.1 Eligible losses in Q2 2026/2027

There has been a total of five eligible losses reported to MBRRACE-UK via the PMRT in quarter two 2026/2027.

One reported case met the criteria for an external investigation conducted by the Maternity and Newborn Safety Investigations (MNSI) however this was rejected.

2. Summary of all losses closed in Quarter 2 2026/2027

There were five perinatal mortality reviews completed in the period Q2 2026/27.

Summary of eligible deaths closed in Q2 2026/2027:

- Five cases were closed: three at Scarborough and two at York.
- All parents were informed and their views sought.
- All five reviews were published within seven months, four within six months.
- Median gestation was 26 weeks (range 23–39); birthweights ranged from 500g to 3,780g.
- External reviewers were involved in four out of five cases.

Grading of care and learning: Learning focuses on neonatal resuscitation, stabilisation, airway management and family engagement during resuscitation incidents. Care grades and any relationship between care and outcome must be supported by individual reviews; these themes do not imply concerns in every case or that care contributed to a death.

Ongoing thematic review and improvement priorities: An ongoing thematic review brings together findings, care grades and families' experiences to identify recurring issues and priorities for resuscitation, stabilisation, airway management and family communication and support. Priorities remain proposed, not completed improvements; agreed actions should have named leads, timescales and measurable outcomes, monitored through maternity and neonatal governance.

Good practice: Good practice was identified in CTG analysis, escalation and MDT communication. The thematic review will consider how to share and sustain this practice, without implying assurance about all care in every case.

3. Compliance as per MIS Year 8 Standards (Appendix A)

The Trust remains compliant with the requirements of NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) Year 8 Safety Action C through the notification of all eligible perinatal deaths to MBRRACE-UK and the completion of reviews using the Perinatal Mortality Review Tool (PMRT) in accordance with national standards. Processes are in place to support multidisciplinary review, parental engagement, identification of learning, and the implementation of improvement actions arising from reviews. Ongoing monitoring is undertaken through established maternity governance structures, with quarterly assurance provided to the Trust Board.

4. Paediatric Deaths

There was one reported additional paediatric death for review through the child death overview panel within Q2 2026/2027. This review is ongoing.

Date: 23rd October 2026

Appendix A – Summary of Compliance as per MIS Year 8 Standards Q2 2026/2027

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Target %	Q1	Q2	Q3	Q4
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within 7 working days	**100%**	**100%**	**100%**		
Seek parents' views of care	**95%**	**100%**	**100%**		
A PMRT review must be started within two months following the death of a baby who has died in the Trust	**95%**	**100%**	**100%**		
A PMRT must be completed and published within six months of the death of a baby's death	**75%**	**100%**	**80%**		
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT.	**50%**	**100%**	**80%**		
Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board	**100%**	**100%**	**100%**		

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 15.9

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Learning Themes Report Quarter One and Two 2026/2027
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midwifery and Stategic Clinical Lead for Family Health
Author:	Jamie Broadbent, Family Health Care Group Quality and Governance 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 brings together learning within the Maternity and Neonatal Directorate for Quarters one and two of 2026/2027, drawing on MNSI, PSII, PMRT, complaints and concerns. It describes three priorities for service development: improving patient experience and timely access to care, strengthening learning from postpartum haemorrhage, and reducing avoidable term neonatal admissions through development of transitional care. For each theme, the report sets out the response and how progress will inform assurance to the Board.

Triangulated learning demonstrates three dominant themes:

1. Complaint Management – Learning concerns behaviours and attitudes, treatment delays and pain-management delays. The proposed response brings these together as a patient-experience and access-to-care review. It will examine communication, listening and respectful care; treatment pathways, waiting times and escalation; and access to analgesia, including the proposed review of epidural provision within 30 minutes of request. Findings will inform service-level actions with owners, timescales and measures. Patient feedback, recurring complaint themes and relevant timing measures will be used to assess whether changes improve experience and timely care.

2. Postpartum Haemorrhage (PPH) – PPH remains a priority for clinical learning. The reported September 2026 site figures are SGH 1.1% and YDH 3.6%. Routine monthly monitoring and reporting, review of all cases with blood loss greater than 1500 ml, and further review of unusual patterns support identification of learning and timely response. The thematic review is scheduled for publication in November 2026, with presentation to the PSI Group planned that month. Its findings will inform priorities for improvement, with subsequent monitoring used to assess the delivery and impact of resulting actions.

3. Unanticipated Admission to SCBU – The Q1 ATAIN rate is 5.3%, with a rolling-year rate of 5.6%; both are below the 6% target. This provides assurance on current performance while supporting a continued focus on opportunities for improvement. ATAIN discussion will review admission themes and identify babies who could benefit from an appropriately staffed transitional-care pathway. Care is currently described through SCBU/LNU, and a business case is in development for transitional care within maternity. Development of this pathway offers an opportunity to reduce avoidable admissions. Monitoring will assess admission trends, suitability for transitional care and the impact of any implemented pathway changes.

Together, these themes connect patient experience, clinical learning and pathway development. Board assurance will draw on the existing PPH monitoring and case-review processes, ATAIN performance within target, and progress with the proposed complaint review and transitional-care business case. Evaluation will focus on both

delivery of agreed actions and their effect on patient experience, timely treatment and avoidable admissions.
Recommendation: The Board is asked to note and approve the report, recognise the ongoing monitoring and learning processes, and support development of the proposed complaint review and transitional-care pathway through the appropriate governance arrangements. Progress reporting should show delivery of agreed actions and their impact on care. The transitional-care business case will follow its separate approval process.

Report Exempt from Public Disclosure
No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Maternity and Neonatal Directorate Group	9th November 2026	Data presented for discussion; proposed actions and governance route agreed.
Maternity and Neonatal Assurance Group	10th November 2026	
Family Health Care Group Board	16th November 2026	
Quality Committee	17th November 2026	

Learning Themes Report Quarter One and Two 2026/2027

1. Purpose of the report

The purpose of this report is to translate learning from maternity and neonatal intelligence into priorities for service improvement. It describes the themes identified, the ongoing and proposed responses, and how progress will be assessed and reported to the Board. The approach supports the Trust's objectives for timely, responsive and safe care, effective clinical pathways and governance. Quality improvement methodology will help turn review findings into practical changes, test their effectiveness and support sustained improvement.

2. Triangulation of learning sources

Learning has been triangulated from the following sources:

- Maternity and Newborn Safety Investigations: Identifying safety signals, variation in practice, and emerging risks.
- Patient Safety Incident Investigations: Deep dive PSIRF investigations providing insight into contributory factors, decision-making, escalation, and system issues.
- Perinatal Mortality Review Tool (PMRT): Structured review of eligible perinatal deaths, including stillbirths and neonatal deaths, to identify learning about care, stabilisation, escalation and communication.
- Complaints and Concerns: Highlighting patient experience issues, communication gaps, delays, and referral problems.
- Incident Reporting: Includes incidents resulting in no harm through to severe harm, supporting consideration of both day-to-day safety issues and events with more serious consequences when identifying themes.
- Neonatal Operational Delivery Network Feedback: External assurance and feedback of organisational systems, process and mechanisms.

Considering these sources together supports identification of recurring patterns and connects patient experience with clinical and pathway learning. Review findings will inform service-level actions, while subsequent feedback and monitoring will help assess their effect. All information has been pseudo-anonymised to protect patient confidentiality.

SCBU means Special Care Baby Unit; LNU means Local Neonatal Unit; SGH refers to Scarborough Hospital; and YDH refers to York Hospital. ATAIN means Avoiding Term Admissions into Neonatal Units and concerns babies born at 37 weeks' gestation or later.

3. Key Learning and Themes – What are we learning?

1. Complaint Management

What is the theme? Complaints identify concerns about behaviours and attitudes, delays in treatment and delays in pain management. Together, these themes highlight the importance of both the experience of receiving care and timely access to treatment. The improvement response brings communication and respectful care, treatment pathways and analgesia access into a coordinated approach to improving the patient journey.

What we are doing about it:

A proposed complaint-learning review will examine three connected areas. For behaviours and attitudes, it will use patient accounts to identify learning about communication, listening and respectful interactions, informing practical service-level changes and reinforcement of expected standards of care. For treatment delays, it will examine pathways, waiting times, decision-making, escalation and communication about next steps, identifying where processes can be improved. For pain-management delays, it will examine analgesia access and barriers to timely epidural provision, using 30 minutes from request as the proposed review criterion. Measurement points will be agreed before the review; this interval is not presented as a verified national standard. Findings will inform an action plan with owners, timescales and measures, with changes evaluated through patient feedback, repeat complaint themes and relevant access-to-care measures.

What is the assurance to the Board? The proposed response addresses all three complaint themes through a single service-level improvement approach. Progress reporting will bring together review findings, delivery of agreed actions and evidence of changes in patient experience and timely care. Recurring complaints and patient feedback will assess communication and respectful care, while waiting-time and analgesia-access measures will assess pathway changes. This provides a clear basis for developing assurance as the review and resulting actions progress.

2. Postpartum Haemorrhage (PPH)

What is the theme? PPH remains a recurring theme requiring continued clinical learning and monitoring. The September 2026 site figures are SGH 1.1% and YDH 3.6%. These site measures provide context for the case reviews and thematic work, helping the service identify patterns and priorities for improvement. The reported indicator covers PPH ≥1500 ml, while the stated case-review process covers blood loss greater than 1500 ml.

What we are doing about it:

Routine monthly monitoring and reporting will continue, together with review of all PPH cases with blood loss greater than 1500 ml. Further review will be

undertaken if an unusual pattern emerges. Case learning and monitoring will inform the thematic review, enabling findings to be brought together and translated into priorities for service improvement. The thematic review is scheduled for publication in November 2026, with presentation to the PSI Group planned that month. Findings will inform any required actions, with owners, delivery timescales and measures agreed through the review process. Subsequent case review and monthly monitoring will help assess whether changes address the learning identified.

What is the assurance to the Board? Monthly reporting and review of all PPH cases over 1500 ml provide ongoing oversight and a mechanism for identifying unusual patterns. The planned November thematic review will bring together the learning and inform the next stage of improvement. Board assurance will be supported by review findings, progress with any agreed actions and subsequent monitoring of their impact.

3. Unanticipated Admission to SCBU

What is the theme? Unanticipated term admissions remain a learning priority. The Q2 ATAIN rate is 5.3% and the rolling-year rate is 5.6%, both below the 6% target. This supports assurance on current performance while leaving scope to improve pathways for babies suitable for transitional care. Care is currently described through SCBU/LNU, and the business case for transitional care within maternity provides an opportunity to develop an alternative pathway where clinically appropriate and safely staffed.

What we are doing about it:

- ATAIN discussion will review recurring admission themes, identify babies suitable for transitional care and consider the availability of an appropriately staffed alternative pathway. This will support case-specific learning about avoidability and identify practical opportunities for pathway improvement. Clinical suitability and safe service availability will both inform the review.
- The business case in development will consider provision of transitional care within maternity. ATAIN learning will help inform the pathway, including suitability, staffing and escalation arrangements. Proposed monitoring will assess ATAIN rates against the 6% target, cases suitable for transitional care and changes in avoidable admissions following implementation. Owners, timescales and evaluation measures will be agreed through the business-case and review processes.

What is the assurance to the Board? The reported Q2 rate of 5.3% and rolling-year rate of 5.6% are below the 6% target. ATAIN review supports continued learning, while the transitional-care business case addresses an opportunity for further improvement. Progress reporting will track development and implementation of the pathway alongside admission trends and case-review findings. This will allow the Board to distinguish current

performance within target from the potential additional benefit of future pathway changes, assessed through evaluation.

4. Forward Plan

The forward plan translates the three themes into review, action and evaluation. The proposed complaint review will develop patient-experience and access-to-care actions; ongoing PPH monitoring will support the November thematic review; and ATAIN learning will inform the maternity transitional-care business case. Delivery planning will establish owners, timescales, reporting milestones and escalation arrangements. Evaluation preparation will agree consistent measurement definitions: confirm the PPH unit and denominator, retaining the source's reported percentages while resolving its accompanying rate-per-1000 label; document ATAIN denominators and rolling-year dates; and define the proposed epidural review's measurement points. This preparation will support meaningful comparison over time and assessment of improvement.

- Develop the proposed review across communication and respectful care, treatment delays and analgesia access. Use findings to agree practical service-level actions with owners and timescales. Define the proposed 30-minute epidural review's measurement points and examine barriers to timely provision. Evaluate changes using patient feedback, recurring complaint themes, waiting times and analgesia-access measures, reporting both delivery and impact.

- Continue monthly monitoring and reporting, review all cases with blood loss greater than 1500 ml, and undertake further review of unusual patterns. Progress the thematic review, with publication scheduled for November 2026 and presentation to the PSI Group planned that month. Translate findings into any required actions, agree owners and timescales, and use ongoing reviews and monitoring to assess their effect.

- Use ATAIN discussion to review admission themes and identify opportunities for an appropriately staffed transitional-care pathway. Progress the business case for provision within maternity, informed by case learning and current care through SCBU/LNU. Agree owners, timescales and evaluation measures. Track ATAIN rates against the 6% target, suitability for transitional care and changes in avoidable admissions following implementation to assess the pathway's benefit.

Continue to bring together learning across intelligence sources, using review findings, patient feedback and monitoring to refine actions and assess their impact. Progress reporting should connect the identified concern, the change made and the outcome observed, supporting sustained improvement and Board oversight.

5. Assurance to board

For complaint management, the proposed review provides a coordinated response to behaviours and attitudes, treatment delays and pain-management delays. Assurance will develop through agreed service-level actions and evaluation of their effect. Reporting will combine delivery milestones with patient feedback, recurring complaint themes and relevant timing measures, keeping the focus on respectful care and timely access to treatment.

For PPH, monthly monitoring and reporting, review of all cases with blood loss greater than 1500 ml and further review of unusual patterns provide ongoing oversight. The September site figures of SGH 1.1% and YDH 3.6% form part of this monitoring. The thematic review scheduled for November 2026, with planned presentation to the PSI Group, will inform further improvement priorities. Assurance will draw on the findings, delivery of any resulting actions and subsequent evidence of their impact.

For unanticipated term admissions, the ATAIN rate of 5.3% and rolling-year rate of 5.6% are below the 6% target, providing assurance on current performance. ATAIN review and development of the maternity transitional-care business case support continued improvement. Evaluation will assess whether an implemented, appropriately staffed pathway reduces avoidable admissions for suitable babies. Reporting will bring together pathway delivery, admission trends and case learning to assess the additional benefit of service development while maintaining oversight of performance against target.

Date: 30th October 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust

Item 16

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Patient Experience Report - Quarter Two 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.
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Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

Q2 demonstrates continued progress in strengthening patient experience, accessibility, involvement and the use of patient feedback. However, the strongest patient experience signal remains the cumulative impact of delays, poor communication and fragmented coordination. Complaint response timeliness is improving but remains below the Trust standard, while the sustained increase in complex complaints requires further analysis to understand the underlying drivers and strengthen prevention, alongside continued improvement in response timeliness.

Key developments included health coaching and person-centred care training attended by 198 staff, recruitment of 19 volunteers, and a new Friends and Family Test dashboard incorporating a measure of carer involvement in discharge planning. A national patient surveys governance and assurance framework was also approved to strengthen accountability for acting on feedback.

During Q2, the Trust and ICB undertook public engagement on the future of Bridlington Hospital following concerns about the proposed closure of the Bridlington Care Unit (BCU). A total of 463 survey responses were received and 250 people attended two public events. Feedback from the engagement informed the proposals for the BCU and wider service developments.

Care Group complaint response performance was mixed this quarter. Complaints and complex complaints improved compared with the previous quarter, with 71% of complaints and 59% of complex complaints meeting the Trust's response standards. However, performance for concerns fell from 57% last quarter to 52% this quarter. Overall performance remains below the Trust's 90% target, and sustained improvement across Care Groups remains a priority.

Complaint themes continue to identify delays in assessment, diagnosis and treatment as key patient experience concerns, often compounded by poor or unclear communication. These findings reinforce the importance of using complaints intelligence to inform improvement alongside continued work to improve response timeliness.

A consistent signal is emerging across complaints, concerns and Healthwatch feedback: compassionate and clinically good care from individual staff can be undermined by delays, poor communication and fragmented coordination across the wider patient pathway.
Progress in these areas needs to be sustained alongside action to address the principal risks to patient and carer experience:

- Delays in digital reasonable adjustment flag functionality limit consistent recording and visibility of patients' support needs and present a risk to delivery of reasonable adjustment and Accessible Information Standard requirements.
- Maintaining reliable access to interpretation and translation during the transition to the newly awarded provider, with supplier engagement planned for Q3 and transition anticipated in Q4.
- Complaint response timeliness remains below the Trust's 90% standard, with investigation capacity under pressure and complex complaints received increasing from 105 in Q1 to 150 in Q2.
- Chaplaincy referrals fell from 685 in Q1 to 435 in Q2 following the transition to Nervecentre and the loss of referral routes and access to the patient register, affecting access to spiritual support.

The key assurance requirement is that Care Groups can demonstrate how complaints and wider patient experience intelligence are being used to identify recurring risks, take targeted action and assess whether those changes are improving patients' experiences. This represents the next stage of maturity in our approach, moving from identifying themes and developing actions to demonstrating measurable impact and assurance.

Reasonable adjustment flagging remains an identified risk due to limitations in current digital functionality. A potential interim mitigation through participation in a SystmOne reasonable adjustment flag pilot is being explored ahead of the planned longer-term Nervecentre solution.

Recommendation:

The Committee is asked to receive the Q2 Patient Experience Report and:

- note progress against the Patient Experience Improvement Plan;
- note the emerging and recurring patient experience themes and associated risks;
- note the improving trajectory in complaint response timeliness, while recognising performance remains below the Trust's 90% standard; and
- seek assurance that Care Groups are using patient experience intelligence to identify recurring risks, implement targeted improvement and demonstrate the impact of actions taken.

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

Meeting/Engagement	Date	Outcome/Recommendation
Patient Experience Subcommittee	11 November 2026	Supported the paper and submission to Quality Committee for review
Quality Committee	17 November 2026	

Quarter 2 (Q2) Patient Experience Report 2026/27

1. Introduction and Background

The Trust's vision is to 'deliver an excellent patient experience every time.' This Q2 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 Q2 and support actions as required.

2. Progress Against Key Priorities

Below provides an overview of progress made during Q2 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 2 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	198 staff attended Health Coaching/Person Centred Care training sessions between 1.7.2026 and 30.09.2026. 42 staff completed the full Health Coaching 8-hour programme.
• Defining and embedding what good communication looks like	A roll-out plan for delivering development sessions for administration staff around enhancing patient experience is underway. Sessions will commence from November. These will be held face to face in York and Scarborough. We will be exploring opportunities for bespoke options for wards and departments and to support accessibility requirements of attendees. We have commenced conversations with NHS Elect for the delivery of communications training for Ward Managers, Matrons, AHP leads and resident doctors in relation to improving patient experience through compassionate communications. This programme of work has not progressed at pace due to the focus of key people on operational priorities including "Coming off Corridors".

• Explore process for patients, carers, members of the public and Trust Members to be involved/ engaged in quality improvement work, to ensure we listen to concerns and suggestions and collaborate to make sustainable changes • Provide complaints training to our staff to enable high-quality communication and responses of concerns and complaints	Patient experience and involvement education has been delivered through the AHP leadership sessions. Members of teams undertaking improvement activities have been supported by mentoring and support to assist with their programmes. Further guidelines to support teams in undertaking engagement activities will be developed and launched in Q3. Following the delivery of complaint letter writing training during 2025/26, the focus is now on ensuring that all Investigating Officers complete the Public Service Ombudsman 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 Complaints Improvement meeting to take place in Q3. This was rescheduled due to operational pressures and the focus on “Coming off Corridors” which was a priority for the Trust 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	Recruitment and engagement activity has continued, with volunteer carer champion roles promoted through existing volunteer networks. Engagement with existing volunteers continues through monthly volunteering newsletter.

• 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 Q2. The Trust Carers survey was launched in Q1. We will be reviewing feedback in Q3, and it will be discussed at the Trust Carers Forum. The survey will assist us in identifying further areas for improvement. The feedback from the survey will be shared with the Patient Experience Subcommittee in Q3.
• Involve Carers in the codesign and development of new builds and services, seeking ongoing feedback as we make changes	Carer and carer representative organisations continued their participation in Trust access audits during Q2, 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 have been embedded within the Trust's Carers Awareness Training to support learning through lived experience. One training session was delivered during Q2, with a further two sessions scheduled for Q3 to continue raising awareness and understanding of carers' roles and needs.
• Implement a process that ensures carer involvement within discharge planning as required by the Care Act	We are working closely with ward teams, particularly Ward Managers, to strengthen ward processes, accountability and ownership for discharge planning, with a particular focus on ensuring conversations with patients and their carers begin early in the admission, ideally within the first 24 hours. As part of the Coming off Corridors Programme, a focused improvement project is underway to strengthen the effectiveness of ward board rounds and ensure that discharge planning is considered proactively throughout the patient journey.
• 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 post tranche 3 deployment 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 • Improving patient experience through the recruitment, training and retention of Volunteers	During Q2, 19 new volunteers were recruited including the recruitment of Ward Support and Activity Volunteers in collaboration with Dementia and Elderly Care wards, Pets as Therapy volunteers and Chaplaincy volunteers. Updates to the Volunteer Handbook, Code of Conduct and Confidentiality Statement have been completed. The revised documents will be communicated to volunteers in Q3. As part of the ICB programme supporting youth volunteering surveys and interviews were undertaken with young volunteers to understand their experiences and inform improvements.
Managing Concerns and Complaints Improve visibility and access to the PALS service, including telephone and walk-in support, to enhance patient and carer experience.	The prolonged absence of 1 WTE has continued to place pressure on PALS capacity this quarter. To mitigate this, the team has focused on making best use of available resources, including appropriate use of AI to streamline administrative activity and release capacity for direct patient and carer support. Alongside this, PALS is exploring opportunities through wider Trust telephone developments to improve how patients and carers access the service.
Continue to improve complaint response times.	Response time performance was mixed in Q2. Performance improved for complaints and complex complaints, while concerns declined compared with Q1. Overall performance remains below the Trust's 90% target, and sustained improvement across Care Groups remains a priority.

	• 52% of closed concerns were responded to within the Trust's 10 working-day target, compared with 57% in Q1. • 71% of closed complaints were responded to within the 30 working-day target, up from 65% in the previous quarter. • 59% of closed complex complaints were closed within the 45 working-day target, compared with 54% in Q1. The priority is now to build on this progress by achieving greater consistency across Care Groups and reducing the number of cases that exceed agreed response times. Maintaining timely responses is important not only as a measure of performance, but in ensuring that patients and families receive answers to their concerns without unnecessary delay.
Healing Environment • Complete the review of Patient Led Assessments of the Care Environment (PLACE) audit outcomes and identify priority actions. • We will support patients with their spiritual needs by increasing referrals to the chaplaincy service supported by education of clinical staff by Chaplaincy.	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 Q2, 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. There was a reduction in Chaplaincy referrals by 36% in Q2. This reduction was due to the transition to Nervecentre and the loss of Chaplaincy referral routes and access to the patient register. To support referrals, changes were made to how Chaplaincy volunteers support the service. They are now based on wards to engage with patients and carers to promote the service. In addition, Chaplains have increased their presence in ED. This has been supported by education of staff and community faith groups. At the end of Q2 Inpatient and ED referrals has been restored so it is anticipated that referrals will increase in Q3.
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 was approved by the Executive Committee at the end of Q2 and will be implemented in Q3.
• 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 York ED.
• 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 now include 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 Q2, the Yorkshire and Humber Procurement Collaborative progressed the contract award following another legal challenge. A preferred supplier, Language Empire, has now been awarded the contract. Engagement with the new supplier will begin in Q3. It is anticipated that the transition to the new provider including staff training and patient communications will take place in Q4. The contract with Dals will continue alongside the new provider until the end of March 2027.

A review of interpretation spend, avoidable waste and tablet usage identified opportunities to improve efficiency, accessibility and reliability took place. Recommendations were presented to the Patient Experience Sub-Committee in Q2. The plan for the replacement of will take place in Q3 supported by the Patient EDI Lead and the digital team who will work with Care Groups to ensure appropriate equipment is purchased and robust ownership arrangements are in place for all devices.

3.2 Equality Diversity and Inclusion- Equality Delivery System

The plan for the FY2026/27 programme was confirmed in Q1 to cover antenatal care, York Acute Frailty Unit and Audiology as focus areas, with a staged review cycle and increased Care Group ownership. Preparatory activity will commence in Q3, so that EDS is embedded within Care Group improvement processes and supporting the development of locally owned equality objectives.

3.3 Widgit Online Communication Tool

Widgit is now being used to support the provision of easy read materials and accessible communication in Trust engagement activity in the Children's Therapy Services and Complex Care Teams.

In Q2, the Head of Profession for Speech and Language Therapy was appointed and will be leading the workplan for expanding access to Widgit Online to other departments and services commencing in Q3.

3.4 Digital Inclusion

During Q2 work commenced to strengthen Digital inclusion focused on improving equitable access to information and services through the Trust website and digital channels. This included engagement with regional digital inclusion networks to increase awareness of the Trust's website accessibility tools and features, enabling network members to support patients, carers and community groups to access information in ways that met their individual needs.

This includes ensuring people are aware of alternative communication methods in addition to telephone contact, helping patients and carers obtain the right information at the right time through channels that are accessible to them.

3.5 D/Deaf community

In response to concerns raised through the ICB we met with the Hull and East Yorkshire Centre for the Deaf to explore barriers to British Sign Language interpretation provision. The findings have informed areas for improvement including staff training requirements, with activity due to begin in Q3 initially focusing on maternity services. Other areas of improvement include the co-production of patient information in BSL, strengthening community relationships and improvements to interpretation services.

We have established a robust process for sharing Datix incidents relating to the provision of interpreting services with the interpreting provider, with assurance incorporated into contract management meetings.

In response to staff feedback, a flowchart for interpretation booking, escalation and incident reporting was published and communicated through internal communications.

3.6 Friends and Family Test (FFT)

FFT development during Q2 focused on strengthening the quality and usefulness of patient feedback. A new organisational FFT dashboard was developed in Q2 to support performance monitoring against key priorities. A new measure of carer involvement in discharge planning was introduced and established as a key KPI, providing greater assurance around patient and carer involvement in care decisions. Work also continued to support care groups to use FFT insights more effectively to identify themes, monitor experience and drive local improvement.

In Q3, an audit will identify active and inactive services, followed by targeted communications and support for those departments and services that are inactive.

Toward the end of Q2, 311 services had been mapped on Gather/FFT, 282 staff had been manually registered on the platform, and 247 gained access to recorded training, resources and support videos. Response numbers fell significantly after SMS messaging stopped but

gradually recovered following targeted support with QR codes, survey distribution and staff training. SMS messaging in specific departments and services will resume in Q3.

3.7 Community Engagement – Bridlington Hospital

The Bridlington Care Unit at Bridlington Hospital was established in 2021 as part of the system's response to the COVID-19 pandemic, providing step-down capacity for patients who were medically fit for discharge but unable to return home due to delays in care arrangements. The model was designed as a temporary intervention to support flow within the acute hospital system, particularly at Scarborough Hospital.

In May 2026 the Trust began a consultation with staff on the BCU with a view to closing the Unit. The East Riding of Yorkshire Health and Wellbeing Scrutiny Sub-committee (OSC) convened an extraordinary meeting following concerns raised about the ICB and the Trust's plans to close the BCU. The OSC recommended that the Trust and ICB undertake a structured public engagement exercise to provide clarity to residents that the proposal related solely to the Bridlington Care Unit and not to wider services at Bridlington Hospital, and to communicate the longer-term strategic vision for the hospital site, including expansion of elective, diagnostic and outpatient services.

The purpose of the engagement was to:

· Reassure residents as to the future of Bridlington Hospital and provide clarity to residents that the previous closure proposal related solely to the Bridlington Care Unit and not to wider services at Bridlington Hospital.

· Provide opportunities for patients, staff, local residents and stakeholders to be involved in the planning of the provision of relevant services and in the development of the proposals for changes to the way services may be provided.

· Communicate the longer-term strategic vision for the Bridlington Hospital site.

· Showcase the positive health and social care work happening in Bridlington.

The engagement was designed to enable feedback to be gathered on the Trust's emerging clinical strategy, alongside broader health and care services provided for the Bridlington population and, specifically, the BCU. This feedback will be considered and helped inform the proposals for changes to the Bridlington Care Unit, as well as other developments in Bridlington.

Feedback was gathered from multiple sources during the engagement period. These included:

· Survey (available in hard copy and online)
· Engagement events in Bridlington
· Written feedback, letters and submissions
· Existing patient experience data.

It was important to ensure that as many people as possible were able to participate and give their views. A number of steps were taken to make the engagement accessible and encourage

participation from a wide a range of people as possible including:

· Translating the survet into different languages (top most-translated versions produced).
· Large print and easy-read versions of the survey.
· Accessible online survey platform offering translation, audio, large font, colour contrast.
· Hard-copy surveys with freepost address for returns.
· Phone number provided for people who wanted to provide feedback into the engagement through a conversation or if they needed help with the questionnaire.

The survey was open from 6 July to 9 August. 463 completed surveys were received.

Two public engagement events were held at the Spa in Bridlington on 27 July, 16:00-19:00 and 28 July, 10:00-13:00. A total of 250 people attended across both days.

Approximately 30 colleagues from health, social care and voluntary and community organisations attended each day to facilitate the events and support the conversations. The following organisations were represented: York and Scarborough Teaching Hospitals NHS Foundation Trust, NHS Humber and North Yorkshire Integrated Care Board, CHCP, East Riding of Yorkshire Council, Healthwatch East Riding, Carers Plus Yorkshire and Surecare. The engagement report was shared with the East Riding of Yorkshire Health and Wellbeing Scrutiny Sub-committee as part of the Trust and ICB response to the OSC recommendations for Bridlington hospital and was be published on the Trust's website.

The engagement findings are being were considered as part of the decision-making process for the future of the BCU, demonstrating how feedback has influenced the proposed model and subsequent decision.

4. Complaints and Concerns

Complaints and concerns provide important insight into how patients experience care across the Trust. This quarter, the findings highlight the cumulative effect of delays, communication difficulties and fragmented pathways, particularly where patients are already experiencing uncertainty or complex care needs. Greater emphasis is therefore needed on using this intelligence alongside wider quality and safety information to identify recurring issues, demonstrate learning and provide assurance that improvement is making a measurable difference to patient experience.

4.1 New concerns and complaints received in Q2

A total of 1,116 concerns were received representing an 8% decrease on Q1. Of these, the Patient Advice and Liaison Services team (PALS) registered 191 cases on Datix for investigation and resolution by Care Groups, while the remaining were managed directly by PALS on behalf of Care Groups, corporate services, and Facilities Management.

The main themes this quarter continue to centre on communication and delays in care pathways. These include communication with patients, delays in treatment or procedures, referral issues, delays in providing information or results, and concerns about clinical advice. Together, these themes highlight the importance of timely care and keeping patients clearly informed throughout their journey.

A total of 325 complaints were received, an increase of 11% compared with Q1.

The number of complex complaints increased, with 150 received compared with 105 in Q1, representing a 43% increase. Care Group Medicine accounted for 44% of all complex complaints. The highest number of cases overall related to Emergency Medicine (16%) and Elderly Medicine (11%). The remaining cases were spread across a broad range of services.

Many complex cases involved patients or relatives raising concerns repeatedly before action was taken, often alongside serious clinical issues such as deterioration, delays in diagnosis or treatment, cancer pathways, infection, neurological symptoms and missed fractures. Communication, coordination of care and discharge planning also featured frequently. This combination of clinical and service-related concerns resulted in complaints requiring input and investigation across several teams or services, contributing to the higher number of complaints being managed as complex complaints.

Emergency Medicine accounted for 24% of the 475 complaints received overall (116 cases).

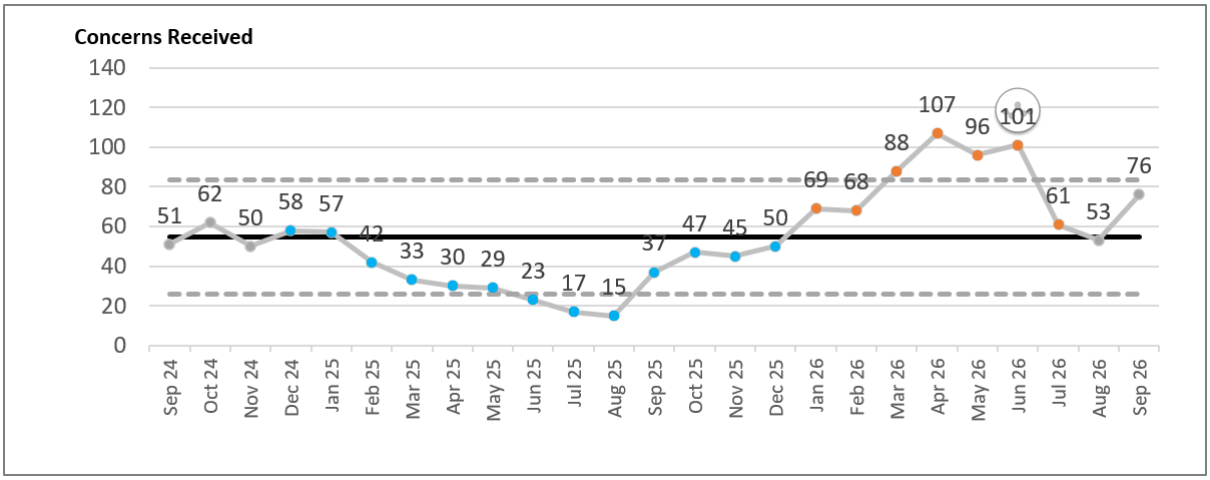
New cases Q2	Concerns	Complaints	Complex Complaints	Total
York Hospital (including Community)	132	226	109	**467**
Scarborough Hospital	54	94	38	**186**
Bridlington Hospital	5	5	3	**13**
Total	**191**	**325**	**150**	**666**

New cases by Care Group in Q2	Concerns	Complaints	Complex Complaints	Total
Medicine	71	147	66	**284**
Surgery	73	80	35	**188**
CSCS	23	42	21	**86**
Family Health	16	43	25	**84**
Corporate Services	8	13	3	**24**
Total	**191**	**325**	**150**	**666**

Please note: Datix data is live and may be subject to minor changes. Figures run by the Datix team at the end of the quarter may therefore differ slightly from SCP charts produced at the end of each month.

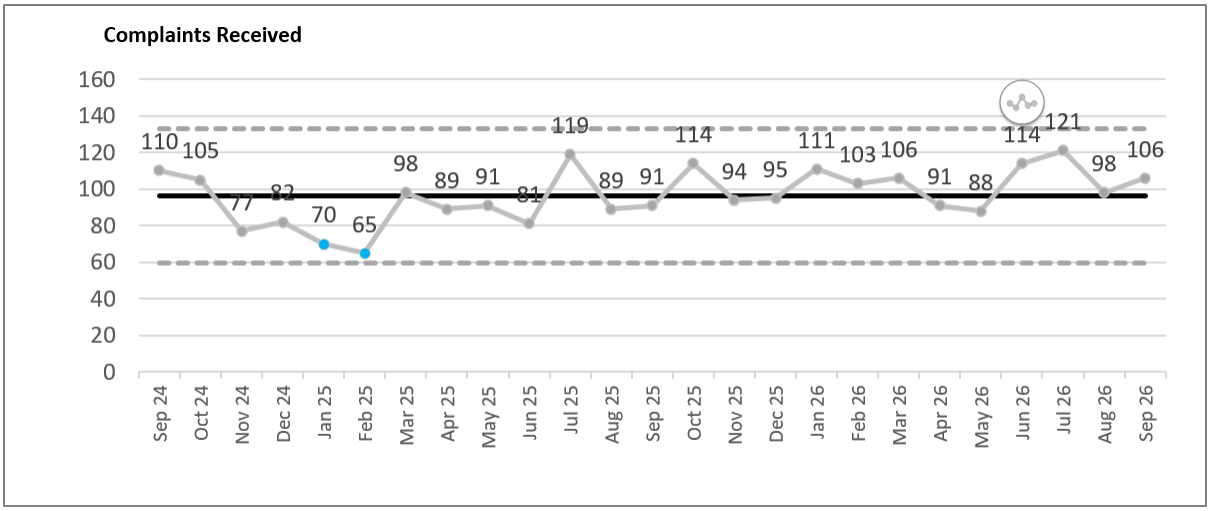
Concerns Received (cases logged on Datix)

Overall, the quarter suggests that the earlier downward trend has begun to reverse. Whilst the September figure of 76 is still below the chart's upper reference line, concern volumes will continue to be monitored to determine whether the upturn at the end of Q2 represents the start of a sustained upward trend.



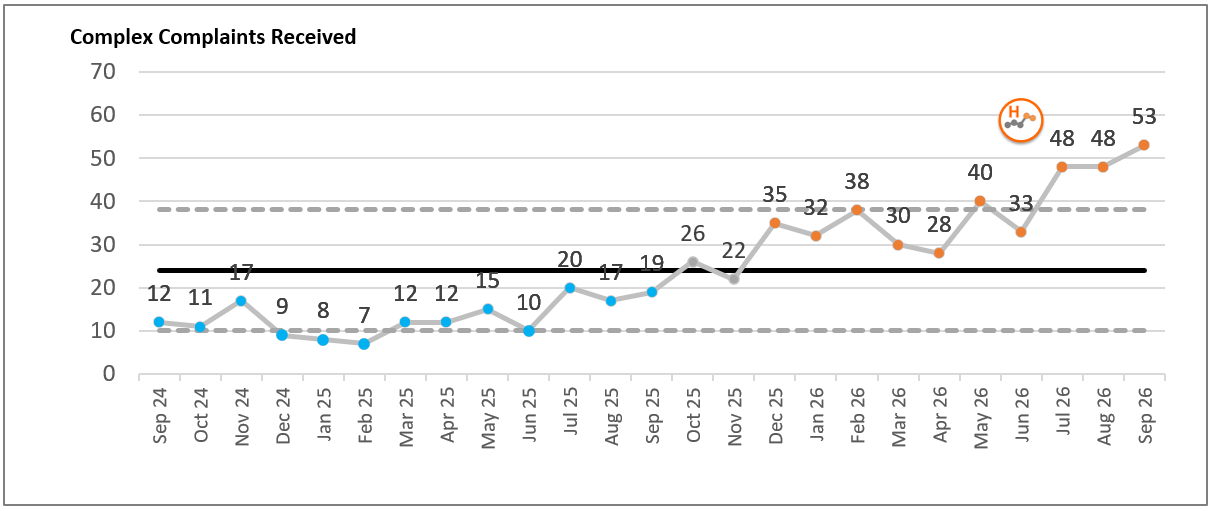
Complaints Received

Complaint volumes continue to fluctuate month to month, with no clear sustained upward or downward trend over the period shown. While Q2 recorded an overall increase in complaints compared with the previous quarter, the monthly pattern remains variable, with a peak in July followed by lower levels in August and September. This reinforces the importance of considering complaint volumes alongside emerging themes and service level data to understand where changes in patient experience may require further attention.



Complex Complaints Received

The longer-term trend shows a clear increase in complex complaints, with volumes moving to a consistently higher level over the past year. This is particularly evident in Q2, with 48 complex complaints received in both July and August and 53 in September, the highest monthly figure shown. All three months were above the upper reference level.



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
Attitude of nursing staff/midwives	Delay or failure in treatment or procedure	Delay or failure to diagnose
Delay or failure to diagnose	Referral Issues	Acting/Reporting Diagnostics
Delay or Failure of Medical Assessment	Delay in giving information/results	Delay or Failure of Medical Assessment
Communication with Patient	Communication - Clinical Advice	Care Pathway Issues

Delays in assessment, diagnosis and treatment continue to represent a significant theme across complaints. Concerns include delays in clinical assessment, diagnostic investigations and results, referrals, follow-up appointments, procedures and treatment. Patients also describe repeated attendances and prolonged waits before their condition or treatment needs were resolved. The feedback highlights the impact that delays can have on patients' confidence in care, particularly where symptoms are worsening or patients are left without a clear diagnosis, treatment plan or timescale for next steps.

Communication remains closely linked to many of the concerns raised. Patients and families describe difficulties obtaining results, updates and clear explanations about diagnosis, treatment, discharge and follow-up. There are also recurring examples of conflicting information and poor communication between teams and services. In some cases, patients and relatives report repeatedly having to chase for information or coordinate different parts of their own care. This also places additional demand on PALS, with patients and families contacting the service when they are unable to reach the relevant department or obtain the information they need directly from the team responsible for their care. This reinforces the importance of clear communication, effective handovers and identifiable clinical ownership throughout the patient pathway. This aligns with the recently published 2025/26 NHS England Data n Written Complaints in the NHS which highlighted that communication was the most common complaint subject area within Hospital and Community Health Services.

Staff attitude, compassion and professionalism continue to have a significant influence on patients' experience of care. Complaints describe patients and relatives feeling dismissed, not listened to or spoken to without sufficient empathy or respect. Concerns involve clinical, nursing, administrative and reception staff and are particularly evident where patients are already experiencing pain, anxiety, uncertainty or prolonged waits. The feedback demonstrates that compassionate and respectful communication remains fundamental to maintaining confidence and trust, even where services are experiencing operational pressures.

Fundamental care, dignity and discharge also remain important areas for assurance. Complaints include concerns about pain management, food and hydration, continence and toileting, personal care, pressure-area care, medication and access to assistance.

There are also repeated concerns about discharge decisions, communication of discharge arrangements and whether appropriate support and follow-up were in place. These issues are particularly significant for older and vulnerable patients and those with additional or complex needs.

Overall, the findings continue to show that poor patient experience is often not attributable to a single event, but to a combination of delays, communication failures and fragmented coordination across the pathway. The findings support continued Care Group oversight of these themes, with complaints intelligence used alongside patient safety, quality and operational information to identify recurring risks and target improvement activity.

Healthwatch Feedback

Anonymous feedback from Healthwatch this quarter provided a mixed picture of patient experience. The themes identified broadly align with those seen within formal complaints, providing additional assurance that the issues identified are reflected across different sources of patient experience intelligence.

A clear feature of the feedback is that patients and relatives often distinguish between the quality of care provided by individual members of staff and their experience of navigating the wider system. Staff are frequently described positively, with patients highlighting kindness, compassion, professionalism, reassurance and good clinical care. Positive experiences include cancer and chemotherapy services, ophthalmology, surgical care, stroke rehabilitation, paediatric care and individual experiences within emergency and inpatient services.

However, negative feedback identifies a number of recurring themes:

- Waiting and access to care: Patients describe long waits in emergency care, waits for beds, procedures and follow-up appointments, and uncertainty about when care or treatment will take place. The impact of waiting appears greater where patients are in pain, frail, seriously unwell or approaching the end of life.

- Communication and keeping people informed: Feedback repeatedly describes patients and relatives not knowing what is happening, what they are waiting for or what will happen next. This includes cancelled or rearranged appointments, follow-up arrangements, test results and discharge planning.

- Involvement of relatives and carers: Some feedback indicates that relatives and carers do not always feel adequately involved in discussions about care, including where they hold important information about the patient's needs or provide significant support at home.

- Coordination and continuity: Several experiences describe difficulties at transition points, particularly between departments or services and following discharge. Patients can be left feeling responsible for chasing appointments, referrals or information themselves.

- Medication and symptom management: Concerns include delays in pain relief, access to usual medication and medication arrangements during admission and discharge. Where patients have complex needs, failures or delays in these areas have a particularly significant effect on their experience.

- Dignity and basic needs during periods of pressure: Feedback about emergency care includes the experience of waiting for prolonged periods in chairs or corridors, difficulties accessing toileting support, food and drink, and delays in receiving pain relief or other basic care.

Importantly, positive and negative experiences are not always separate. Some patients describe excellent, compassionate care from individual staff within an overall experience which they found difficult or poorly coordinated. This suggests that the quality of interpersonal and clinical care can remain strong even where operational pressures, communication or processes adversely affect the patient's overall experience.

The feedback also shows what patients value when care works well. Patients particularly recognise staff who listen, explain what is happening, involve them in decisions, respond to individual needs and show kindness and compassion.

Examples of personalised care, including adapting care for patients with additional needs and supporting relatives and carers, are particularly positively received.

Overall, the feedback suggests that communication, coordination and management of waiting are important factors influencing confidence in Trust services. Keeping patients and families informed, particularly when there are unavoidable delays, and ensuring that carers are appropriately involved could improve experience even where wider operational pressures cannot immediately be resolved.

The consistency between these sources strengthens the case for continued focus on communication, management of delays, coordination between services and ensuring that fundamental care and dignity are maintained during periods of operational pressure.

Taken together, complaints, concerns and Healthwatch feedback present a consistent patient experience signal. Patients can experience compassionate and clinically good care from individual members of staff, while still experiencing the overall pathway poorly because of delays, communication failures and fragmented coordination. This reinforces the need for improvement actions to focus not only on individual services or episodes of care, but also on how patients experience the whole pathway.

4.3 Care Group Themes

Medicine: accounted for the largest proportion of complaints during the quarter. Delays in clinical assessment, diagnosis, investigations and treatment were the most common themes, particularly within Emergency Medicine, which accounted for more than half of the Care Group’s complaints.

Patients described prolonged waits, delayed observations and pain relief, missed or delayed diagnoses, and concerns about the recognition and escalation of deterioration. In inpatient

services, complaints also highlighted medication issues, unsafe or poorly coordinated discharge, continence and personal care, nutrition and hydration, pressure-area care and communication with families.
The findings indicate continued pressure across emergency, acute and inpatient pathways, with vulnerable patients and those with complex needs particularly affected by delays, unsuitable care environments and fragmented coordination.

Surgery: Complaints most commonly related to delays in diagnosis, investigations, procedures and follow-up, alongside cancellations and prolonged waits for planned treatment. General Surgery, Trauma and Orthopaedics and Urology generated the highest volumes within the Care Group.

Patients described cancelled operations, delayed specialist review, unclear waiting-list positions, missed or delayed follow-up and difficulty obtaining information about treatment plans.

Concerns were also raised about pain and medication management, post-operative care, discharge arrangements, staff attitude and communication. Several complaints described patients having to repeatedly contact services to clarify who was responsible for progressing their care, contributing to uncertainty, distress and loss of confidence.

Family Health: Complaints were concentrated within Gynaecology, Maternity and Paediatrics. Recurring themes included delays in assessment, diagnosis, treatment and specialist referral, together with poor communication and patients or parents not feeling listened to.

Within Gynaecology, concerns frequently related to delayed diagnosis and treatment, long waits for surgery, pain management and inconsistent follow-up.

Maternity complaints highlighted communication, compassion, escalation of concerns, feeding support, continuity and the handling of pregnancy loss or other sensitive circumstances.

In Paediatrics, parents described delays in referrals and investigations, poor coordination between services and concerns that their knowledge of their child’s needs was not always given appropriate weight.

Reasonable adjustments, support for neurodivergent patients and family involvement also featured across the Care Group.

Cancer, Specialist and Clinical Support Services: Complaints commonly concerned diagnostic processes, access to specialist services and communication of results and treatment plans.

Radiology generated the highest number of complaints within the Care Group, with concerns including delayed or unreported results, appointment and referral problems, cancellations, conflicting information and difficulties contacting services.

Similar themes were evident in Dermatology, Ophthalmology, Neurology, Rheumatology and Oncology. Patients frequently described having to chase results, appointments or prescriptions and experiencing uncertainty about diagnosis, treatment and clinical ownership.

Staff attitude and communication were also prominent, particularly where patients were awaiting potentially serious diagnoses or receiving complex and emotionally difficult care.

Corporate Services: Complaints primarily related to Estates and Facilities, Patient Access and discharge or flow processes. Themes included car parking arrangements and charges, appointment booking and cancellation, difficulties contacting services, access to suitable food and staff attitude.

Although smaller in number, these complaints show how administrative and environmental processes can create additional barriers and distress for patients and families who are already managing illness, disability or prolonged hospital attendance.

Clear information, accessible processes and compassionate communication remain important in reducing avoidable frustration.

Across all Care Groups, the findings show a consistent interaction between delays, communication failures and unclear coordination or ownership of care. Patients frequently describe the cumulative impact of waiting without information, having to repeat or chase concerns, and being uncertain about what will happen next.

Staff attitude and compassionate communication remain important, particularly where patients are in pain, vulnerable, anxious or experiencing prolonged and complex pathways.

The key assurance requirement is that Care Groups can demonstrate how complaints intelligence is being used to identify recurring risks, take targeted action and monitor whether changes improve patients' experiences.

Particular attention is required around timely assessment and escalation, communication of results and next steps, waiting list and referral management, discharge coordination, fundamental care, reasonable adjustments and compassionate interactions.

4.4 Complaints Reopened

Monitoring reopened complaints provides an important measure of the effectiveness of complaint handling. Understanding why complainants remain dissatisfied helps identify opportunities to improve the quality, clarity and completeness of responses and strengthen learning across Care Groups.

Reopened complaints increased to 7% in Q2, compared with 5% in Q1. The predominant reasons were that complainants felt their concerns had not been fully addressed or that responses did not provide sufficient supporting evidence. This is an important indicator of the quality, rather than simply the timeliness, of complaint responses and will continue to be monitored. It reinforces the need for Care Groups to ensure responses address every element of the complaint, clearly explain the evidence considered and demonstrate how identified learning has been translated into action.

4.5 The Public Service Ombudsman

The Public Service Ombudsman (the Ombudsman) provides an independent review of complaints where people remain dissatisfied following the Trust's complaints process. Complainants are advised of their right to approach the Ombudsman following the Trust's final response. Ombudsman enquiries and investigations provide an additional source of learning, helping the Trust identify where complaint handling, communication or services may need to improve.

During Q2, the Ombudsman opened three new investigations: One relating to Stroke Rehabilitation at White Cross Court, one relating to the Upper GI Medical Team within Surgery and one relating to the DN Team within Family Health. The outcomes of these cases, including any findings and learning identified, will be reported once the Ombudsman's investigations are concluded. No Ombudsman cases were concluded in Q2.

5. Concerns and Complaint Performance

On average in Q2:

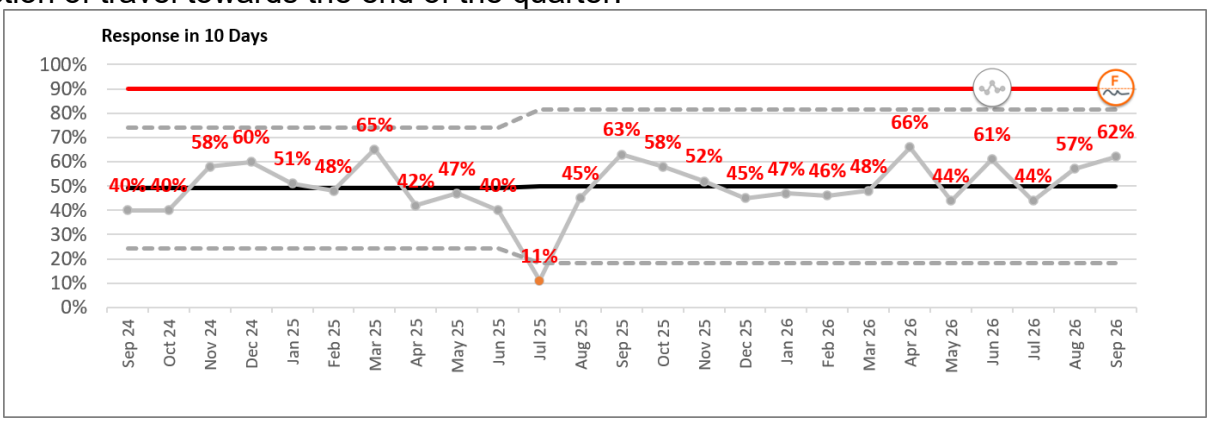
- 52% of closed concerns met the Trust's 10 working-day response target.
- 71% of closed complaints met the Trust's 30 working-day response target.
- 59% of closed complex complaints met the 45 working-day response target.
  Please note: Datix is a live system, and data may be subject to minor changes. Figures produced by the Datix team at the end of the quarter may therefore differ slightly from the monthly SPC charts, which reflect the data available at the time they were produced.
- PALS acknowledged 666 formal complaints and concerns, with an average acknowledgement time of 4 working days, slightly above the national 3-working day target. Performance during the quarter was affected by a prolonged whole-time equivalent staffing absence in September.
- PALS provided the timely resolution of 925 concerns on behalf of Care Groups, with an average response time of 5 working days, meeting the Trust's internal target.

Q2 performance showed progress in complaints and complex complaints, although response performance remains below the Trust's 90% standard across all case types. Concern performance was lower overall than in Q1, but improved during the quarter, providing some assurance that the direction of travel towards the end of Q2 was positive.

The priority for Q3 is to build on this improvement and increase consistency across all case types. Care Groups will need to maintain oversight of outstanding cases, progress investigations without unnecessary delay and intervene early where agreed response timescales are at risk. Continued focus on these areas will be important to improve timeliness while maintaining the quality and thoroughness of responses to patients and families.

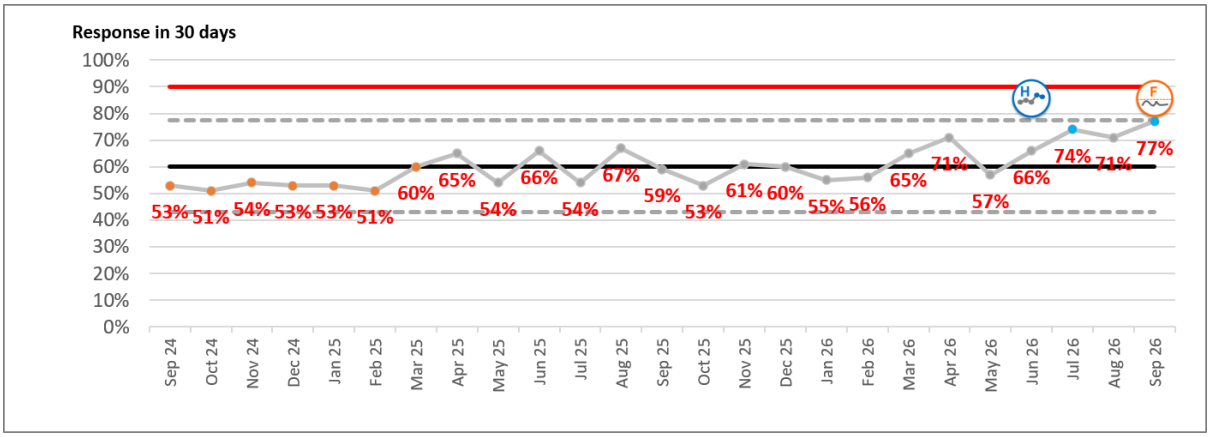
5.1 Concerns Closed Response Rate

52% of concerns were responded to within the Trust's 10-working-day target in Q2, compared with 57% in Q1. Although overall quarterly performance declined, there was positive improvement during Q2, with performance rising to 62% in September, indicating an improving direction of travel towards the end of the quarter.



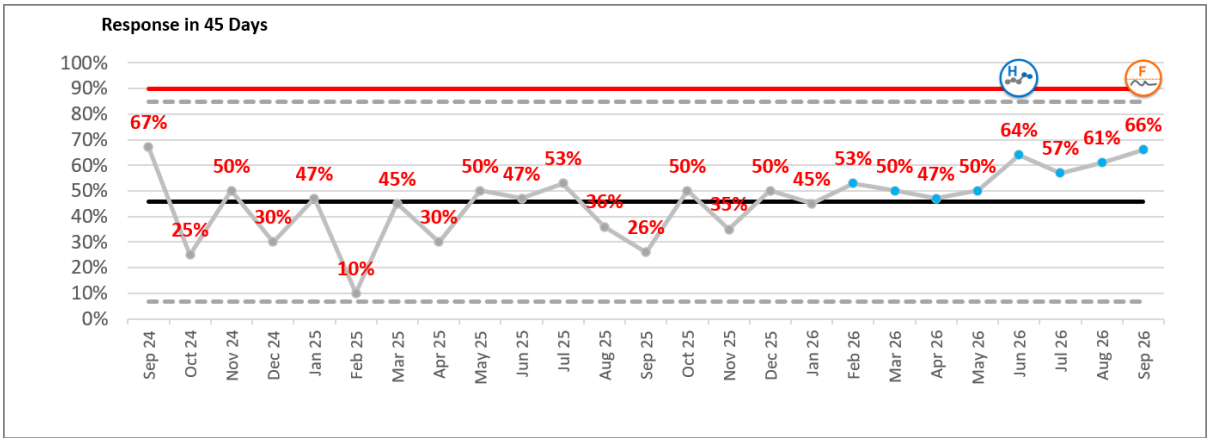
5.2 Complaints Closed Response Rate

During Q2, an average of 71% of closed complaints were responded to within the Trust's 30 working day target, an improvement from 65% in Q1. Performance remained consistent across the quarter. This represents a positive improvement in timeliness. However, performance remains below the Trust's 90% standard. Continued focus is therefore required on timely investigation and response, with Care Groups maintaining oversight of cases at risk of exceeding the agreed timescale.



5.3 Complex Complaints Closed Response Rate

Performance in responding to complex complaints within 45 working days improved during Q2, with a quarterly average of 59%. While the continued improvement is positive, performance remains below the 90% target, and sustained improvement is required to further reduce delays in providing complainants with a response.



6. Examples of service improvements made in response to complaints

Learning from complaints is an important part of improving patient experience and the quality of services. By understanding what matters to patients and families, and acting on the issues they raise, the Trust can use their experiences to inform improvements in the quality, safety and experience of care.

The following examples demonstrate improvements made by Care Groups in response to feedback and learning identified through complaints.

Family Health Care Group - Maternity and Neonatal Services

Feedback from maternity and neonatal services in Q2 highlights compassionate, skilled care and the value of trusted relationships. Families praised continuity with community midwives, attentive labour care and reassuring support during complications. Positive experiences also included timely triage, specialist care and clear explanations that helped families understand their care.

However, experiences varied across services and care settings. Some families described dismissive or insensitive communication that left them feeling “belittled” and less willing to seek help. Conflicting advice and gaps in information sharing caused confusion.

Feedback identified a need for more consistent postnatal pain relief, privacy, wound-care information and follow-up, alongside personalised infant feeding support.

Families also highlighted occasions when staff did not sufficiently acknowledge birth preferences or the emotional impact of emergencies, loss and separation.

These areas are being addressed through the improvement plan for maternity and neonatal services. Some specific areas to highlight include:

- Establishment of a quality improvement plan in response to pain management to ensure that epidurals can be administered within 30 minutes. This includes a workforce review of anaesthetics in Scarborough to ensure the clinicians have the appropriate skills.

- A review is being undertaken of patient information leaflet to improve the quality of patient information. An Audit and Guidance Midwife is being recruited who will have accountability for this area.

- Personalised care plans have been introduced which will include infant feeding.

The feedback provides assurance of staff compassion and capability, while identifying priorities for greater consistency. The directorates focus remains on compassionate communication, listening and escalation, postnatal dignity, feeding support and reliable information sharing. Ongoing collaboration and engagement with the Maternity and Neonatal Voices Partnership and the directorate includes their involvement in the pain relief project, development of a wound-care leaflet, review of antenatal education on emergency communication and collaboration with the bereavement team.

Family Health Care Group - Child Health

In Q2 Child health have led a healthy eating initiative with fresh fruit and vegetable crudites being offered daily for children and young people on the children’s wards, this has been received well with children and families enjoying alternative snack options.

We were delighted to see 19 paediatric GREAT-ix submissions in September alone, recognising compassionate care, effective teamwork, leadership, safeguarding practice, high-quality communication and documentation, with positive practice used to reinforce learning across teams.

Family Health Care Group - Community

Positive feedback was received across Community services, with patients and carers praising compassionate care, clear explanations, prompt responses, follow-up communication, dignity and practical support. Feedback from District Nursing, Community inpatient units, Community Response Team and Community Therapy Team highlighted feeling listened to, appreciation for end-of-life care and support for independence. Alongside this positive feedback, service-specific learning and improvement priorities are outlined below.

District Nursing feedback identified opportunities to improve written care records, access to appointments and local blood clinics, continuity and communication when planned visits change. Proposed actions include reviewing caseload allocation to support a core staff group where possible, reinforcing pre-visit record review and handover, and notifying patients of significant changes to visit timing or staff. PALS contacts and patient feedback will inform team and governance reviews, supported by documentation spot checks.

Learning from a continence complaint identified opportunities to strengthen ordering processes, communication about supply arrangements and timely responses to patient enquiries. Learning was shared across teams to improve coordination and consistency of care, with specialist advice and escalation where needed.

Learning from Community inpatient units identified priorities around discharge delays, responsiveness and the care environment, with implications for dignity, comfort and safety. Actions focus on strengthening partnership working and progressing environmental and equipment improvements, with progress monitored through governance, patient feedback and safety and quality reviews. Patient engagement is also being strengthened through goal setting and multidisciplinary review.

Community services are strengthening patient-feedback participation to better identify experience themes and inform improvement. Participation and emerging themes will continue to be monitored alongside complaint-related learning.

Surgery Care Group

Ward 15 – improving communication: In response to complaints about communication and information sharing, the Ward Manager and Matron now undertake daily ward rounds to increase their visibility and improve communication and relationships with patients and families. The rounds include patients in side rooms, following feedback that they sometimes felt isolated and ‘ignored’. A reduction in complaints about communication and basic care has been reported following the introduction of these rounds.

Urology – trial of Super-Clinics: Patients have historically needed to see two or three specialist team members for a single urological issue. Depending on their needs, these may include urology, gynaecology or colorectal consultants, a urology nurse specialist, and pelvic floor clinic staff or a physiotherapist. This can prolong the referral, assessment and treatment process and be frustrating for patients. The Super-Clinic brings these specialties together in a one-stop clinic, allowing patients to see the relevant specialists at a single appointment. The approach is currently being trialled, with early indications that it is a positive development.

CSCS Care Group

The Care Group has completed a thematic review of complaints and concerns received during the previous year to identify recurring themes, emerging trends, and opportunities for improvement. By the end of Q2, development of the Care Group improvement plan was underway, with a focus on appointment delays, referral issues and communication. This work

is monitored through the Care Group Patient Experience Group to support oversight of progress and shared learning across specialties and services.

The thematic review identified communication and information provision as the main areas contributing to complaints in Oncology and Haematology services. Gaps in communication and information provision may leave Oncology and Haematology patients unclear about their treatment, what to expect and when or how to seek help. This may increase anxiety and reduce confidence in managing symptoms and accessing timely support.

Work is underway to update patient information materials, including pre-assessment videos and information leaflets, to improve patient understanding and support throughout their treatment journey. Additional focus will be placed on improving documentation of clinical discussions, safety-netting arrangements and escalation plans to ensure patients receive consistent information and have clear routes for seeking support when required.

By the end of Q2, specialty dashboards within DCIQ were live, strengthening access to patient experience and governance data. Smart sheets are in development for all specialties to triangulate Friends and Family Test (FFT) feedback, complaints and other relevant data, supporting targeted improvement discussions. Specialties are developing improvement plans based on these findings and presenting their work through the Care Group Patient Experience Group. These arrangements support the Care Group's ongoing work to embed and sustain learning from patient feedback.

In August CSCS delivered 100% of standard complaints within the 30-day timeframe. 100% of complex complaints in August were delivered within the timeframe. In September 100% of standard complaints were delivered within the 30 days' timeframe. This improvement is supported by weekly check-ins for all Investigating Officers with the Associate Chief Nurse or Associate Chief Operating Officer. This ensures complaint responses are on track and any concerns from IOs are addressed early and appropriate support in place.

Medicine Care Group

Medicine Care Group has continued to implement a range of improvement initiatives in response to complaint themes, patient feedback, and learning from complaints. These actions are focused on improving communication, responsiveness, patient experience, and timely access to care.

Complaint Reduction Initiatives

- Rapid Complaint Improvement Days have been successfully implemented across both York and Scarborough hospital sites, with two events held at each location. Early evaluation indicates these have contributed to a reduction in outstanding complaints by up to 35% on the day of the events, improving timeliness of responses and patient experience.

- A dedicated Complaints Lead post has been appointed and is due to commence on 23rd November2026. This role will provide additional capacity to support investigations, organisational learning, and the implementation of service improvements arising from complaints.

Learning from Complaints and Service Improvements

Actions implemented in response to complaint themes include:

- Revised therapy referral criteria have been implemented on the Acute Medical Unit (AMU) and Ward 24 to improve prioritisation and reduce delays in patients being assessed. Post-implementation data is currently being collected to assess impact and inform future service development.

- Additional therapy resource has been front-loaded within Lilac services to better understand demand and capacity requirements. Data analysis is underway to inform future service coverage and referral pathways.

- Following complaints relating to delays in therapy assessments, referral criteria changes have also been introduced on Ward 36 and Beech Ward. Subject to evaluation, this approach will be extended into Elderly Medicine services.

- Work is underway to introduce communication boards in ED displaying expected wait times for patients and relatives. This initiative has already been established at York and plans are progressing to implement the same approach within Scarborough Hospital. A leaflet has also been developed and is going through governance processes for approval.

- Improvements have been introduced to support the timely prescribing and administration of PRN analgesia. Impact will be monitored through a reduction in complaints relating to pain management and delays in treatment.

- Patient-facing business cards have been rolled out across wards to improve communication, provide named points of contact, and enhance the patient experience.

- Targeted improvement work has commenced on wards with higher levels of complaints relating to recognition and escalation of deteriorating patients. Working alongside Clinical Educators, the programme has commenced on Ward 24 and focuses on improving staff knowledge, early recognition, and escalation processes.

Next quarter, Medicine will continue to monitor the impact of these interventions through complaint themes, patient feedback, operational metrics, and outcome data. Particular focus will be placed on embedding learning from complaints, evaluating referral pathway changes, improving communication with patients and families, and reducing complaints associated with delays in care and the recognition of deteriorating patients.

Discharge Planning

The Care Group is working closely with ward teams, particularly Ward Managers, to strengthen ward processes, accountability and ownership for discharge planning, with a particular focus on ensuring conversations with patients and their carers begin early in the admission, ideally within the first 24 hours.

As part of the “Coming off Corridors Programme” which was implemented in Q2, a focused improvement project is underway to strengthen the effectiveness of ward board rounds and ensure that discharge planning is considered proactively throughout the patient journey. This is supported by:

- Bitesize Choice Policy training for ward teams, reinforcing the importance of early and appropriate conversations with patients and carers.

- A quick ward guide on the above and escalation process, designed to support teams to identify potential discharge barriers early, communicate expectations consistently and escalate appropriately.
- Discharge Liaison Nurses from the discharge command centre are now attending ward board rounds more consistently, providing a supportive and coaching approach to complex discharge planning and helping ward teams build confidence and capability.
- Proactive discharge advice before patients being classed as medically fit for discharge. Although a Discharge Readiness Form cannot be completed until the patient is medically fit for discharge, the Discharge Liaison Nurse can work proactively with the ward beforehand to identify potential barriers, advise on discharge planning and support earlier conversations with patients and carers.
- Implementation of the Discharge Standards, with particular emphasis on the admission phase so that discharge planning begins from the outset rather than becoming a focus later in the patient's stay.

The overall aim is to create a more proactive approach to discharge, where discharge planning is everybody's responsibility from admission, ward teams feel confident to start conversations early, potential barriers are identified sooner, and specialist discharge support is used proactively rather than only once a patient is medically fit for discharge.

Corporate

Outpatient Services: Patient complaint and concern themes are reviewed monthly through the Datix review meeting between Operational Managers, Service Managers and the Head of Outpatient Services. This provides a structured approach to identifying learning and ensuring appropriate actions are taken in response. Feedback and training have also been provided for Operational Managers to strengthen complaint responses, with greater emphasis on learning, improvement, and clear actions. Key themes are reported to the Executive Team through the Outpatient Services PRIM.

LLP

Following a complaint concerning cleanliness within the Dermatology Department, YTHFM undertook a review of the issues raised and implemented a number of improvement actions.

The affected furniture was inspected and cleaned, and cleaning and inspection standards were reinforced with Domestic Services staff. In addition, enhanced supervisory monitoring and quality assurance checks have been introduced to strengthen oversight of cleanliness standards and reduce the risk of recurrence. A suggestion regarding preventative signage has also been shared with the relevant team for consideration.

Overall, the complaint has been used as an opportunity to strengthen local assurance arrangements and reinforce expected cleaning standards, demonstrating how learning from patient feedback is translated into practical service improvements.

7. National Patient Surveys

A ' National Patient Surveys Governance, action planning and assurance framework' has been written and approved by PESC in August 2026. The paper outlines the governance arrangements for reviewing, responding to and monitoring improvement actions arising from national patient surveys. It establishes a consistent Trust-wide approach.

The framework ensures that national patient survey findings are systematically reviewed, translated into meaningful improvement actions, embedded within existing Care Group and corporate improvement plans rather than managed through separate action plans, and are monitored through a single, consistent assurance process.

This approach reduces duplication, strengthens accountability, and provides clear evidence that patient feedback is informing service improvement across the Trust.

The table below shows the National Patient Surveys where results were received during Quarter 2.

National Survey	Progress
National Inpatient Survey 2025	The embargoed report was presented to PESC in July with key actions identified. The final report was published in August. The findings from the 2025 National Inpatient Survey showed that scores for York and Scarborough Teaching Hospitals NHS Foundation Trust are mostly in line with the sector scores. Despite our challenging operational pressures, we have seen a positive improvement in the scores over the last 12 months. We have 5 scores where we are ranked in the top 20% of Trusts compared to 1 in 2024. We have seen a decrease in the bottom scoring 20% from 10 to 6.
Cancer Patient Experience Report	The public report was presented to PESC in July with key actions identified. The preliminary findings provide positive assurance that the Trust's cancer patient experience scores are broadly within the expected range, with no statistically significant deterioration and three areas of statistically significant improvement. There is evidence of improvement in communication, involvement and support.
NHS Maternity Survey 2026	Overall, most survey questions remain within the expected range when compared with similar trusts. There are areas of positive experience, particularly around mental health conversations and contact with staff. However, the more important year-on-year signal is deterioration in several fundamental aspects of women's experience, particularly after birth: information and advice, partner involvement, pain management and infant feeding support in hospital and the community. These findings require focused review and action, supported by triangulation with complaints, concerns, Friends and Family Test feedback, Maternity and Neonatal Voices Partnership intelligence and workforce data. The Care Group will be reporting to PESC in Q4 on their improvement actions following co-creation of the plan with the MNVP.

8. Health Inequalities

The table below summarises progress during Quarter 2 against the five workstreams in the health inequalities programme. Alongside each activity, it sets out why the development is important for patients, staff or the Trust.

The programme brings together the practical changes needed to reduce avoidable differences in access, experience and outcomes.

Each area of development addresses a different part of the patient journey: understanding where inequalities exist, building staff capability, involving communities, identifying and recording individual needs, improving pathways and embedding equitable, person-centred care in routine practice.

Taken together, these workstreams support safer care, better use of resources and delivery of the Trust's responsibilities for health inequalities, reasonable adjustments and accessible information

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 understand what matters to each patient and tailor care to their individual needs. This improves communication, safety and patient experience, while reducing barriers, avoidable delays and inequalities in health outcomes.
Defining data to support health inequalities	• The NHSE statement for health inequalities has a set of core metrics. Work is ongoing to produce a selection of health inequalities core metrics, currently focussing on a solution for the geographical boundaries of York and Scarborough. This is important because agreed health inequalities metrics provide a consistent way to identify where access, experience and outcomes differ between population groups. Clear geographical boundaries for York and Scarborough will allow the Trust to compare local patterns fairly, identify communities with greater need and avoid Trust-wide averages masking variation between areas. The metrics will also support better decisions about service design, improvement priorities and resource allocation. It will provide Care Groups and senior leaders with a reliable baseline, show whether targeted action is reducing inequalities over time and provide evidence that the Trust is meeting its NHS responsibilities. • Engagement with the Leeds Public Health Specialist Programme Manager who shared their progress around HI data and examples of their reports. This engagement allows

	the Trust to learn from an organisation that has already made progress in developing health inequalities data and reporting. This can help us adopt proven approaches, avoid duplicating work and identify practical solutions to common challenges.
Health Inequalities Training matrix	• Health inequalities / Inclusion Health education sessions delivered to Professional AHP Leaders Forum and the ED Mentor Day in September to raise awareness of this complex health inequalities group. • Health Inequalities session delivered at Care Group Surgery Board meeting to raise awareness. • Online health literacy education has been added as a link in the health inequalities foundation training • Rolling out health inequalities and inclusion health education across the organisation gives staff the knowledge and confidence to recognise barriers, reduce stigma and adapt care to individual needs. A consistent Trust-wide approach will help reduce unwarranted variation and improve access, experience and outcomes for patients most at risk of poorer health • Initial discussions have begun with the Psychological Medicine Lead and Mental Health Liaison Nurse about trauma-informed care education. Trauma informed care education will enable staff to recognise how trauma may affect a patient's behaviour and engagement, respond without causing further distress, and provide safer, more compassionate care.
Pathways to engage with communities / pathway redesign work with system partners	• Continue to share data on high intensity users (HIU) of emergency departments users with primary care. This is important because sharing data and coordinating care across partners helps identify the underlying needs of high-intensity users, reduce avoidable emergency attendances and provide more joined-up, person-centred support • Selby PCN now have an active HIU MDT with key system partners to manage a cohort of 10-15 HIU patients. They are already actively managing patients in a different way to avoid repeat non elective attendance. • Scarborough CORE PCN are reviewing data on HIU patients to select a small cohort to pilot 'care co-ordination'. • Recent engagement and sharing of HIU data with North riding PCN and discussion around local good practice. • Commenced engagement with Bridlington PCN, awaiting data sharing agreement so we can meet and provide HIU data and share local good practice. • Continue engagement with neighbourhood meetings to share HIU learning and create connections across neighbourhoods for learning. North & central neighbourhoods are in discussions regarding models for supporting HIU's.

Apply HI Framework into QI and research programmes	• QI Lead for health inequalities presented at QSIR education session as a regular session to cover health inequalities / inclusion health content. Including health inequalities in quality improvement training helps teams identify who may be disadvantaged and design changes that improve access, experience and outcomes for all patients • Community Voices session in August – community members (22 in total) in collaboration with SHARC, asking what is important to them. Community engagement helps the hospital understand what matters to local people and involve them in designing services. This reduces barriers, builds trust and ensures improvements respond to community need.
Embed Health inequalities into all organisational priorities, strategic documents	• Health inequalities will be at the centre of the clinical strategy, shaping priorities, service design and improvement work to ensure that every patient can access high-quality care and achieve the best possible outcomes. The strategy will recognise that some people face greater barriers or have different needs, and will use data, patient insight and targeted action to reduce unwarranted variation and provide equitable care for all patients.
Health Promotion	**Progress**
Alcohol	• Continue work on the drug and alcohol care team business case. A drug and alcohol care team provides timely specialist support, improves withdrawal management and links patients with community services. This can reduce complications, repeat admissions and pressure on emergency care while improving patient outcomes • Promotion of the eLearning for health module – alcohol / tobacco conversations for staff to support health promotion / prevention to support improving health outcomes for patients • We now have 3 VCSE in-reach colleagues working in the organisation with honorary contracts. Having VCSE colleagues working in the hospital gives patients earlier access to practical, trusted support for issues such as alcohol or drug use, housing, finances and social isolation. This helps address their wider needs, improves links with community services and supports safer discharge and ongoing recovery • Reviewing the feasibility of having some alcohol-based questions within Nervecentre working towards audit C tool to be embedded. Embedding alcohol screening questions in Nervecentre will help staff identify harmful alcohol use early, offer timely support and improve referrals to specialist services • A member of the Trust attends the 'inclusive recovery cities steering group'. This is important because it strengthens partnership working, shares good practice and supports more joined-up care for people affected by drug and alcohol use locally.

	• Information-sharing agreements are in place with system partners, including York in Recovery and CGL, to support the secure sharing of relevant patient-level information across organisations. This enables more coordinated care, reduces the need for patients to repeat their story and helps services manage risk, referrals and follow-up more effectively. • Comprehensive resource files have been developed for pilot areas to include all alcohol guidance /referral guidance, prescribing guidance. Having these resources provide staff with clear and consistent guidance, supporting safer decisions, timely referrals and better care for patients with alcohol-related needs
Tobacco dependency	• Planned Trust wide communication on the smoke free environment policy which will increase awareness and compliance. Clear communication helps staff, patients and visitors understand and follow the smoke-free policy, reducing exposure to tobacco smoke and supporting a safer, healthier hospital environment • The patient experience survey for people using the tobacco dependency service is continuing. Feedback will be used to identify barriers; understand what patients find helpful and make ongoing improvements to the accessibility and quality of the service. • The Trust is addressing problems with tobacco dependency service referrals not reaching the service through Nervecentre. Resolving this is important because missed referrals reduce access to timely specialist support, limit service uptake and may result in opportunities to support patients to stop smoking being lost. • Staff 'swap to vape ' scheme trialling with city of York health trainer team with free vape kits. This supports staff who are wanting to stop smoking, improves their health and supports a smoke-free hospital environment.
Reasonable adjustment (RA) / Accessible Information Standards (AIS)	**Progress**
Accessible information enablers	• Meeting with the communications team to start to design a shared intranet area to support making care fair, to include RA/AIS/person-centred care/health inequalities. Having a single, easy-to-access intranet area will help staff find consistent guidance and resources quickly, supporting fair, person-centred care and compliance with reasonable adjustment and accessible information requirements • Commenced internal websites reviews in Q2 and this will continue into financial year to ensure they are line with AIS requirements. Ensuring websites meet Accessible Information Standard requirements helps patients with communication needs access, understand and act on health information, reducing barriers and supporting safe, equitable care

	• A description of the Accessible Information Standard has been drafted for the Trust's public-facing website. This will help patients understand what support they can expect, how to tell the Trust about their communication needs and how those needs should be met when they use our services. • The AIS self-assessment has been drafted, ready for publication in Q3. An AIS self-assessment identifies gaps, supports compliance and provides assurance that patients' communication needs are being recognised and met consistently. • A staff pocket quick reference guide has been developed as a quick 'in the moment' education guide for RA /AIS • Provided instructions on how to use 'ReachDeck' within our Trust internet to the digital inclusion network so they can disseminate instructions to patient groups. ReachDeck is a website accessibility toolbar that helps people read and understand online information. It can read text aloud, translate content, enlarge text, reduce visual distractions and simplify web pages. It supports people with visual impairments, dyslexia, low literacy, cognitive differences or those who use English as an additional language • The Trust attended doctors' induction events to provide early awareness of doctors' responsibilities for reasonable adjustments and the Accessible Information Standard. Introducing these requirements at induction helps establish safe and consistent practice from the start of employment. • A meeting was held with the Volunteer Services Lead to explore how volunteers could support patients with accessible information and reasonable adjustment needs. Appropriate volunteer support may help patients navigate services, access information and communicate their needs, while complementing rather than replacing staff responsibilities. • Reasonable adjustment (RA) flagging remains an identified risk, as current digital systems do not yet provide the functionality required to consistently record and share patients' reasonable adjustment needs. As a mitigation, it is planned that the Trust will work with the provider of SystmOne to participate in a pilot of RA flags, supporting earlier implementation ahead of the planned March 2027 rollout and providing practical learning to inform Tranche 3 implementation within Nervecentre. The pilot would be supported by an education package, developed with IT educators, to ensure staff understand the importance of RA flags and how to use them effectively to support patients across the organisation.
Identifying needs	• A sentence, approved by patient groups, has been developed for inclusion in patient letter templates and information leaflets. It includes a direct link to the Accessibility Hub, helping patients find relevant information before visiting the hospital.

	• The AHP Administration Team's customer service training included guidance on asking patients about their reasonable adjustment needs, reinforcing that identifying and responding to these requirements is everyone's responsibility. • The waiting list team will promote the Accessibility Hub during patient calls and ask about any reasonable adjustment needs before patients attend for surgery. This helps identify patients' reasonable adjustment needs before admission, so appropriate support can be arranged in advance. It reduces delays, improves safety and helps patients feel prepared for surgery
Recording Needs	The rollout of reasonable adjustment flags in Nervecentre is planned for Tranche 3 in June, as there is currently no capacity or budget to implement the required changes sooner. K Beatson will confirm the proposed implementation date for SystmOne, which is planned before March 2027. The reasonable adjustment flags will make a patients identified needs visible within the clinical record. This will prompt staff to provide the right support, such as communication assistance, an interpreter, extra time, accessible information or changes to the care environment.
Meeting and reviewing the needs of patients	An initial review has been undertaken of the guidance available to help staff meet patients' needs, including how to book an interpreter. Further staff engagement will continue during Quarters 3 to identify the guidance, resources and support needed to meet reasonable adjustment and accessible information requirements consistently. This is important because clear, practical guidance helps staff arrange support promptly, reduces variation between services and lowers the risk of delays, misunderstanding or avoidable harm.
Continuous Improvement	**Progress**
Care Group health inequalities projects	• Care Group CSCS – Ophthalmology – review of patients with multiple DNA • Care Group CSCS – reviewing Dermatology service provision through a health inequalities lens to ensure a reduction in travel to York from the east coast • Care Group Surgery - MSK Community Appointment Days ensuring flexibility for patients to attend appointments in the community, closer to home. Successful application/funding for Autism inclusion award. The Autism Inclusion Award helps services make care more accessible and responsive for autistic patients. Expected outcomes include staff who better understand autism, clearer communication, reduced sensory distress, quieter waiting options, better use of reasonable adjustments and hospital passports, and care tailored to individual needs. • Care Group Surgery - 1st Paediatric surgical list (multi-specialty) at Bridlington in place. Discussions with all specialties to discuss increasing the scope of surgical procedures in Bridlington – key specialty orthopaedics. These

	changes will mean less travel to Scarborough and York; care can be provided locally in Bridlington. • Children's therapy teams are now attending toddler groups in more deprived areas where referral rates are low. This outreach can raise awareness among parents, identify needs earlier and reduce the risk that children miss support because families are less able to navigate or access referral routes. • Care Group family – Dates confirmed for paediatrics community assessment day (CAD) across the Trust, Scarborough, York and Selby. The CAD will help to reduce the waiting list and to provide a quicker response to children and parents • Care Group Family - Circle by the sea – research packs provided for research project • Care Group Family – Community – roll out of reasonable adjustment flag on SystmOne pre-March 2027. • Care Group Family - Secured funding in house for tobacco dependency service which will provide specialist, non-judgemental support to help pregnant women stop smoking and remain smoke-free after birth • Care Group Family - Appointed Public Health Midwife starts on 5th November – tobacco service initially then vaccinations in community • Care Group Medicine – supporting primary care to manage HIU's of emergency departments in the community so more proactive care • Care Group Medicine is establishing a Homeless Voices Action Group to turn feedback from people experiencing homelessness into clear improvement actions. This will ensure that concerns raised through engagement lead to accountable changes in access, communication, discharge and care experience.
Person Centred Care	**Progress**
Building capability	• Defined a health literate organisation and mapped our trust to the recommended domains. Mapping current practice against the recommended domains helps identify strengths and gaps, set priorities and measure progress • Established the Health Coaching faculty, Health Literacy Interest Group and the ICB health coaching community of practice. Together, these groups support a more consistent approach to person-centred care. They help staff understand what matters to patients, communicate clearly and support people to take an active role in decisions about their health and care. This can improve patient experience, safety and outcomes, particularly for people who face communication or access barriers. • Continue to provide health coaching training across the Trust. The training equips staff to support shared decision-making and tailor care to what matters to each patient, helping

	improve experience, safety and outcomes while reducing inequalities. Community nursing was planned but cancelled due to demand on service. • Promote Making Every Contact Count (MECC). MECC enables staff to use routine patient contacts to offer brief, timely support on healthier choices, helping prevent ill health, improve outcomes and reduce inequalities. • Continue teaching sessions on Person Centred Care (including nurse induction, F2s induction). Early, consistent training gives staff the skills to involve patients in decisions and tailor care to individual needs, improving safety, experience and outcomes. • A link to eLfH Health literacy online learning has been added to the Health Inequalities foundation level training Health literacy is important because patients must be able to understand and act on information about their care. Clear communication supports informed decisions, safer treatment and discharge, and helps reduce avoidable harm and inequalities. • Launch of the 'What Matters to You' campaign, including screen savers and promotional materials. This helps embed a consistent culture of asking what matters to patients, supporting shared decisions, more personalised care and better experience and outcomes. • Presented the Person-centred care model to the National personalised care institute as one of the ambassadors. This provides a connection to ensuring we receive up-to-date knowledge and it also promotes YSTHFT nationally and our work on person-centred care.

9. Key risks

The principal ongoing risks to delivery of the patient experience strategy remain:

- 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: 2 November 2026

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	NHS EDI Improvement Plan, Pay Gaps High Impact Action 3 – Ethnicity Pay Gap
Director Sponsor:	Sarah Dexter-Smith, Chief Culture and People Officer
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:

This paper provides a summary of the ethnicity pay gap data for York and Scarborough Teaching Hospitals NHS Foundation Trust and Scarborough Facilities Management colleagues and is presented to the Trust's Board of Directors for approval and assurance. Ethnicity Pay Gap analysis is required by the NHS EDI Improvement Plan. The snapshot date is 31 March 2026.

The NHS EDI Improvement Plan, High Impact Action 3, requires Trusts to:

- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This is tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.

A decision has been made to postpone reporting on all Protected Characteristics other than Gender and Ethnicity, until the Electronic Staff Record (ESR) interface has been updated to capture the data.

The analysis compares employees recorded as Black and Minority Ethnic (BME) with employees recorded as White.

- BME employees comprised 18% of the ethnicity-recorded workforce in 2026.
- The whole workforce mean and median hourly pay figures were higher for BME employees than for White employees, which means there is no ethnicity pay gap for the entire workforce.
- Within Medical and Dental roles, the mean ethnicity pay gap was 19.99%, and the median gap was 32.56%, both in favour of White employees, which means there is an ethnicity pay gap within Medical and Dental. However, the mean ethnicity pay gap for 2026 has improved by 3.02%.
- The consultant mean and median bonus gaps were 17.28% and 50.00% respectively, in favour of White employees.

Key Assurances:
Whole workforce mean and median hourly pay are higher for BME colleagues than White colleagues, and the Medical and Dental pay gap has reduced since 2025.

Key Risks:
Significant ethnicity pay gaps remain within Medical and Dental roles, with mean and median gaps of 19.99% and 32.56% respectively, in favour of White colleagues.

Key concerns:
Consultant bonus inequalities remain substantial: the mean bonus gap has increased to 17.28% and the median gap remains 50%, both in favour of White colleagues.

Next Steps:

- Share the results with the Trust's Staff Networks and publish the results on the Trust's website

Recommendations:

- Note the whole-workforce ethnicity pay findings and the different position within Medical and Dental roles.
- Continue focused analysis of representation, recruitment and progression across medical grades and senior roles.
- Review access to and outcomes from consultant bonus payments by ethnicity.

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	17 November 2026	Noted

NHS EDI Improvement Plan, Pay Gaps High Impact Action – Ethnicity Pay Gap

1. Introduction and Background

This paper provides a summary of the ethnicity pay gap data for York and Scarborough Teaching Hospitals NHS Foundation Trust and Scarborough Facilities Management colleagues and is presented to the Trust's Board of Directors for approval and assurance. Ethnicity Pay Gap analysis is required by the NHS EDI Improvement Plan. The snapshot date is 31 March 2026.

The NHS EDI Improvement Plan, High Impact Action 3, requires Trusts to:

- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This is tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.

2. Considerations

A decision has been made to postpone reporting on all Protected Characteristics other than Gender and Ethnicity, until the Electronic Staff Record (ESR) interface has been updated to capture the data.

3. Current Position/Issues

The ethnicity analysis included 10,479 employees: 1,896 BME employees and 8,583 White employees.

Ethnicity	2025 headcount	2025 %	2026 headcount	2026 %
BME	1,768	17%	1,896	18%
White	8,222	83%	8,583	82%
Total	9,990		10,479	

Whole-workforce hourly pay

Measure	White 2025	BME 2025	2025 gap	White 2026	BME 2026	2026 gap
Mean hourly rate	£19.45	£21.11	-8.54%	£21.18	£24.42	-15.29%
Median hourly rate	£15.33	£18.66	-21.73%	£14.53	£15.67	-7.86%

Across the whole workforce, BME employees had higher mean and median hourly rates than White employees in 2026. The reported mean gap was -15.29% and the median gap was -7.86%.

Medical and Dental workforce

Measure	White 2025	BME 2025	2025 gap	White 2026	BME 2026	2026 gap
Mean hourly rate	£47.49	£36.57	23.01%	£52.51	£42.02	19.99%
Median hourly rate	£53.56	£29.65	44.64%	£55.66	£37.54	32.56%

Within Medical and Dental roles, the mean ethnicity pay gap reduced from 23.01% in 2025 to 19.99% in 2026. The median gap reduced from 44.64% to 32.56%. Both 2026 gaps were in favour of White employees.

Pay quartiles

Pay quartile	BME headcount	BME %	White headcount	White %
Lower	248	9%	2,409	91%
Lower middle	460	18%	2,166	82%
Upper middle	614	23%	2,013	77%
Upper	574	22%	1,995	78%

BME employees comprised 18% of the ethnicity-recorded workforce, 23% of the upper-middle quartile and 22% of the upper quartile. BME representation was lowest in the lower quartile at 9%.

Consultant bonuses

Measure	White 2025	BME 2025	2025 gap	White 2026	BME 2026	2026 gap
Mean bonus	£7,531.99	£6,478.32	13.99%	£7,518.93	£6,219.83	17.28%
Median bonus	£6,032.04	£3,015.97	50.00%	£6,032.04	£3,015.97	50.00%

The consultant mean bonus gap increased from 13.99% in 2025 to 17.28% in 2026. The median bonus gap remained 50.00%. Both gaps were in favour of White employees.

4. Summary

- BME employees comprised 18% of the ethnicity-recorded workforce in 2026.
- The whole workforce mean and median hourly pay figures were higher for BME employees than for White employees, which means there is no ethnicity pay gap for the entire workforce.
- Within Medical and Dental roles, the mean ethnicity pay gap was 19.99%, and the median gap was 32.56%, both in favour of White employees, which means there is an ethnicity pay gap within Medical and Dental. However, the mean ethnicity pay gap for 2026 has improved by 3.02%.
- The consultant mean and median bonus gaps were 17.28% and 50.00% respectively, in favour of White employees.

5. Next Steps

- Share the results with the Trust's Staff Networks and publish the results on the Trust's website

Recommendations:

- Note the whole-workforce ethnicity pay findings and the different position within Medical and Dental roles.
- Continue focused analysis of representation, recruitment and progression across medical grades and senior roles.
- Review access to and outcomes from consultant bonus payments by ethnicity.

Date: November 2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	NHS EDI Improvement Plan, Pay Gaps High Impact Action 3 – Gender Pay Gap
Director Sponsor:	Sarah Dexter-Smith, Chief Culture and People Officer
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 ☒

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☐ Financial Balance
☒ Effective Governance

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This paper provides a summary of the gender pay gap data for York and Scarborough Teaching Hospitals NHS Foundation Trust and Scarborough Facilities Management colleagues and is presented to the Trust's Board of Directors for approval and assurance. Gender pay gap analysis is required by legislation and the NHS EDI Improvement Plan. The snapshot date is 31 March 2026.

The gender pay gap is the difference between the average hourly earnings of men and women across the organisation. It is not the same as equal pay, which concerns equal pay for the same work, similar work or work of equal value.

A decision has been made to postpone reporting on all Protected Characteristics other than gender and ethnicity, until the Electronic Staff Record (ESR) interface has been updated to capture the data.

Key Assurances

The headline gender pay gap has improved. The mean gender pay gap reduced from 23.89% in 2025 to 20.21% in 2026. The median gap reduced from 17.85% to 3.46% over the same period. Both figures remain in favour of men, but the year-on-year direction is positive.

The median pay gap has reduced substantially. Median hourly pay was £19.65 for men and £18.97 for women, a difference of £0.68 and a reported median gap of 3.46%.

Women are represented across all pay quartiles. Women were the majority in every quartile, ranging from 67.58% in the upper quartile to 82.22% in the upper-middle quartile.

The Agenda for Change and personal salary workforce shows a different and more favourable position. Within this group, the mean gender pay gap was -3.15% and the median gap was -8.55%, both reported in favour of women.

Key Risks

A substantial mean gender pay gap remains. Men's average hourly pay was £25.93 compared with £20.69 for women, producing a mean gap of £5.24 or 20.21% in favour of men.

Women are under-represented in the upper pay quartile relative to their overall workforce representation. Senior medical roles remain predominantly male.

There is a significant pay gap within the Very Senior Manager grouping. Although women had a higher average mean hourly rate in most individual bands, the largest reported gap was 25.42% within the Very Senior Manager grouping.

Clinical Excellence Award gaps remain substantial. The mean bonus gap was 30.92% and the median bonus gap was 50%, both in favour of men. Of 125 bonus payments, 37 were paid to female consultants and 88 to male consultants. The mean bonus gap has deteriorated. The mean gap increased from 27.04% in 2025 to 30.92% in 2026, in favour of men.

Key Concerns

Although the gender pay gap has improved, this should be treated as progress rather than resolution.

The workforce profile suggests a senior representation issue. Women comprise most of the workforce but have their lowest representation in the upper pay quartile. Men also form the majority in key senior medical groups **Next Steps:** • Share the results with the Trust's Staff Networks and publish the results on the Trust's website
Recommendations: • Note the 2026 gender pay gap position and the reduction in the headline mean and median gaps from 2025. • Continue focused work on gender representation and progression in senior and higher-paid roles. • Review access to and outcomes from Clinical Excellence Awards.

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	17 November 2026	Noted

NHS EDI Improvement Plan, Pay Gaps High Impact Action – Gender Pay Gap

1. Introduction and Background

This paper provides a summary of the gender pay gap data for York and Scarborough Teaching Hospitals NHS Foundation Trust and Scarborough Facilities Management colleagues and is presented to the Resources Committee for assurance. Gender pay gap analysis is required by legislation and the NHS EDI Improvement Plan. The snapshot date is 31 March 2026.

The NHS EDI Improvement Plan, High Impact Action 3, requires Trusts to:

- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This is tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex (gender) and race by 2024, disability by 2025 and other protected characteristics by 2026.

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 require public sector organisations with more than 250 employees to report and publish their gender pay gap annually.

The gender pay gap is the difference between the average hourly earnings of men and women across the organisation. It is not the same as equal pay, which concerns equal pay for the same work, similar work or work of equal value.

2. Considerations

A decision has been made to postpone reporting on all Protected Characteristics other than gender and ethnicity, until the Electronic Staff Record (ESR) interface has been updated to capture the data.

3. Current Position/Issues

Gender Pay Gap

The full-pay relevant workforce comprised 11,023 employees: 8,387 women and 2,636 men.

Measure	Men	Women	Difference	Pay gap
Mean hourly pay	£25.93	£20.69	£5.24	20.21%
Median hourly pay	£19.65	£18.97	£0.68	3.46%

The mean hourly rate for men was £5.24 higher than for women, giving a mean gender pay gap of 20.21%. The median difference was £0.68, giving a median gender pay gap of 3.46%.

Year-on-year comparison

Year	Mean gender pay gap	Median gender pay gap
2022	28.8%	16.8%
2023	26.96%	7.4%
2024	21.91%	7.28%
2025	23.89%	17.85%
2026	20.2%	3.4%

The supplied comparison data shows that both the mean and median gender pay gaps improved between 2025 and 2026.

Pay quartiles

Pay quartile	Women	Men
Lower	76.44%	23.56%
Lower middle	78.16%	21.84%
Upper middle	82.22%	17.78%
Upper	67.58%	32.42%

Women were the majority in every quartile. Their representation was lowest in the upper quartile, where women accounted for 67.58% and men 32.42%.

Agenda for Change and personal salary workforce

This group comprised 9,930 employees: 7,906 women and 2,024 men. The mean gender pay gap was -3.15% and the median gender pay gap was -8.55%, both reported in favour of women.

At individual band level, women had a higher average mean hourly rate in all but Band 3, Band 8d, Very Senior Manager personal salaries and non-VSM personal salaries. The largest reported gap was 25.42% within the Very Senior Manager grouping.

Medical and Dental workforce

The Medical and Dental workforce comprised 1,093 employees: 481 women and 612 men. Men formed the majority among Specialty Doctors, Associate Specialists and Consultants.

Medical group	Women %	Men %	Mean gender pay gap
Specialty Doctors	35.83%	64.17%	0.34%
Associate Specialists	33.33%	66.67%	1.21%
Consultants	36.58%	63.42%	2.72%

Clinical Excellence Awards (bonus payments)

Only Medical Consultants receive bonus payments. There were 125 bonus payments: 37 to female consultants and 88 to male consultants.

Measure	Men	Women	Bonus gap
Mean bonus pay	£8,015.57	£5,537.09	30.92%
Median bonus pay	£6,032.04	£3,015.97	50.00%

The proportion receiving a bonus was 0.44% of the entire female workforce and 3.34% of the entire male workforce.

The mean bonus pay has deteriorated since 2025; in 2025 the difference was 27.04% (in favour of men).

4. Summary

- Mean whole-workforce gender pay gap: 20.21% in favour of men.
- Median whole-workforce gender pay gap: 3.46% in favour of men.
- Women accounted for 67.58% of the upper pay quartile compared with 76.09% of the workforce overall.
- The mean and median bonus pay gaps were 30.92% and 50.00% respectively, in favour of men.

5. Next Steps

- Share the results with the Trust's Staff Networks and publish the results on the Trust's website

Recommendations:

- Note the 2026 gender pay gap position and the reduction in the headline mean and median gaps from 2025.
- Continue focused work on gender representation and progression in senior and higher-paid roles.
- Review access to and outcomes from Clinical Excellence Awards.

Date: November 2026

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	NHS England Annual Self-Assessment Report
Director Sponsor:	Dr Karen Stone, Medical Director
Author:	Rachael Snelgrove, Head of Medical Education

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 NHS England Workforce, Education and Training (NHSE WTE) Self-Assessment (SA) is a multi-professional report encompassing all clinical training posts.

The report identifies areas of continuous quality improvement and best practice alongside areas of challenge.

We as an education provider are asked to submit this report indicating our assessment to whether the standards have been met or not against the below mandated sections:

- Section 1**:** Achievements and Challenges
- Section 2: EFA Schedule 3 and KPIs
- Section 3/3a: Financial Accountability
- Section 4: EFA Schedule 3 Quality Performance
- Section 5: Library and Knowledge Services and Technology-Enhanced Learning
- Section 6: Educators

- Section 7: Improving the Working Lives of Resident Doctors
- Section 8: Equality, Diversity and Inclusion
- Section 9: Final submission and data quality checklist

The paper highlights three main challenges and successes from across all professional learner groups for the 2025/2026 academic year.

Recommendation:
The Board is asked to review and approve the self-assessment for submission to NHS England.

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

NHS England Self-Assessment for Placement Providers 2025/6

Introduction

The NHS England Self-Assessment for Placement Providers supports organisations to review and carry out their own quality evaluation against the required education and training standards, including compliance with relevant Education Funding Agreement obligations. The survey should be completed on behalf of the whole organisation, with input from the colleagues responsible for each section. All sections of the Self-Assessment must be completed before final submission.

Sections of the Self-Assessment

Section 1: **Achievements and Challenges – P3**
Providers should identify up to three achievements and three challenges, selecting relevant categories and professional groups. Responses should summarise impact, evidence, actions and support requirements.

Section 2: Education Funding Agreement (EFA) Schedule 3 and KPIs – P6
Providers should provide assurance against contractual requirements, including governance, learner safety, quality concerns, regulator activity, Freedom to Speak Up arrangements and survey response improvement plans.

Section 3/3a: Financial Accountability – P8
Providers should identify appropriate use of the education funding, financial governance arrangements, allocation processes, funding oversight and management of any irregularities. Where applicable, providers should also describe undergraduate medical and dental arrangements and governance.

Section 4: EFA Schedule 3 Quality Performance – P12
Providers should confirm compliance with quality standards using an assurance-by exception approach. Where standards are not fully met, responses should describe affected groups, risks, mitigations, actions, timescales and support.

Section 5: Library & Knowledge Services, Technology-Enhanced Learning – P16
Providers should describe access to NHS-funded library services, digital learning resources, clinical decision tools and actions supporting educational modernisation.

Section 6. Educators- P18
Providers should demonstrate how educators are trained, supported and provided with sufficient time and capacity to undertake their roles. Responses should also address end-of-life care and advance care planning learning opportunities where relevant.

Section 7: Improving the Working Lives of Resident Doctors – P20
Providers should summarise the delivery of the Resident Doctor 10 Point Plan, including leadership, governance, wellbeing, facilities, leave processes, payroll, training transfer and rota management.

Section 8. Equality, Diversity and Inclusion – P24
Providers should describe EDI governance, learner experience, reasonable adjustments, international graduate support, management of discriminatory behaviour and sexual safety arrangements.

Section 9: Final submission and data quality checklist – P26
The final submission should confirm that learning environments, facilities, premises and equipment are safe, accessible, compliant and suitable for training and education in line with NHS Education Funding Agreement.

Please select from the list below the professional groups which your organisation currently trains.

Advanced Practice	☒
Allied Health Professionals	☒
Dental Undergraduate	☐
Dental Postgraduate	☒
Healthcare Science	☒
Medicine Undergraduate	☒
Medicine Postgraduate	☒
Midwifery	☒
Nursing	☒
Paramedicine	☐
Pharmacy	☒
Physician Associate	☒
Physician Associate Anaesthetics	☒
Psychological Professions	☐
Social Workers	☐
Surgical Care Practitioner	☒
Other (please specify)	☐

Section 1: **Achievements and Challenges**

Achievement category	Workforce recruitment / retention initiatives
Achievement professional group	Nursing, AHP & Medical

Nursing and Midwifery: Student nurses continue to face national challenges in securing first-destination posts following NMC registration. In response information was collaborated with our partner Approved Education Institutions (AEIs) to strengthen the recruitment pathway and support students into employment. As a result, 76 student nurses received offers of employment within the Trust, representing a 100% success rate among those who entered the application process. To support a safe and effective transition into practice, each newly registered nurse completes the Trust's clinical induction, begins a 12-month preceptorship programme and receives dedicated support from an allocated link educator.

AHP: A collaborative partnership has been established between AHP educators across York and Scarborough, Hull and Harrogate, alongside York St John University, in response to increasing challenges relating to professionalism during placements. By working collectively across organisations, the partnership is developing a more consistent and practice approach to supporting students, educators and placement teams, with a shared focus on strengthening professional behaviours and positive learning experiences.

Medicine: Medical Education continues to strengthen supervisor development through a programme of Supervisor Masterclasses addressing neurodiversity-inclusive practice, supported return to training (SuppoRTT), effective induction, and the needs of Locally Employed Doctors (LEDs) and International Medical Graduates (IMGs). These sessions support experienced supervisors to develop their practice, while introductory workshops provide new supervisors with guidance on their roles and responsibilities and the support available to them and their trainees. Relevant trust and NHS England updates are shared with supervisors to ensure they remain informed about changes to guidance, available resources and learner support arrangements. Together, these activities aim to promote consistent, inclusive supervision and equip supervisors to recognise and respond to individual learning and support needs.

During 2026, 61 trainers, comprising of Consultants and SAS doctors, successfully completed the GMC revalidation training, and 31 new supervisors were added to the medical education faculty.

Achievement category	Quality improvement initiatives / response to data / positive feedback
Achievement professional group	Nursing, AHP

Nursing, AHP: Evaluation of student-related incident reporting data identified an opportunity to strengthen oversight and ensure all reportable incidents were reviewed, escalated and acted upon appropriately and promptly. In collaboration with the Patient Safety Team, a process has been developed to identify and capture Datix reports involving Nursing, Allied Health Professional and Midwifery students. A dedicated student incident dashboard now supports systematic monitoring, timely escalation and follow-up of actions, providing clearer assurance and enabling themes and learning opportunities to be identified across student placements.

AHP - Following feedback, an improvement project has been undertaken to refresh and clarify the Learning Environment Manager (LEM) role and responsibilities to strengthen expectations for learning environments. The work aims to provide greater clarity and consistency, improve the quality of learning environments, and enhance the experience of students and learners. As part of this work, LEM Time Out events have been developed to strengthen leadership of high-quality, supportive learning environments by providing protected time for reflection, shared learning and collaboration. The events have successfully brought LEMs together to exchange good practice, explore challenges and identify practical improvements, reinforcing our commitment to providing positive, safe and effective learning experiences.

Achievement category	Technology-enhanced learning (TEL) provision
Achievement professional group	Nursing, Medical

Nursing: An electronic Padlet platform has been developed internally to provide student nurses and the nursing workforce with a clear, accessible source of education information and development opportunities. The visual platform strengthens communication by bringing current guidance, learning resources and opportunities together in one place. It enables undergraduate nursing students and registered nurses to access consistent, up-to-date information when needed, supporting engagement, professional development and connectivity across the education pathway.

Medical: During 2025–26, Postgraduate Medical Education strengthened its technology-enhanced learning provision through expanded simulation and procedural skills training across York and Scarborough. Developments included Care of the Elderly simulation in Scarborough, established Emergency Department multi-professional simulation in Scarborough with further development underway in York, quarterly multi-professional paediatric simulation, and collaborative critical care and simulation-based teaching involving Anaesthetics, Critical Care and Medicine. These developments are intended to enhance postgraduate training by providing opportunities to practise clinical and procedural skills, decision-making, communication and teamwork in simulated settings before applying learning in patient care. The emphasis on collaborative learning aims to support safer clinical practice and strengthen preparation for complex clinical situations. Investment in sustainable, low-cost training models and specialist technical equipment, including a new pericardiocentesis trainer has broadened the procedural skills offer and enabled more training to be delivered in-house.

Challenges category	Placement management / capacity
Achievement professional group	Nursing, AHP

AHP: The trust has supported the trial of the Fair Share set-capacity model for AHP placements, demonstrating commitment to increasing and strengthening placement capacity. While the approach provided valuable learning, maintaining a fixed level of capacity has not proved sustainable due to fluctuations in workforce availability, including sickness and vacancies. This learning highlights the need for a more flexible approach that supports placement growth while remaining responsive to operational pressures and available educator capacity.

Medical: Expanding medical training numbers remains challenging. Growth must be supported by sufficient placement capacity, meaningful training opportunities and

appropriate supervision. This requires balancing the needs of medical learners with competing demands from educator time, training resources and sharing the learning environments with other professional groups. Expansion in training numbers therefore needs careful planning to ensure that all learners retain access to the clinical experience, procedural opportunities and supervision required for their programmes, without compromising education quality or patient safety. Capacity planning must also take account of service pressures and the availability of suitably trained supervisors with protected educational time. Alongside these capacity constraints, funding for expansion posts has been challenging along with short response times set by NHS England have further limited the opportunity to assess capacity, agree funding and develop coordinated workforce and education plans.

Challenges category	Burnout / wellbeing
Achievement professional group	AHP

Further work is needed to strengthen staff confidence and understanding of reasonable adjustments for learners and new staff joining the organisation. Ensuring colleagues are confident in identifying, discussing and supporting individual needs will be an important focus in creating more inclusive, equitable and supportive learning and working environments. In response, HR has been included on the agenda for the next AHP Leadership Forum to provide guidance and support discussion around reasonable adjustments. We are also working closely with students and Higher Education Institutions (HEIs) to identify opportunities to improve how reasonable adjustments are communicated, planned and supported in practice.

Challenges category	Funding requirements / unpredictability / timeliness
Achievement professional group	Nursing and Medical

The Trust faces a significant challenge in securing sufficient, suitable and sustainable training facilities to support workforce education. Nurse education is currently delivered from temporary accommodation, with no confirmed timescale for a permanent solution. Existing facilities are becoming outdated and are too small to meet growing demand. For medical education, insufficient classroom and clinical teaching space limits the capacity to accommodate increasing numbers of medical students and resident doctors who require space for structured teaching and training. These pressures create a risk to the accessibility, quality and continuity of education and constrain the Trust's ability to expand training provision in line with learner numbers and the long-term workforce plan.

The challenge extends across professional groups, with approximately 3,000 non-medical learners and staff, and 1200 medical learners supported over a 12-month period. Greater certainty over funding, delivery timescales and future accommodation is required, alongside sufficient classroom capacity and modern, fit-for-purpose clinical training facilities to sustain current provision to support future growth.

Section 2: EFA Schedule 3 and KPIs

Does the organisation have formal board oversight of education and training?	Yes
Please provide the name and email address of the board named individual responsible for education and training	Dr Karen Stone, Medical Director Karen.stone14@nhs.net
Did the organisation, or any third party deliver EFA-funded activity on its behalf, have any material breaches of the NHS Education Funding Agreement requirements in the last 12 months?	No breaches
Have there been any actual or suspected data protection breaches in the last 12months relating to education and training activity or leaner information?	No
Did the organisation have any material health and safety incidents or breachers in the last 12 months affecting learners or the learning environment which required investigation?	No

Does the organisation have effective arrangements for cross-system collaboration with ICS, education providers and other relevant stakeholders to support safe, high-quality delivery of education and training?
Partially in place.
The Trust maintains effective cross-system collaboration in nursing through attendance at the monthly Preceptorship Community of Practice, NHS England regional workforce meetings, and quarterly lead partnership and stakeholder meetings with our Approved Education Institutions (AEIs). These established forums support shared planning, timely communication, escalation of emerging issues and the exchange of good practice, enabling coordinated action to maintain safe, high-quality education, placement provision and workforce development for nursing.

Have any material education quality concerns, learner safety issues or contractual breaches relating to the EFA-funded activity been escalated to NHS England through the appropriate route and timescales?
No concerns identified
Has the organisation been subject to any education and training-related regulatory referral, review, condition, concern or escalation in the last 12months, including by GMC, GDC, HCPC, NMC, GPhC or another relevant regulator? Do not include referrals relating only to an individual learner.
No.
Is the organisation actively implementing and embedding the Safe Learning Environment Charter across all relevant professions and learner groups?
Nursing, Midwifery and Allied Health Professionals: Are supporting the ongoing implementation of the Safe Learning Environment Charter (SLEC). A maturity matrix self-assessment identified gaps in implementation across learning environments; associated actions have been developed and areas identified to date have been addressed. The Charter is reinforced through training for practice supervisors and assessors and through Learning Environment Managers (LEMs).

Medical Education: Implementation is in the early stages, with seeking feedback from College Tutors and senior educators to how SLEC can be embedded alongside existing platforms, feedback mechanisms and wellbeing initiatives.
Does the organisation have a Freedom to Speak Up Guardian and actively promotes the process for raising concerns through them to their learners?
Yes.
The Freedom to Speak Up Guardian attends all corporate induction sessions, ensuring that learners are introduced to the role and informed about how to raise concerns directly with the Guardian. This information is reinforced through posters displayed in the Education Centres, providing a visible reminder of the support available and the route for raising concerns. The Guardian also attends the Education Centres when requested, providing opportunities for direct engagement with learners. Together, these arrangements promote awareness of the Freedom to Speak Up process and support access to the Guardian throughout the learning experience.

Has the organisation reviewed NETS findings at board governance level and taken action to address the findings
Yes.
NETS findings are presented to the Resource Committee through a multidisciplinary paper, providing a shared overview of learner feedback across professional groups. The paper sets out the survey data, highlights areas of success and good practice, and identifies challenges alongside the associated action plans. This reporting provides a forum for governance-level consideration of the findings and planned responses, supporting oversight of education quality and the use of learner feedback to inform improvement priorities. NETs results and student feedback are reviewed within the Learning, Education and Training Committee (LEaD), enabling triangulation of challenges and the development of appropriate action plans, which feeds into Resource Committee.

How will your organisation ensure you continue to improve your year-on-year response rate/number for the NETS and GMC NTS? Please provide examples or evidence.
Following an improved NETS completion position in 2025, the Trust will continue targeted measures to increase year-on-year participation. Link Educators promote and support survey completion with students in clinical areas, and dedicated spaces are advertised where learners can complete the survey. A direct QR code is available through the Nursing and Midwifery student Padlet to make access simple and timely, alongside displaying posters in the Education Centres, Doctor Mess and communal staff areas The survey is also promoted through established communication channels, with partner Approved Education Institutions (AEIs) sharing information with all undergraduate learners. Completion will be monitored to inform further targeted action.

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name	Rachael Snelgrove
Email	Rachael.snelgrove@nhs.net

Section 3: Education Financial Accountability (EFA)

How assured is the organisation that the EFA funding is used for its intended training and education purposes?
Highly assured
Describe the evidence informing the assessment, such as financial oversight, internal audit, budget mapping or governance review
Within Medical Education, assurance is supported by reconciliation of Education Funding Agreement income against undergraduate and postgraduate placements, agreed regional initiatives and other funded activity. Records of active supervisors, senior educator roles, allocated educational time and associated costs provide a basis for checking expenditure against educational responsibilities. Faculty spreadsheets are reviewed with finance to identify recharges that need to start or stop. Undergraduate tariff expenditure is mapped across teaching, supervision, administration and infrastructure costs, with funding tracked and reported through the Medical Directors office.
Is there formal board-level oversight of EFA funding, with regular review of expenditure and performance?
Yes.
Financial oversight is supported through regular review of Medical Education cost centres and budget reports, with ongoing work between Medical Education and Finance to strengthen the identification and tracking of education income and expenditure and reconciliation of expenditure against education funding. This is reported through the Medical Education annual Board report.
Does the organisation deliver any EFA-funded activity through a third party, sub-contractor or external provider? Please include apprenticeship providers where they delivery EFA
No.
If response is Yes to the above question, do you have effective financial oversight and assurance arrangements in place?
/
Does the organisation have arrangements to identify, investigate, correct and where necessary report any misallocation or financial irregularity relating to EFA funding?
Yes.
Within Medical Education, tariff funding is reviewed against agreed education and training activity to identify gaps, missing payments or discrepancies in funding allocations. Where issues are identified, the team liaises with NHS England to clarify the allocation, investigate the discrepancy and agree the action required to resolve it. Liaison with local finance teams supports reconciliation of the funding and any necessary adjustments required internally.

Can the organisation evidence how EFA funding is allocated, monitored and used for education and training activity during the reporting period?
Yes.
Funding is allocated based on learner and educator numbers and training requirements. Each team (Nursing, Midwifery, AHP, Medical) keep records of learner and educator numbers, alongside the cost of running educational services to reconcile how the EFA funding is allocated and spent during the reporting period. Monthly finance meetings with the education teams ensure funding is reaching the correct departments and is being used to fund education and training of learners and educators.

Does the organisation reconcile EFA funding with actual delivery of education and training activity, such as learner numbers, placements or other agreed activity measures?
Yes.
Funding is reconciled against learner placements, agreed regional initiatives and other activity i.e. Training Programme Director (TPD) posts, SuppoRTT income and SAS funding. Education budgets are protected and used for their intended education and training purposes. Records of funding allocations and expenditure are maintained by both the Postgraduate and Undergraduate Medical Education teams.

Can the organisation evidence how EFA funding supports educator/supervisor time, senior educator roles and required training extensions where applicable?
Yes.
The Medical Education teams, UG and PG, maintain records of all active supervisors and senior educator roles, including their allocated educational time and associated costs. These records support financial accountability and assurance against contractual requirements. Training extensions are agreed collaboratively with the Head of School (HoS) or Training Programme Director (TPD), the hosting department and Medical Education. Senior financial approval is required before any extension is agreed.

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name Email	Rachael Snelgrove Rachael.snelgrove@nhs.net

Section 3a: Financial Accountability- Undergraduate Medical

Will any of the Undergraduate Medical tariff be used to cross-subsidise other learner groups in 2026/2027, if yes please detail	No.
How assured is the organisation that Undergraduate Medical tariff within the Trust flows down to the individual clinical directorate level?	Moderately assured
There is board level support for this at the organisation. Any Tariff funding is used explicitly for the purposes of supporting and delivering education and training. All funding is tracked and reported as appropriate. PA's allocated at clinical directorate and educator level are timetabled and tracked, time being ring fenced and educators	

supported to ensure this is protected. An individual record of all educators within the organisation is held locally in the UG team and updated regularly.

Please confirm the percentage of Undergraduate tariff funding allocated to the following areas:	
Administration percentage	**4.83%**
Delivery of education and training percentage	**45.75%**
Clinical supervision salaries percentage	*
Please provide further detail	

TOTAL budget 2025/2026	**£6,735,675.00**	
		% of total budget
Teaching	£2,081,287.30	30.90%
Accommodation	£1,236,736.24	18.36%
Admin staff	£325,106.16	4.83%
Senior Faculty	£249,378.08	3.70%
Clinical Supervision	N/A	
Teaching Fellows	£750,823.56	11.15%
Overheads to Trust	£1,347,135.00	20.00%
	£5,990,466.34	83.84%

*Clinical supervision is incorporated into delivery of education and training percentage, unable to easily split out.

How frequently do you meet the Medical School each financial year to discuss quality and delivery of education
The Trust meets with HYMS annually through its formal monitoring visit to discuss the quality and delivery of medical education. Clinical Learning and Teaching Board (CLTB) meetings also take place on a bi-monthly basis.

Does the Trust provide clinical placements for additional international medical students from overseas Medical Schools. If yes, identify the names of the overseas Medical Schools
Yes.
The Trust provides time-limited clinical attachments for medical students from the Medical School at V. N. Karazin Kharkiv National University, Ukraine. In addition, the Trust arranges time-limited elective placements for fifth-year medical students from a range of medical schools worldwide.

Please briefly describe how Undergraduate Medical tariff funding will be used to improve the quality of healthcare for patients in 2026/2027. Please describe the impact on education and patient care (up to 150 words)
Undergraduate medical tariff funding is used directly to ensure students are able to meet learning objective, clinical requirements and professional standards as set by the GMC. The tariff covers the direct costs associated with this, for example (and not exhaustively) teaching/supervision, admin and infrastructure, pastoral support, educational supervision, examinations and assessment, accommodation and transport. Medical student training also supports patient care by developing the clinical skills, professional behaviours and readiness for practice needed by future doctors. Supervised clinical learning enables students to develop patient-centred communication, understand patients' concerns and work effectively within multidisciplinary teams. With appropriate supervision and patient consent, participation in care provides opportunities to apply these skills while recognising the limits of their competence. This investment aims to prepare graduates for safe practice and support the future delivery of high-quality, compassionate care.

Please provide the name of the person responsible for Undergraduate Medical financial governance at board level
Dr Karen Stone, Medical Director

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name Email	Dr Chris Wilkinson Christopher.wilkinson10@nhs.net

Section 4: EFA Schedule 3 Quality Performance

Organisations must ensure the physical and psychological safety and wellbeing of all learners and educators at all times. Systems should not only exist but also foster an environment where learners feel safe and empowered to use them without fear of negative repercussions. **Do systems and culture enable learners and educators to raise concerns without fear of negative repercussions?**	
We meet the standard for all professions / learner groups we train	☐
We have exceptions to report and have provided narrative	☒

Induction programmes must be tailored to meet the specific needs of the learners and are essential for both quality and service user safety. Inductions should be regularly reviewed to ensure they remain relevant and effective. **Are induction programmes tailored to learner needs, regularly reviewed and effective in supporting education quality?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Continuous supervision must be provided for all learners, aligned with the requirements of the relevant professional bodies and the Educator Workforce Strategy. **Is appropriate supervision available for all learners, aligned to learner need, professional requirement and placement setting?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Providers should actively promote quality improvement throughout education and training, leadership skills development should be embedded within the learning environments. **Are learners supported to participate in education quality improvement relevant to their programme or profession?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

The learning environment must support and encourage multi-professional education and collaboration. **Does the learning environment support and encourage multi-professional education and collaboration**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Organisations must promote equality, diversity and inclusion in all aspects of the learning environment. **Are equality, diversity and inclusion promoted in all aspects of the learning environment, with detailed assurance captured in section 8?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Organisation must facilitate cross-system and collaborative approaches to quality, working with partners to drive improvement. **Does the organisation work with NHS England and relevant partners to identify and improve education quality issues?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Organisations must ensure there are accessible systems and processes at all levels for raising concerns. These systems must be actively promoted, and learners should feel confident and safe to use them. **Are accessible processes in place for learners and educators to raise education quality or safety concerns, and are these actively promoted?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Organisations must have robust systems and processes in place to ensure patient safety and provide appropriate training for all healthcare learners and educators. **Are robust systems in place to ensure patient-safety related training and supervision for healthcare learners and educators?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

The system used for online and virtual learning must be suitable and accessible for all learners and educators participating in these modes of education. **Are online and virtual systems suitable and accessible for all learners and educators using them?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Organisations must support learners to complete their courses and enter the workplace confidently, within expected timeframes. **Are learners provided with suitable learning opportunities to acquire required skills, meet curricula/course requirements and progress within expected timeframes?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Ensure all regulatory conditions are met and is actively engaging and co-operating with system and professional regulators. **Is the organisation meeting relevant education and training regulatory standards and actively engaging with system and professional regulators where required?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Ensure that regular communication is taking place between the provider and NHS England and any other stakeholders as are necessary to deliver the required services safely and effectively.	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Are communication routes with NHS England and relevant education/placement partners sufficient to deliver education and training safely and effectively?	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

Ensure that issues or concerns must be reported to NHS England in line with the education concerns process. **Are education quality issues or concerns reported to NHS England Education Quality Teams in line with agreed regional or national processes?**	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐
Areas of exception: From the professional groups you train, please select which professional group(s) are impacted. Where you have multiple sites, if the issue is site specific select site and enter the name in the comments box	
We meet the standard for all professions / learner groups we train	☒
We have exceptions to report and have provided narrative	☐

For the exceptions listed above, please provide further details including a brief summary of the issues and challenges impacting your ability to meet the standard, any barriers you are facing, and what support you need from NHSE WT&E
Do systems and culture enable learners and educators to raise concerns without fear of negative repercussions? The Trust has established systems and feedback mechanisms for learners and educators to raise concerns. However, national survey findings indicate that learners do not always feel confident to speak up without fear of negative repercussions. This remains an area for improvement. Work is ongoing to increase awareness of speaking up channels, reinforce the importance of raising concerns and demonstrate how feedback informs learning and tangible improvements. The aim is to build confidence in reporting and foster a culture in which concerns are welcomed and used to improve the learning environment.

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name Email	Rachael Snelgrove Rachael.snelgrove@nhs.net

Section 5: Library & Knowledge Services and Technology-Enhanced Learning (TEL)

Has the organisation developed and implemented a service improvement plan for NHS-funded Knowledge and Library services where applicable
The latest Library Service Improvement Plan was developed following an assessment against the Quality Improvement Outcome Framework. The plan is reviewed and updated regularly by the Library Manager, with progress reports submitted to the Lead for Workforce Planning and Development.

Is the organisation promoting the national clinical decision support tool funded by NHS England to learners?
Partially promoted
How is the tool promoted and what outcome is expected from the promotion?
BMJ Best Practice is included in the Library Marketing Plan and actively promoted at induction events, including Resident Doctor events and New Starter Welcome Fairs. Usage is monitored through national dashboards to track engagement and uptake. Details of the BMJ subscription have been shared with the Trust's Chief Nursing Information Officer to explore the possibility of integrating the tool within the Electronic Patient Record (EPR) system.

Do learners have access to appropriate technology, digital learning tools and virtual learning support required for their education and training activity?
Partial access
The library offers PCs and dedicated study spaces for all Trust staff, with additional computers available in the Doctors' Mess at each site.

To what extent is the organisation aware of the appropriate evidence-based principles for modernising healthcare education effectively?
Awareness of evidence-based principles is demonstrated through Technology Enhanced Learning (TEL) in Medicine, where digital resources and interactive tools complement clinical placement learning within clinical skills and simulation teaching. These approaches focus on developing clinical, communication, teamwork and digital literacy skills and are consistent with national priorities for educational technology, educator support and collaborative learning. The Trust also holds Copilot licences, providing a further foundation for digital development, alongside the implementation of a new Electronic Patient Record, Nervecentre. From a library perspective, online information platforms provide more efficient access to relevant, evidence-based resources.

My organisation actively address barriers to modernising healthcare education, for example technological, cultural or structural barriers?
The Trust is taking steps to address barriers to modernising healthcare education, although challenges remain. Technological barriers are being addressed through access to library PCs, study spaces and online resources. Simulation Steering Group meetings

support coordination, faculty engagement and development of teaching across multi-professional groups, helping to strengthen collaboration and adoption of new approaches. Structural constraints include clinical pressures, educator capacity, limited teaching space and funding for digital solutions.

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name Email	Rachael Snelgrove Rachael.snelgrove@nhs.net

Section 6. Educators

Are training and supervised opportunities in end-of-life care and advance care planning embedded in the organisation?
Partially embedded
Nursing, Midwifery: Undergraduate second and third year nursing students, together with second year Student Nursing Associates, have the opportunity to undertake end of life care education delivered by Clinical Teaching Fellows through dedicated teaching sessions and Professional Development Days. This supports learners in achieving the proficiencies required for programme progression and sign-off. End of life care education is also provided to new Trust staff through both the Healthcare Support Worker Academy and Registered Nurse induction programmes. These sessions cover care after death and the associated documentation and processes required in practice **Medical:** Although there is no specific mandatory end-of-life care training for medical and dental staff, Internal Medicine doctors in training receive this education through regional training days as part of their curriculum. In Scarborough, Emergency Medicine and Palliative Care Educators deliver in-situ simulations for multi-professional teams. Each scenario is followed by a debrief to support reflection and learning from the simulated experience. As a trust there is End of Life Care Elearning modules available, along with a two-day face to face advanced communications course open to all clinical staff to attend.

To what extent are educators and supervisors across the professions appropriately supported and given the time or capacity required to undertake their education
Partially embedded
Nursing, Midwifery and AHP: Educators, practice supervisors and assessors are supported through role-specific training and, once appropriately prepared, are recorded on the relevant educator register. Ongoing support is provided by a dedicated Practice Education Facilitator and the Learning Environment Manager, including curriculum updates and advice on role requirements. Clinical areas allocate time for staff to undertake their educational responsibilities; however, this is managed locally and is not formally defined or consistently protected. Further work is required to standardise capacity arrangements and strengthen assurance across clinical areas. **Medical:** Named supervisors should have 0.25 PA allocated in their job plans for educational and clinical supervision responsibilities. However, this allocation is not yet reflected in all relevant clinicians' job plans. Medical Education is working with Clinical Leads to ensure supervisory time is correctly accounted for and protected through job planning. Supervisor development is supported through Trainer Accreditation workshops and face-to-face Educational Masterclasses, covering topics such as neurodiversity awareness, International Medical Graduate support and psychological safety.

What approaches are used to ensure educators across all professions consistently use protected time set aside for their educational duties?
There is no consistent approach to supporting access to protected educator time across the professional groups. Within Medical and Dental, Medical Education encourage educators to job plan educational activities to protect the time.

Does the organisation maintain a register or other reliable record of educators across the professions it trains?
Yes
Nursing, Midwifery and AHP: All trained Practice Supervisors, Practice Assessors and Learning Environment Managers are recorded on the relevant register. Trained Preceptors are identifiable through Trust Learning Hub reports. Records are also maintained for Nursing Clinical Educators working in both corporate education and specialist clinical services, enabling oversight of educator preparation and capacity across nursing practice settings. **Medical:** Medical Education, UG and PG, maintain local records of all named educators. Within Postgraduate the team maintain a record of GMC trainer accreditation status and liaise with individuals when refresher training is required to ensure faculty are adequately trained and maintain their accreditation status.

Please provide the name and email address(s) of Senior Educator(s) or Educator Leaders responsible or accountable for education and training across all groups:	
Advanced Practice	Julia Spencer julia.spencer6@nhs.net
Allied Health Professionals	Laura Walton laura.walton20@nhs.net
Dental	Hannah Slevin hannah.slevin1@nhs.net
Healthcare science	Trudy Walker trudy.walker1@nhs.net
Medical	Lucy Glanfield - PG l.glanfield@nhs.net Chris Wilkinson – UG christopher.wilkinson10@nhs.net
Non-clinical roles	N/A
Nursing and Midwifery	Vicky Angel victoria.angell1@nhs.net
Pharmacy	Kajal Wilkinson kajal.wilkinson@nhs.net
Psychological Professions	N/A
Other	

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name Email	Rachael Snelgrove Rachael.snelgrove@nhs.net

Section 7: Improving the Working Lives of Resident Doctors

Please provide the name and email addresses of the Non-Executive Director, Executive Lead for Resident Doctors and Resident Doctor Peer Lead who have responsibility for overseeing and delivering the 10 Point Plan.	
Non-Executive Director	Mr Richard Reece Richard.reece@nhs.net
Executive Lead	Dr Karen Stone Karen.stone14@nhs.net
Resident Doctor Peer Lead(s)	Dr Ruaridh Owen Ruaridh.owen@nhs.net Dr Edward Kenny edward.kenny@nhs.net

What support have you put in place to ensure that the next Resident Doctor Peer Leads are inducted and supported when their roles rotate?	
Dedicated local induction programme	☒
Meeting with Executive Lead for Resident Doctors in the first week	☒
Leadership training	☒
Handover meeting with outgoing Resident Doctor Peer Lead(s)	☒
Other – please specify	

How frequently does the Executive Lead of Resident Doctors experience report to the board on Resident Doctor experience and the 10 Point Plan progress, risks and opportunities?
At present an annual report is submitted to Board regarding the 10 point plan. Moving forwards a report will be incorporated within the medical and dental workforce report to Resource Committee quarterly, along with the standing annual board paper.

What forums do you have to facilitate regular engagement and feedback to identify and act on Resident Doctors concerns in a timely and effective way	
Meet regularly with local representative body	☒
Meet regularly with British Medical Association representatives	☐
Resident Doctor Forum	☒
Resident Doctor Survey	☒
Direct engagement with the Resident Doctor Peer Lead, such as walk arounds, drop-ins or meetings	☒
Other – please specify	Resident Education Forum (REF) Bi-monthly

Do you currently have a clear action plan for improving the working lives of Resident Doctors?
A working document has been produced by a group of stakeholders for each point of the 10-point plan. This plan then feeds wider pieces of work across the Trust and are held to account though a bi-monthly stakeholder group chaired by the Head of Medical Education and Resident Doctor Peer Leads.
If yes, is this shared with the Trust board as part of the governance for this programme?
Yes a local self-assessment was completed in July 2026 and the results formed part of the board paper. The exercise will be completed in February 2026.
If yes, what are your top 3 priority areas from your local action plan?
1. Reducing payroll errors and implementing a reporting structure 2. Improving access to rest facilities 3. Developing robust mechanisms to collect feedback

We are keen to hear about initiatives and good practice relating to improving the working lives of Resident Doctors within your organisation. Please provide a brief description of the initiative or good practice
A working group has been established with key stakeholders from Medical Governance, Medical Education, Medical Employment, Payroll and Medical Deployment teams, along with the Trust Peer Leads.

Which of the following facilities and amenities are available to all resident doctors? Please select all that apply:	
Beds or sleeping pods, free of charge for those who feel too tired to drive home	☒
The ability to take a rest break when rostered for 5hours or more	☒
Facilities which allow Resident Doctors to safety park and each or leave the hospital building when on call, such as dedicated on-call parking	☒
Resident Doctors can typically complete self-directed learning from a flexible location	☐
Mess Facilities	☒
If any of the above are not or only partially available, please outline briefly below the rationale for different local practice or alternative arrangements	
There is no dedicated on-call parking arrangements but for those working out of hours parking provision is provided by allowing staff to park in the visitor carpark which is closer to the main hospital building in York. Security are also available to escort staff to their cars if they feel unsafe to walk there in the dark. Self-Development Time (SDT) is challenging to fully implement for all Resident Doctors. SDT is rostered for Foundation Doctors and conversations are underway to roster for Core trainees. Residents can take SDT time, but this is by request to the rostering team.	

Are hot and cold food facilities accessible 24/7, for example either canteen or vending machine and microwave? **If yes, what is provided, if no please explain why what actions are being taken to address this**
Yes, hot and cold food vending machines are situated in the canteens and available 24/7 with ID badge access. A microwave is also available 24/7 in the canteens

Does the organisation have a Guardian of Safe Working, if postgraduate doctors in training are being trained, and actively promote the process for raising concerns through them to their learners
Yes, the Guardian of Safe Working presents at all Doctor corporate inductions, promoting exception reporting and how to raise concerns along with a dedicated lunchtime session for F1 doctors. The Guardian also attends in person to Resident Doctor Forums (RDFs).

Are you compliant with the minimum standards in annual leave for Resident Doctors?
A new Medical and Dental annual leave policy has recently been published which supports the minimum standard for resident doctors, along with other medical and dental staff.
Please provide the number of breaches in the 12 months for this standard
This was not monitored over the last 12months, data is not available.
Are there clear mechanisms in place to identify and correct payroll errors for Resident Doctors in a timely manner?
Payroll errors are usually identified by the Resident of which the process is to contact payroll to correct. For known payroll errors these are adjusted for the following pay-run
Are payroll errors for Resident Doctors reported to your board on a regular ongoing basis?
At present no, this will be incorporated within the Medical workforce report in the future and within the annual 10-Point Plan Board paper.
Are you compliant with the National Payroll Improvement Programme data request?
Yes
What actions are in place to further reduce payroll errors for Resident Doctors?
Payroll error monitoring is now in place. Data will be reviewed for trends and themes and if applicable training will be implemented to avoid future errors.
Please confirm the number of payroll errors in the last 12months
This has not been monitored over the last 12months.
Are Resident doctors now able to claim reimbursement of course fees at the point of incurring the expense?
Yes, the early reimbursement process has been communicated with Resident doctors and is active.

Please confirm the percentage of course fee reimbursement paid within six weeks
Upon submission, 100% of course fee reimbursements have been made within a six-week timeframe.
Does your Trust comply with the May 2025 Statutory and Mandatory staff movement Memorandum of Understanding to accept prior mandatory training?
Yes
Have you fully implemented the new exception reporting process for Resident Doctors
Yes
What actions are you taking locally to follow up on areas highlighted by the revised exception reporting processes?
The Guardian of Safer Working Hours (GOSWH) office has developed and published local guidance to support the revised exception reporting process. This reflects the removal of supervisor sign-off and the requirement to anonymise data so that individuals cannot be identified. The guidance includes an escalation document setting out triggers based on the number of exception reports relating to an individual or specialty, or on emerging patterns. The Guardian's office investigates when these triggers are met.
What actions are you putting in place to improve compliance with the rota and scheduling standards for Resident Doctors, providing work schedules at least 8 weeks before the rotation commences, and detailed rotas at least 6 weeks in advance?
Medical Deployment teams monitor rota and work scheduling standards. The Trust has employed a Leadership Fellow focusing on 'Improving Doctors Working Lives' with a focus on improving rostering for Residents. A best practice SOP has been developed to address delays in receiving work schedules and rotas, particularly for departments not centrally managed by the medical deployment team. The SOP includes escalation processes and best practice guidance, aiming for timely and fair rota distribution, especially for less than full-time staff.
What is your organisations current percentage of compliance to provide work schedules 8 weeks before the rotation commences?
For those rotas centrally managed by the rostering team, work schedules are currently 90% compliance at 8weeks. For those rosters managed by local departments, work is underway through the roll-out of the best practice SOP to bring the compliance rates up
What is your organisations current percentage compliance to provide detailed rotas 6 weeks in advance?
For those rotas centrally managed by the rostering team, work schedules are currently 90% compliance at 8weeks. For those rosters managed by local departments, work is underway through the roll-out of the best practice SOP to bring the compliance rates up

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name Email	Rachael Snelgrove Rachael.snelgrove@nhs.net

Section 8. Equality, Diversity and Inclusion

Does your organisation have an Equality Diversity and Inclusion Lead, or equivalent, with responsibility for or a clear link to education and training. Please provide their name, role and contact details and briefly describe the governance arrangements and how education and training teams liaise with them	
Yes. Virginia Golding, Head of EDI, is responsible for the equality, diversity and inclusion portfolio. Liaison with education and training takes place through educational leads and in response to escalations received. There is currently no formal governance structure linking the Head of EDI and education and training. The Trust has an Anti-Racism Steering group of which membership includes Educational leads from Nursing, Midwifery and Medical. Themes from data and lived experiences are shared and form part of this groups workplan.	
Name	Virginia Golding
Role	Head of EDI
Email address	Virginia.golding@nhs.net

How assured are you that learners from protected groups experience education and training equitably?
Moderately assured
What evidence informs this assessment
All training is reviewed to ensure it is inclusive for learners from protected groups, enabling all leaners equal opportunities to access to education and training. Whilst there is no measurement to this, as each professional group has responsibility for their own area, we feel moderately assured learners have access to equal opportunities.

Please confirm whether your organisation has arrangements in place for the following in relation to education and training. Please tick all that apply	
Learner-inclusive reporting and data collection	☐
Reasonable adjustments for learners with a disability	☒
Review of policies and procedures to avoid negative impact on learners with protected characteristics	☐
Managing discriminatory behaviour from patients	☒
A policy to manage sexual harassment in the workplace	☒
Initiatives to support reporting of sexual harassment	☒
Sign-up to the NHS England Sexual Safety in Healthcare Organisational Charter	☒
A designated sexual safety lead	☒
Appropriate processes for managing reports	☐
Please provide additional comments where arrangements are not in place	
Policies and procedures are reviewed not just for learners but for all staff and learners in the organisation to ensure staff with protected characteristics are not negatively impacted.	

The Trust does not have a learner-inclusive reporting and data collection; this is conducted in line with all trust staff. Learners specific feedback received is through National Training Surveys.

Please describe any equality, diversity or inclusion initiative that are specific to, or have a positive impact on, education and training in your organisation. Please also provide the email address or a contact who can discuss these initiatives further	
The Trusts equality, diversity and inclusion initiatives include the Living Library, which supports conversations about identity and belonging, and awareness sessions available to colleagues through the Trusts Learning Hub. The Inclusion Forum shares information to raise awareness of inclusive practices for colleagues and patients. The Trust also marks International Womens day and Disability History month and promotes information about cultural and religious events and celebrations through its communication channels.	
Contact name	Virginia Golding
Contact role	Head EDI
Contact email address	Virginia.golding@nhs.net

For education and training, what have been your organisations main EDI successes during the reporting period, and what are the main EDI challenges. Please summarise key points and include any actions underway or support needed
The Trust continues to build on its International Staff induction programme, originally developed by International Nursing colleagues. Two years ago, Postgraduate Medical Education joined the initiative to collaboratively develop a two-day, face-to-face programme for clinical staff with less than six months of NHS experience. This joint approach brings nursing, AHP and medical education expertise together and provides a shared induction opportunity for colleagues across clinical professions who are new to the NHS. The sessions consistently receive highly positive feedback.

Section completion declaration: I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.	
Name Email	Rachael Snelgrove Rachael.snelgrove@nhs.net

Section 9: Final submission and data quality checklist.

I confirm that our premises, learning environment, facilities and equipment are: suitable for the performance of the services; accessible, safe and secure; comply with any applicable Health and Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant Regulator; and are sufficient to enable to Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.

Board level sign-off	
I confirm that the responses in this SA have been signed off at board level	☐
Name of board representative for education and training	
Email address	
Role	
Please confirm the date that board level sign off was received	

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Review and update of the Green Plan
Director Sponsor:	Chris Norman, Managing Director, YTHFM
Author:	Graham Titchener, Head of Sustainability

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:

Since the summer of 2022 when the current version of the Green Plan was published following the arrival of the Head of Sustainability, this has meant that the current plan has been ahead of most other Green Plans in terms of its review and update. However, since then NHSE have updated their Green Plan guidance, which has meant our current plan is a little out of step with this guidance but given the data and our emissions target has changed since 2022, this is an opportune time to review the current plan and submit a revised version for approval.

As we approach our first major milestone on our Trust Net Zero journey, which is to meet 80% of our Net Zero obligatory target, the revised version will provide a clearer

road map to get us to that 80% target, taking the Trust up to 2028, where the next revision will take place to clearly lay out the next part of our net zero journey to ensure measures are in place to meet this 80% target date.

As readers will know, the plan is broken down into several themes, run by a senior member, or members, of staff with expertise and authority in the subject area of the theme they lead on. They have been asked to firm up their targets and actions, with greater inclusion of KPI's that will help the sustainability team better measure progress against the current 1350 t/CO2e per annum target. The accumulation of these combined works and efforts will significantly contribute towards achieving this saving per annum but also to support the ongoing sustainability ambitions and drive the Trust has to become more sustainable for its staff, patients and the communities in which it serves.

So, this plan has revised data, KPI's and targets, which focuses on the themes to drive the Trust towards the 80% target as well as greater recognition of other environmental local and regional government strategies, including the City of York, York and North Yorkshire Combined Authority and the Yorkshire and Humber Climate Commission.

This has been through the YTHFM Management Group and Resources Committee. Both were supportive of the plan and this going forward for approval and publication.

Recommendation:

To look through the report and ensure you are comfortable with what is in the Green Plan and ensure support from each Director is given to any workstream leads within your directorate and hold regular meetings to ensure progress is being made.

Agree to the approval and publication of the Green Plan.

We recommend updates to the Green Plan can be made, where there are smaller changes such as updates to the data section or workstreams, with delegation to the Director Sponsor /Head of Sustainability to make these changes.

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation

Review and update of the Green Plan

1. Introduction and Background

As readers will be aware, NHSE has a legal obligation to achieve Net Zero CO2e (equivalent) emissions by 2040, these are also obligations Trust and other large NHSE organisations have to follow. As a result, the local policy for these is delivered through a Green Plan, based on the NHSE Green Plan Support Tool guidance, that follows several themes to deliver to this obligation and the organisations sustainability ambitions.

The current version runs until 2027, however with the NHSE Green Plan guidance being updated last year and the Trust's progress to becoming more sustainable and reduction of its emissions.

This version takes the Trust through to the end of 2028, is greater recognition the local and regional governments climate change strategies within the Trust 's area as well as the Yorkshire and Humber Climate Commission's action plan. In addition, workstream leads have been asked to update their workstream sections within the Green Plan and make develop more specific targets and actions.

For these, the health impacts are reflected in these strategies, as part of the Head of Sustainability teams partnership working, alongside the ICB and NHSE.

The Green Plan will still be reviewed annually and where there are meaningful updates to be made, such as updates to the data sections or changes in targets from workstream leads, these will be reviewed and incorporated into the Green Plana report will be brought for approval to update the plan, where this will likely be the data sections and workstream sections.

2. Considerations

The Green Plan is a high-level policy document that supports the delivery against the Trust corporate objective "To use resources to deliver healthcare today without compromising the health of future generations."

The delivery of this is through the incorporation and embed of sustainable principles across the whole of the Trust's business ranging from sustainable healthcare, installation of renewable energy technologies, all teams to review and move away form single use items to reusable, where economically and environmentally practicable and embedding this across all teams to think more sustainably.

These messages must come from top down and ensure all staff are aware and committed to this, with the support of the Green Champions network and the integration and ownership of workstreams, such as the Sustainable Models of Care workstream across all care groups.

Sustainability and our net zero journey are not just a nice to have or something that is on the periphery but central to how we operate. In turn by incorporating sustainability into our business will likely see increased cost savings and a better patient experience. Looking at the scope 1 to 3 sections and what falls under this,

will help given readers an idea of the breadth sustainability covers across our Trust and beyond.

3. Current Position/Issues

We currently have a Green Plan that was published in the summer of 2024, that was delivered ahead of other Trust's. Since then, new guidance has come out from NHSE for Green Plans and regional climate change and sustainability policies have come about from local and regional bodies and governments. As a result, our current Green Plan needs to better recognise these external polices and NHSE guidance. Importantly our Plan needs to incorporate updated data sections and improved KPI's and targets across the workstreams, which have been developed by workstream leads.

Since the publication of our current Green Plan the incorporation of sustainability as its own corporate objective and mandatory item in all new policies and business cases is a significant step forward and something we should be proud of.

We now need to build upon this and ensure the Green Plan is fully incorporated and followed when it comes to decision making, investments (revenue and capital) and changes to the ways we do things, which will form part of the broader cultural change led by the Chief Executive.

Turning words into actions remains an issue, where it is not the lack of will but time. While we have and continue to do well in attracting external funding, we need to ensure sustainability is incorporated into any and all capital investment decisions.

Clinically the broadest impacts can be made for example moving to reusable forms of equipment or where single use is deemed the best option, ensuring it has the least plastic incorporated into this.

While the integration of the sustainable models of care workstream into the Care Groups will be significant, the drive from the Chief Nurse and Medical Director to ensure this approach is adopted and working, remains vital and their support, as with all other board members, continues to be welcomed.

Over this last year we have seen a number discrepancies between different data sets, both from NHSE and the Trust, which has made the calculations of our carbon footprint equivalent, difficult. More detailed work is required but we are hopeful towards the end of this year we will have a more assurance set of data in place to better present our current Co2e emissions and trajectory to net zero.

This revised Green Plan is now the main opportunity to ensure we are on track to meet our obligatory net zero targets for 80% by the end of 2032, which should not just be seen as legally binding but for the benefit of the communities we serve and of course our future generations. Therefore, this must be seen and taken as personal and not simply professional.

4. Summary

This updated Green Plan has a number of revisions to it including:-

- Revised data sections, where work will need to continue to finalise these.

- Recognition of NHSE Green Plan guidance as well as local and regional climate change policies within our Trust geographical boundary
- Revised KPI's, where possible and targets for the workstreams.

5. Next Steps

To consider the recommendations in this report and noting the responsibility for all Directors to ensure sustainability/the Green Plan is central across their directorates and ensure effective governance is in place to provide this assurance and support to their staff to embed this across working practices and decision making.

The Sustainability team will review the data on a quarterly basis, in line with NHSE reporting and will review and update the Green Plan's data section annually.

Date: October 2026



NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

York and Scarborough Teaching Hospitals NHS Foundation Trust Green Plan 2024-2028



York and Scarborough Teaching Hospitals Green Plan 2024 – 2028

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1. CEO Foreword



"York and Scarborough Teaching Hospitals NHS Foundation Trust strives to encourage, promote, and achieve zero carbon emissions in line with NHS targets in all that it does, through its staff, services, premises, patients, partners and visitors."

Trust mission statement

Sustainability is not something separate from our core purpose. It is fundamental to how we care for our patients, support our communities and safeguard the future of our services. That is why it remains one of our Trust's Strategic Priorities, and why I am delighted to support this refreshed Green Plan for 2024–2028.

As one of the largest organisations in our region, we have both an opportunity and a responsibility to make a meaningful contribution to reducing carbon emissions and improving sustainability. This is about more than meeting national targets. It is about creating a healthier future for the people we serve, using our resources wisely, and ensuring our hospitals and services remain resilient for generations to come.

This Green Plan sets out ambitious goals, but they are goals we must be prepared to embrace. It outlines the scale of change required, the carbon reductions we need to achieve, and the partnerships that will help us make a real and lasting difference across our communities.

I am confident that, together, we can rise to this challenge. By working collaboratively, embracing innovation and living our values every day, we can build a more sustainable organisation while remaining focused on what matters most: providing outstanding care and keeping patients at the heart of every decision we make.

Just as importantly, this plan recognises that meaningful change happens through the actions of all of us. It empowers colleagues to make practical, everyday choices that collectively have a significant impact. Every action counts, and together those actions will help us create a healthier, greener and more sustainable future for our patients, our communities and our Trust.



Clare Smith
Chief Executive

2. Executive Summary

This 2024-2028 Green Plan, version 2, builds on the latest NHSE Green Plan guidance that was published February 2025 and the increasing work the Trust is going to achieve the CO_2e targets and sustainable ambitions. This version replaces the 2024-2027 Green Plan with this version 2 that takes the Trust up to 2028. This allows the Trust to take stock and review this current Green Plan and make any changes to ensure we are on track to meet the 2028-2032 80% net zero target. In addition, this plan incorporates more specific KPIs and outcomes the Trust aims to achieve, against the newly developed emissions reduction target we have calculated which is 1350 tonnes of CO_2e per annum saving we need to make. This CO_2e saving builds upon our journey to reach 80% reduction of our emissions by 2032 and ultimately net zero emissions by 2040.

As well as the NHSE Green Plan guidance, this also takes into account the October 2020 publication of “Delivering a Net Zero National Health Service" and other guidance include the NHS Net Zero Building Standards, published in February 2023 to support our net zero journey and strengthening the Trust’s plan for improving our sustainability and tackling carbon reduction.

The net zero target for emissions that we directly control (referred to as our NHS Carbon Footprint) through reducing our energy use, our fleet and business travel, inhalational anaesthetic agents and nitrous oxide and with changes to prescribing inhalers, is to be achieved by 2040 with an 80% reduction delivered by 2032 compared to our baseline year of 1990.

For emissions that we can influence but can’t directly control, the net zero target is 2045. This is referred to as our NHS Carbon Footprint Plus and includes the embodied carbon emissions from the things we buy (such as medicines and medical devices) and the carbon footprint of patient and visitor travel, and staff commuting.

This plan identifies a range of recent achievements in delivering the pathway to net zero as well as achievements against some of the new targets, reducing nitrous oxide use and waste and increase uses of intravenous anaesthesia, capturing of gas emissions, increasing use of dry powder inhalers through to reviews of moving away from single use items to reusable, where possible, the increased use of technology to allow patients to receive consultations at home and staff to work from home. The creation of an environment for staff to develop initiatives and feel empowered is an ongoing behavioural change item that requires and has full support from the Trust’s leadership, but it remains clear that the speed of transitioning to lower carbon alternatives needs to accelerate despite increased demand on Trust resources.

An analysis of our NHS Carbon Footprint shows for 2023/24 that 77% of the footprint is due to our energy use (62% from fossil fuels and 15% from electricity). The second-largest category is inhalational anaesthetic agents and nitrous oxide, at 9%. Fleet and business travel contributes 8% of our carbon emissions. The largest component of our NHS Carbon Footprint Plus is medicines and chemicals (34%), and the second largest is related to medical equipment (15%). Staff commute, patient and visitor travel also accounts for 16% of our NHS Carbon Footprint Plus.

In summarising the actions required to achieve carbon and greenhouse gas reduction, there is a strong focus on energy, through better control, improvements to building fabric, installation of renewables and building to net zero standards and new builds set against BREAAM Excellence standards. Travel is another key aspect, through improvements of facilities for active travel and electric vehicle charging. Using emerging technologies, redesigning the way that we deliver services, minimising waste and making procurement decisions that reduce carbon impact will all contribute to moving towards net zero. All of which are supported through the ongoing successes in applying and be award external funding to take forward some of these capital initiatives.

Whilst the latter sections of the report highlight the importance of communication, tracking progress, risks and finance, it is noted that the real cost of emitting carbon is the long-term impact of the changing climate leading to irreversible change. Many of the actions needed to reduce carbon emissions to achieve net zero has a cost and this currently has to be borne by the organisation meeting the targets and, where successful, external funding. Whilst the Trust was successful in obtaining external funding, we are moving in the right direction but without increased targeted funding, the journey will continue to be challenging. It remains the hope that government addresses this matter by providing funding to cover the cost burden for organisations like the Trust and works to increase renewable energy to better balance the costs for electricity against the much lower price of gas. Whilst work must continue to deliver the required carbon savings to achieve net zero and encourage our staff to do all that they can, reducing the impacts on climate has to be done in partnership, where the Trust will continue to build on its work with Local Government, Combined Authorities, neighbouring Trusts and other public and private sector establishments, including our supply chain.

This new Green Plan also needs to align, where possible, with similar climate change polices, ranging from the Yorkshire and Humber Climate Commission action plan, City of York Council Climate Change Commission and the York and North Yorkshire Combined Authority (YNYCA) Strategy for a Sustainable Future. Within the NHS, greater alignment to the ICB’s Green Plan and the recently published NHS 10 year plan for England that will aim to see a shift towards community care, digitisation and prevention. Most of which will have positive impacts on our Green Plan but recognition that there is balance where it is likely we will see an increase in our grey fleet as more staff will be traveling out into the communities, verses less patients traveling into our hospitals, but as Sustainability is one of the Trust Corporate Objectives, this will inform any changes in services to support the Green Plan ambitions and our legal CO2e targets.

3.1 Introduction

Delivering a Net Zero National Health Service

Why do we need this plan?

As an NHS organisation and a spender of public funds, we must work in a way that has a positive effect on the communities we serve. Our opportunities to make a positive impact extend beyond reducing emissions. We can also help to influence our local community and workforce's health as well as our local environment.

By reducing single-occupancy car journeys, encouraging uptake of active and public travel, and reducing our business mileage, we can contribute to local air pollution reductions and increase the fitness of our staff. We can also reduce our environmental impact by stopping the usage of single-use plastics where an alternative is available and ensuring that resources are used sustainably with minimal possible waste.

In October 2020, the "Delivering a Net Zero National Health Service“ was published, outlining a strategy on how the NHS will achieve its ambitious targets. NHS institutions across the country commit to this strategy by publishing their own Green Plans, further informed by their own work and the latest NHSE Green Plan guidance February 2025. This Green Plan shows how the Trust will align with the national strategy and reduce its carbon emissions to net zero.

In addition to Net Zero NHS carbon reduction targets, we also must ensure that the Trust can meet sustainability-related targets within the NHS Long-Term Plan, Standard Service Contract and Operational Planning and Contracting Guidance. We are committed to using the NHS’s new strategic sustainability framework as established in “How to Produce a Green Plan 2021” and the latter Green Plan Guidance, which contains many work streams that are outlined later in this document. We must take a proactive stance on carbon reduction and take advantage of new technologies and methods of working to reduce our emissions as these become available. Realising the impacts each of our staff has to make a difference and supporting them to take action and meet the targets found later in this report that requires holistic measures to ensure carbon reduction across the board. By collaborating with local partners and other NHS institutions, we can share best practices and ensure that we are at the vanguard of the process of becoming a Net Zero National Health Service.



3.2 Introduction

The Regional and National Picture

While this is the Trust's Green Plan, it is important to touch on the broader regional and national picture that our Trust, and this Green Plan, supports and how the Trust's sustainability strategy needs to acknowledge and allow these external governmental strategies to influence ours in order to support and reduce our impacts on our surrounding communities, while prioritising our requirements and needs.

Sustainability in healthcare is about working with partners, especially Local and Regional Government bodies, to create healthier communities, in line with Public Health principles. The work the ICB, NHSE and this Trust has done ensured 'health' is one of the key focuses across these local and regional climate strategies as defined in the City of York and YNYCA strategies and broader Yorkshire and Humber Climate Commission.

This plan aligns to the ICB Green Plan where viable for this Trust, given measures have either been achieved or expanding on some of them to better meet our Trust ambitions and current workings where the ICB Green Plan cannot be fully delivered without all organisations under the ICB, especially from Trusts, delivering theirs.

The Humber and North Yorkshire ICB Green Plan 2025-2028 aims to:

1. Achieve a net zero health care system
2. Adapt to the effects of climate change, and
3. Enhance biodiversity and enable people to healthier lives and experience better wellbeing through access to the natural environment and sustainable infrastructure.

Building on the direction set by our previous Humber and North Yorkshire Green Plan, together with the exceptional achievements of commissioners and providers during this period, our plan for 2025-2028 provides the strategic framework for us to achieve the aims described above. Critically, it defines the Common Purpose for the action needed to take health infrastructure into sustainable future – a future in which every person and family in every neighbourhood can be assured that health infrastructure will support their wellbeing without causing harm to the environment.

This Green Plan is not prescriptive. It provides the space for our approach to commissioning and delivering health and care to continue to evolve. Our focus on the three shifts – from hospital to community, from analogue to digital and from treatment to prevention provide a unique opportunity to reform how we achieve better health outcomes for people.

In addition the newly launched NHS 10 year plan will also have a significant impact on this and other Green Plans, which should mainly be positive however given the increases in community care this may well see an increase in our grey fleet use and emissions, so how this is implemented will be important to assess the sustainable impacts on the Trust.

Through the collective effort of every organisation within it, an environmentally sustainable health and care system can and should be at the heart of this reform. By connecting with each other, our work can create real change for a better, more sustainable future. We can help create this change by aligning all that we commission and deliver across health care with this plan.

Let's all play our part in this.



4.1 Overview

About Us

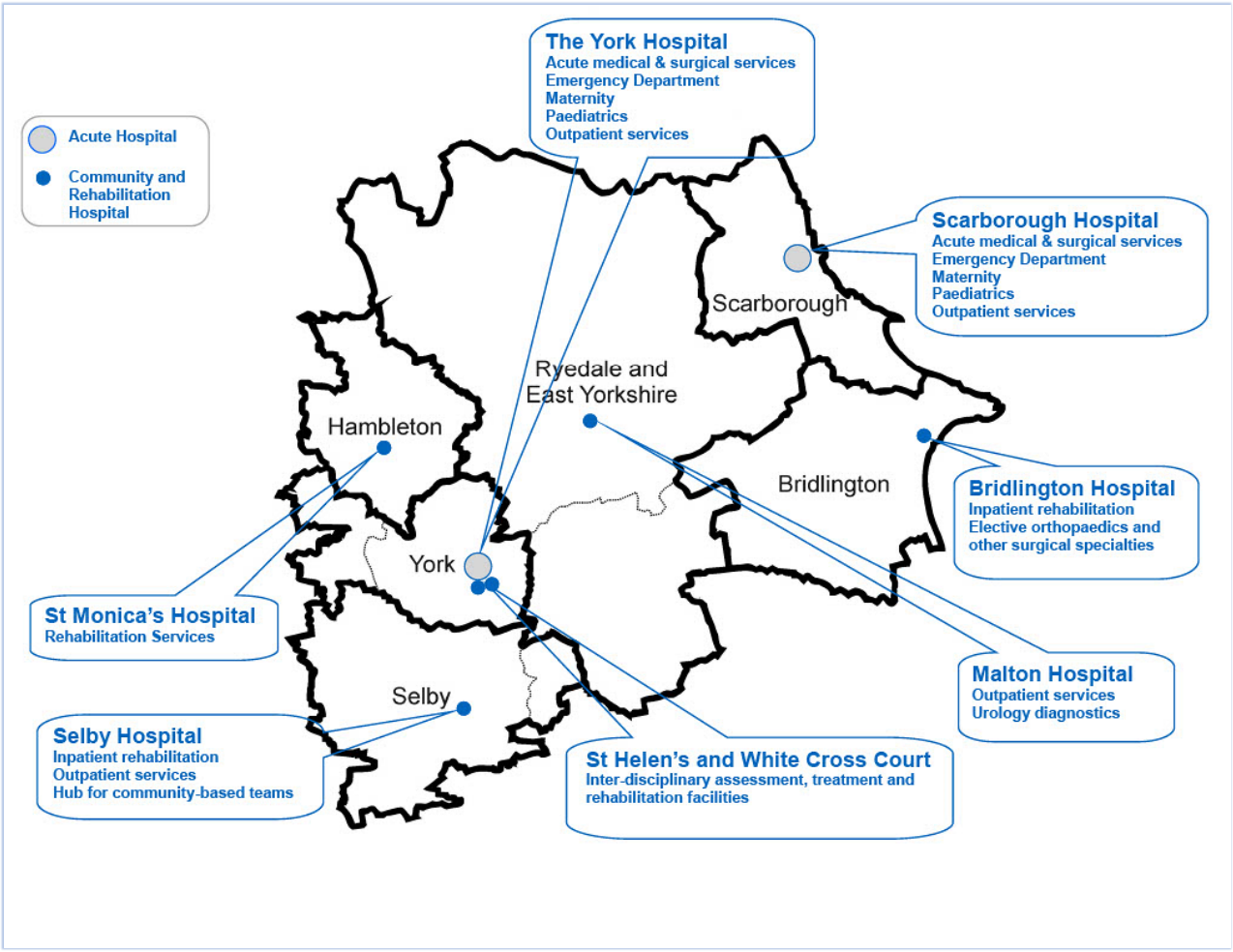
Our Hospitals

- York Hospital
- Scarborough Hospital
- Bridlington Hospital
- Malton Hospital
- The New Selby War Memorial Hospital
- St Monica's Hospital Easingwold
- White Cross Rehabilitation Hospital
- Nelson's Court Rehabilitation Hospital (Previously St Helen's)

Our Activity

The Trust operates a wide range of inpatient, outpatient and community services across the region and provides emergency care through A&E units in York and Scarborough, serving over 800,000 people.

In 2023/24, the Trust had approximately 1.5 million patient contacts across our sites, and an annual turnover of over £800 million.



4.2 Overview

Achieving Strategic Goals

Overview

The transition to net zero is an exciting and challenging process to be a part of, and each NHS organisation will experience its own specific challenges and opportunities in achieving this goal. It is important that both are highlighted and addressed to maximise progress and share these experiences both with other NHS and Public Health organisations and other external partners and as mentioned aligning where possible with local and regional climate strategies across our region.

Successes

The Trust has made good progress in reducing carbon emissions from various sources, including implementing CO2 limits on business vehicle leases, removal of desflurane, the volatile anaesthetic agent with the highest global warming potential from use and now the reduction of nitrous oxide, and moves towards dry powder inhalers through to electrifying our vehicle fleet and measures to reduce the use of single-use items and building emissions. Widening the scope of actions taken allows for increased integration of sustainability into everyday working practices and supports awareness from staff in all roles. Core to all of this is embedding this Green Plan at the centre of the Trust, where sustainability is now one of the corporate objectives and is a mandatory item to cover in all reports, polices and business cases. More examples of successes can be found on pages 12-14.

Opportunities

While the Covid-19 pandemic unquestionably impacted all sectors, resulting in unprecedented changes to how we live our lives, climate change and the environment remains high on the national agenda. But the need to change the culture of our staff remains a priority to influence this behavioural change. Through the Green Champion network, ongoing communications, team agenda items, campaigns such as Gloves Off, these changes are being seen and staff feeling increasingly empowered to help do their bit.

From an environmental perspective, the pandemic has presented and continues to present new challenges such as the disposal of high volumes of PPE, but through incentives projects we are seeing increases in public transport and active travel utilisation. Still, there have also been areas where the pandemic has quickened positive change and provided inspiration for the post-Covid future. The use of videoconferencing by staff has increased tenfold since the start of the pandemic primarily because of social distancing measures and an increase in home working.

The development of the new staff travel plan is an essential part of the work in how we can influence staff commuting and support changes in staff travel, while recognising the large geographical area the Trust covers and the mixed settings from rural and coastal to urban areas.

As we see the increasing climb to higher temperatures, we must be able to adapt to these and do what we can to lessen our impacts, where the recognition of these changes, as we see in the media, has helped fuel positive buy-in and action by staff and our partners, to do more. The development of the Green Champion network is one but significant part of this journey, where within the first 3 months of this being launched, we had over 100 people. Their role is to simply do what they can and influence change and measures in each of their work areas, where cumulatively this will make big difference, ranging from what we use, how much of items we use and changes in working practices under the methodology of the triple bottom line to ensure measures are sustainable, effective and recognise any value added.

4.2 Overview

Achieving Strategic Goals

Challenges

With a growing, ageing population and one of the highest rates of obesity in Europe and ongoing health inequalities, the outlook is challenging for the Health Service and the changes it is going through at the NHSE and ICB levels. While the provision of a central NHS strategy and support to reach net zero is highly welcome, future strategies across all areas of the NHS must be consistent with meeting these sustainable commitments as well as obligatory CO2 targets.

York and Scarborough Teaching Hospitals provide healthcare to a resident population of circa 800,000 spread across York, North Yorkshire and East Riding of Yorkshire, with an area covering 3,400 square miles, makes the Trust one of the largest in the country. Our hospitals include York Hospital, Scarborough Hospital, Bridlington Hospital, Malton Hospital, Selby War Memorial Hospital, St Monica's Hospital (Easingwold), White Cross Rehabilitation Hospital and Nelson's Court Inpatient Unit. This geographical spread results in high levels of business and patient travel between sites, which makes up two of the areas we have to address if we are to reduce our carbon emissions by 2040 and for patient travel by 2045.

Combined Heat and Power (CHP) generators, provide most of the York site power and heating, but through external funding the Trust, with its CHP provider, has installed heat pumps at York and especially at Bridlington Hospital along with a solar farm. Later in 2025 a battery storage facility will be installed at Bridlington that will bring it closer to becoming one of the UK's first zero hospitals and by the spring of 2027, Scarborough General Hospital will have fossil fuels use removed from the site and replaced with heat pumps. All of which significantly contributes to the biggest emitter for the Trust, its buildings and energy usage. Our Scope 2 emissions are dependent on the National Grid's decarbonisation, where the Trust only uses green tariffs but has resulted in the electrically driven CHPs (Combined Heat and Power) as a cost saving option and a lower carbon method to generate heat and power but we will not achieve the required carbon savings to meet future targets until we address the full move of the main sites to heat pumps, supported by self-generation of electricity such as through solar. Secured funding through the Public Sector Decarbonisation Scheme has been essential to deliver these significant savings that we have seen and will see at our three main sites and doing what we can at our smaller sites.

Away from the buildings heat and power generation and emissions, anaesthetic gases (volatile anaesthetic agents and nitrous oxide) are the next-largest source for the Trust in term of emissions (CO2e) following closely by emissions from transport, calculated from our Fleet emissions, including pool cars, and business travel fall under Scope 1; staff commuting, patient travel and suppliers travel fall under Scope 3, which we can only influence and not control.

From these main emission areas, the smaller areas are to reduce, reuse and recycle items, moving away from single-use items to reuseable, and changing working practices to ones that are more sustainable and less costly is part of the main day to day working of the Sustainability team, where the support from our Chief Sustainability Lead and sustainable portfolio holder, alongside the Trust Communications team, and the recently Green Champions network (launched January change shift across all of the Trust's staff. These softer measures must be done alongside harder measures, in setting frameworks and processes to limit staff choice to these principles, where the Trusts Head of Sustainability has adjusted his focus to increase support for the clinical side of the Trust to help with this transition and increasing sustainable practices, with clinical leads.



4.3 Overview
Partnership Working

Working Together

Partnership working is a key aspect in our work to achieve the carbon reduction and sustainability aspirations as outlined in this Green Plan. All our partner organisations are working to reach Net Zero. Some, such as City of York Council, have gone further and set more ambitious targets including a 2030 Net Zero target for scope 1 and 2 emissions. It is vital that we link with these partners to share best practices and ideas so that all parties can make progress towards these ambitious targets and the broader collective good.

The Trust works with local and combined authorities to help achieve our aims, and more broadly with other public and private sector organisations ranging from sharing best practices, working on specific projects through to shared funding opportunities, for example encouraging uptake of active and public transport. Within the health sector, working in partnership with Greener NHSE, HNY ICB, neighbouring Trusts and other regional health organisations, we are working on supporting each other and identify common areas we can work on together to active our ambitions net zero and broader sustainability ambitions, including the development of the Sustainable Leaders Consortium, developed and lead by this Trust's sustainability team. In addition, the bringing together of a York-wide collection of likeminded organisations to work, including local universities and Councils on travel and transport through to the chairing of a northern NHS travel planning group by the Trusts Sustainability team.

Our Partners

- City of York Council
- North Yorkshire Council
- East Riding of Yorkshire Council
- Humber and North Yorkshire Health and Care Partnership
- Humber and North Yorkshire Integrated Care Board (ICB)
- Northern Lincolnshire and Goole NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Harrogate and District NHS Foundation Trust
- Humber Teaching NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- York & North Yorkshire Combined Authority
- Hull and East Yorkshire Combined Authority

4.4 Overview

Sustainability Timeline



The Trust publishes its first Sustainable Development Management Plan (SDMP)

The Trust updates its SDMP to cover the following three years

First Trust-wide Travel Plan published to encourage greater use of active and public forms of travel

Green Plan updated in 2024 covering 2024-2027 and redrafted in 2026 covering 2024 to 2028+

Green Plan to be updated to reflect 80% net zero target achievement by 2032

The Trust to achieve 80% of its CO2e emission reduction by 2032

Keys Dates to achieve net zero CO2e



The Trust achieves 100% net zero by 2040.

The Trust achieves 100% of its Carbon Footprint Plus targets by 2045.

4.5 Overview

Achievements

In recent years, the Trust has made good progress on sustainability across a range of areas. Some of our highlights are shown below, aligned to the NHS's recently updated Strategic Sustainability Framework outlined in section 7.1

We believe that the scope of our achievements demonstrates our commitment to carbon reduction and decreasing our environmental impact. We aim to further widen the range of areas that we are addressing during the lifetime of this strategy and look forward to reporting back on further successes in the future.

Workforce and System Leadership
The Trust operates the Sustainable Development Group, with an escalation route to the Trust Board.

Workforce and System Leadership
Sustainability is a mandatory consideration in all new business cases and policies that is further supported by being one of the Trusts corporate objectives

Workforce and System Leadership
A Net Zero Carbon Data Analyst post created in the Sustainability Team to monitor progress on carbon reduction and NHS net zero targets.

Workforce and System Leadership
Re-establishment of the Green Champions network

Sustainable Models of Care
The Trust has rapidly increased the use of teleconferencing, reducing unnecessary patient travel, air pollution and traffic congestion.

Sustainable Models of Care
A mobile chemotherapy unit where patients can receive treatment in Bridlington, Scarborough, Malton and Selby, instead of travelling all the way to York.

Digital Transformation
Roll out of the first phase of Nervecentre EPR system, a digital information workflow system will see patient records going digital leading to significant reduction in paper, saving of staff time.

Digital Transformation
A more robust IT infrastructure where inefficient data centre equipment has been replaced with a cloud-based system that will see a reduction in direct energy consumption, saving of staff time and increased security.

Digital Transformation
Increased use of Microsoft Teams reducing the need for staff to travel, increased remote working and helping to enable agile working across the Trust estate.

4.5 Overview

Achievements

Digital Transformation
Widespread use of Microsoft Teams reducing the need for staff to travel, increased remote working and helping to enable agile working across the Trust estate.

Digital Transformation
Digitisation of patient case notes delivering significant operational and financial benefits in the form of lower paper consumption, heating costs and inter-site file movement

Digital Transformation
Trials of CoPilot AI continue and there are many examples of the greater efficiencies that can be achieved through use of AI. Due to the progress made in this area funding from NHS England has been secured through to March 2027

Travel and Transport
Subsidised bus travel offer for NHS staff at York and Scarborough Hospitals from 2023 with up to 50% discount for a single bus journey in place.

Travel and Transport
Salary sacrifice vehicles only to be available in HEV, PHEV and EV forms.

Travel and Transport
Cycle to work scheme promoted Trust-wide and active travel promotion taking place at York, Scarborough and Bridlington.

Travel and Transport
Increasing the number of electric vehicles in the transport fleet (9 vehicles) and awarded NHSE funding to roll out up to 10 new EV charge points.

Travel and Transport
Installed secure cycle parking at Tribune House in York and at Bridlington Hospital

Estates and Biodiversity
Since April 2020, all electricity imported from the National Grid is on a 100% Green Tariff.

Estates and Biodiversity
Sustainable Design Guide introduced reinforcing the need to integrate BREAAM Excellent standards and whole life costs for all new buildings.

Estates and Biodiversity
Sustainability team winning several funding bids to implement PV panels, EV charge points, desteaming of Scarborough Hospital, battery storage at Bridlington and LED lighting, where up to 90% of the Trust covered (2025)

4.5 Overview

Achievements

Estates and Biodiversity
At York Hospital, decarbonisation work has been done with the installation of heat pumps, building insulation, new windows and insulation of pipework.

Estates and Biodiversity
At Bridlington Hospital, a solar farm, solar panels on roofs, high efficiency motors and air source heat pump system was installed. It is predicted that carbon emissions will be reduced by 53%.

Estates and Biodiversity
During construction of the Urgent and Emergency Care Centre at Scarborough, 31 young trees were carefully dug out and replanted elsewhere.

Estates and Biodiversity
Area around Scarborough Hospital Helipad sown with wildflower seeds to encourage bees and insects, plus hedgehog and owl boxes installed.

Estates and Biodiversity
£200,000 charitable funding secured for well-being gardens for patients and staff, with the first five green areas delivered in 2021/22.

Facilities Management - Waste
The CO2e levels for the clinical wastes produced in our Community Hospitals is now 46% lower than the NHS England target for 2026 and is on track to exceed the 2028 target of 80%

Facilities Management – Laundry & Linen
YTHFM's Linen Services delivered a reduction of bed linen consumption of 448,000 items during fy2025/26 by systematically cancelling stock during deliveries from our supplier to avoid using excess linen across our sites.

Facilities Management – Domestic Services
The introduction of microfibre cleaning systems and rollout of dilution control units has significantly reduced chemical use and water consumption, thus supporting lower environmental impact and operating costs.

Facilities Management – Support Services
During 2025/26 YTHFM implemented 2nd class post as the default mailing option, thereby driving a substantial shift away from carbon intensive first class postage.

4.5 Overview

Achievements

Medicines
Agreement has been reached to remove piped anaesthetic gas with a shift to intravenous forms of anaesthesia, with reserve supplies of portable gas cylinders where required. Significantly decreasing our second largest CO2e emissions.

Medicines
Clinical prescription of greener inhalers in local care pathway in conjunction with ICS partner organisations.

Medicines
Development of an inhaler recycling scheme in partnership with the Leeds Teaching Hospitals NHS Trust and increases in dry powder inhalers away from the higher CO2e emitting Metered-Dose inhalers.

Supply Chain and Procurement Work has commenced to embed sustainability and social value considerations within procurement processes, including early-stage development of templates, guidance, and supplier engagement approaches aligned to NHS Net Zero and Social Value requirements.

Supply Chain and Procurement
Suppliers on Framework Agreements and for contracts worth over £5 million have Carbon Reduction Plans in place.

Supply Chain and Procurement
A Scan4Safety initiative is being rolled out across all clinical sectors to digitise a new tracking system for all items and there use and inform measures to reduce waste, over-ordering and more sustainable alternatives.

Food and Nutrition
Catering suppliers are now selected not only for cost efficiency but also for the strength of their sustainability and carbon reduction strategies.

Food and Nutrition
Single-use plastics have been replaced with wooden cutlery (KFS), recyclable cardboard cups and takeaway dishes thereby supporting the NHS Plastics Pledge to reduce disposal emissions.

4.6 Overview

Targets



Ensure that car leasing schemes for staff promote zero and ultra-low emission vehicles only by 2027



Reduce fleet air pollution by using exclusively zero and ultra-low emission vehicles.



Increase the percentage of virtual outpatient consultations (video and telephone) by……



Reduce water usage and waste to stay below Government waste targets.



Work towards optimum usage of IT devices, reducing the number of devices where appropriate and enabling access to the right data in the right place at the right time



Decommission piped nitrous oxide by 2026, with point-of-use cylinders where clinically required; minimise nitrous oxide use; and reduce volatile agent emissions through low fresh gas flows and TIVA where clinically appropriate.



All non-recyclable plastic to be stopped and replaced with recyclable containers and promote bring your own containers and cups by 2026.



Increase use of dry powder inhalers replacing their MDI equivalents.



Work towards ensuring that all new builds and refurbishments conform to NHS Net Zero Building Standards by end of 2026.



Move away from IV to pill forms of medication where viable by 2030



Embed ISO 19650 compliance and Net Zero design principles in all new builds & refurbishments to bed adapt our estates resilience to adverse weather impacts.



Increase electrical heat pumps, and solar panel provision across our main sites. Improvements to building fabrics, year on year supported by external funds.

4.6 Overview

Targets



Identify the top 10 suppliers by spend and engage them on contract-level carbon reduction commitments, for example carbon reduction plans and Evergreen Assessment tool.



Introduce robotic cleaning machines in high footfall areas within our Acutes sites by 2028



All lighting to be replaced with LED alternatives by 2027.



To have developed and implemented a tree and plant strategy and plan for all Trust main sites for Co2 reduction and improved biodiversity



Implement digital meal ordering Trust wide to improve forecasting and to reduce food waste by 10% within fy2026/27.



Working with our walking aid suppliers, we will aim to have at least a 10% return per annum of walking aids.



Identify top 10 suppliers by delivery frequency and engage them to explore delivery consolidation and packaging reduction.



Continuing to reduce the avoidable use of single- use plastics.



Continue to influence staff behavioural change and increases in Green Champions.



An 8-year roadmap is in place to eliminate reliance on two York-based warehouses currently used for paper record storage.



Reduce unnecessary bed linen changes trust wide between 2-5% in Q4 of fy2026/27 across all inpatient areas, including our community hospitals sites and acute sites.

Targets derived from the NHS Standard Contract Service Conditions 2023/2024[4], NHS Long Term Plan 2019[5] and the Greener NHS MoU requirements April 2021.

4.6 Overview

Targets

Achieve the NHS England Clinical Waste Strategic objective of improving waste segregation and compliance of 20-20-60 waste spilt – 20% incineration, 20% infectious and 60% offensive waste within fy2026/27.

Digitise uniform processes to replace paper-based systems within fy2026/27

Establish a baseline for high-volume procurement categories (e.g. gloves, aprons, cleaning consumables, catering disposables) to inform waste and carbon reduction initiatives - for this we can use our procurement data to provide additional information to understand how much we buy, how often, from whom, and at what environmental cost so we know where to focus waste and carbon reduction efforts.

Targets derived from the NHS Standard Contract Service Conditions 2023/2024[4], NHS Long Term Plan 2019[5] and the Greener NHS MoU requirements April 2021.

4.7 Overview

Drivers For Change - General

Legislative

- Civil Contingencies Act 2004
- Climate Change Act (CCA) 2008 (as amended in 2019)
- Public Services (Social Values) Act 2012
- Health and Care Act 2022

UK guidance

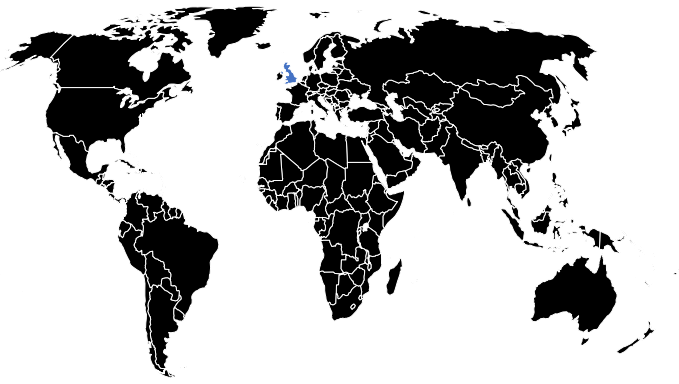
- National Policy and Planning Framework 2012 (revised 2024)
- Department of Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013
- DEFRA Government Buying Standards for Sustainable Procurement 2016
- The Stern Review; The Economics of Climate Change 2006
- Health Protection Agency (HPA) Health Effects of Climate Change 2012
- The National Adaptation Programme; Making the country resilient to the changing Climate 2013
- DEFRA 25 Year Plan 2018
- HM Government Clean Growth Strategy 2017 (Amended 2018)

Mandatory

- Standard Form Contract requirements for Sustainable Development 2020
- HM Treasury's Reporting Framework
- Public Health Outcomes Framework

International

- International Panel on Climate Change (IPCC) AR5 2013
- United Nations (UN) Sustainable Development Goals (SDG's) 2016
- World Health Organisation (WHO) toward environmentally sustainable health systems in Europe 2016
- WHO Health 2020; European policy for health and wellbeing
- The Global Climate and Health Alliance; Mitigation and Co-benefits of Climate Change



4.8 Overview

Drivers For Change - Healthcare Specific

Drivers for Healthcare

The drivers outlined on the previous page are not specific to healthcare and the NHS. As sustainability must be considered in a range of settings, there is a wide variety of guidance, requirements, and legislation to be mindful of - this list is not exhaustive.

In addition to more general drivers, there are healthcare-specific requirements that must be incorporated into our plan, particularly the “Delivering a Net Zero National Health Service” strategy released in October 2020, which includes more ambitious carbon reduction targets than legislated for by the Climate Change Act (CCA). The NHS now has a target to be Net Zero by 2045, 5 years earlier than the CCA legislates.

Health Specific Requirements



- Delivering a Net Zero National Health Service 2020
- NHS Standard Contract (updated yearly)
- NHS Long Term Plan 2019
- NHS Priorities and Operational Planning Guidance (updated yearly)
- Fourth Health and Care Adaptation Report 2025[6]
- The Carter Review 2016
- National Institute for Clinical Excellence (NICE) Physical Activity; walking and cycling 2012
- Health Technical Memoranda (HTM) and Health Building Notes (HBN)
- Sustainable Transformation Partnership (STP) Plans
- NICE guideline (NG70) 2017
- The Marmot Review: Fair Society, Healthy Lives 2010
- Health and Care Act 2022
- Fit for the Future - 10 Year Plan for England

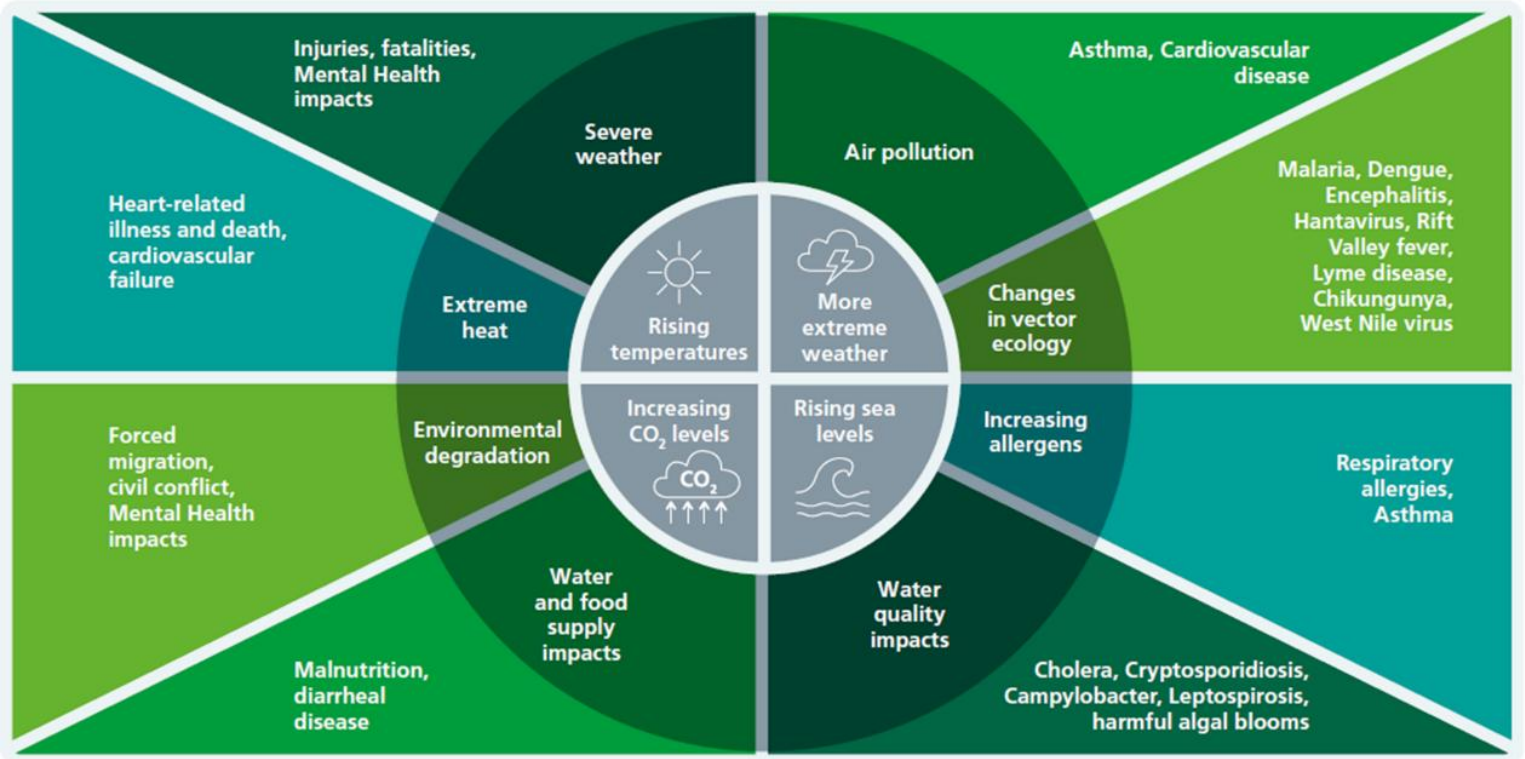
4.8 Overview

Drivers For Change - Healthcare Specific

Impact of Climate Change on Human Health

The impacts of climate change on us all, and specifically our health, is increasingly apparent as our climate moves to seeing record after record broken for increased heat, longer droughts and wetter winters. The table below provides a broad view of the impacts of climate change on our heath.

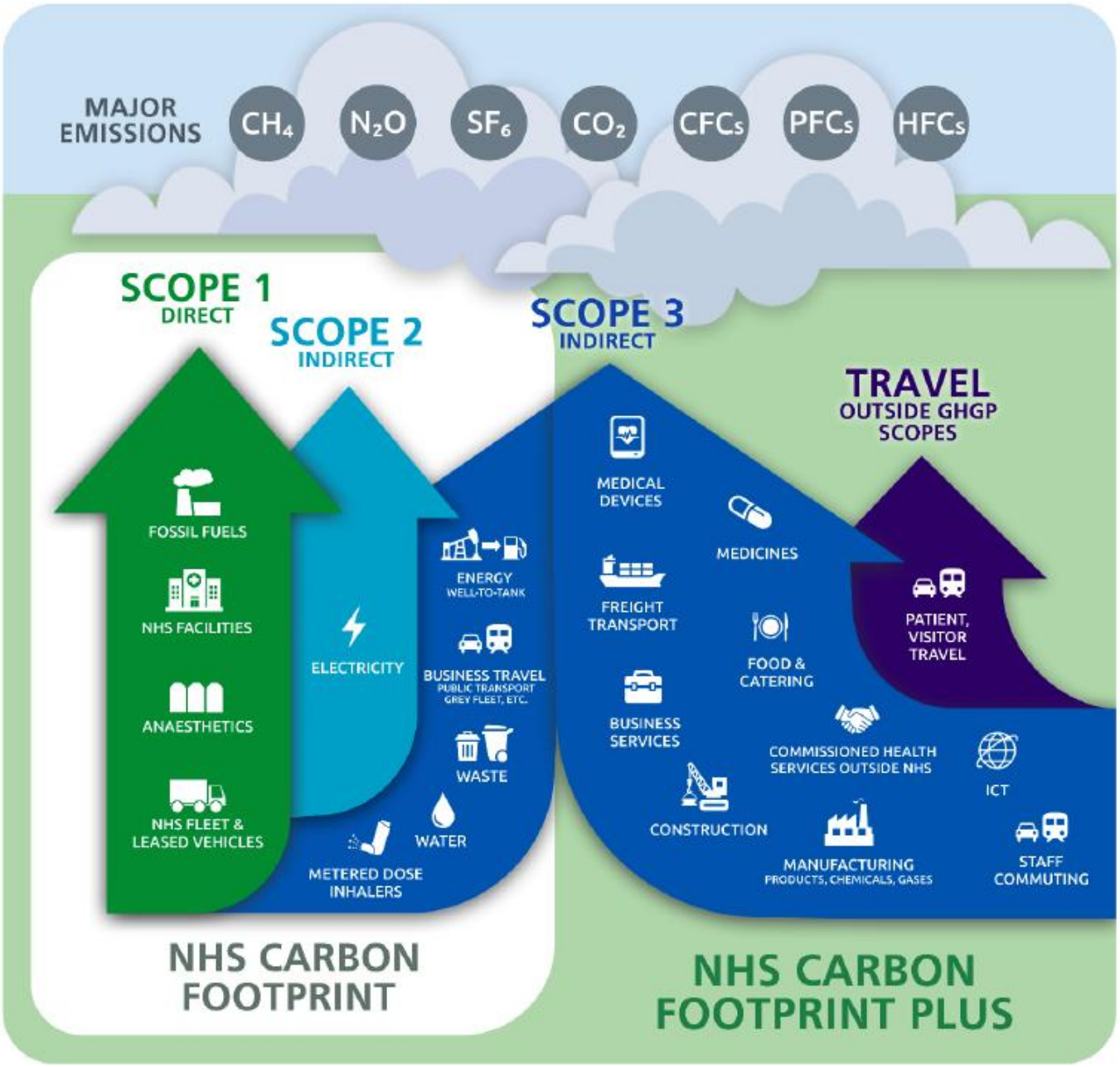
We will need to move more into a position of adapting to these more extreme climatic events alongside the work we must continue to do to mitigate the effects of our emissions. We have to align our services to these changing events, ranging from how we run and adapt our estates through to being adapting how we provide clinical services that will be needed more and more.



5.1 Delivering A Net Zero NHS

Targets and Scopes

In October 2020, the NHS committed to becoming a Net Zero organisation by 2045 in the “Delivering a Net Zero National Health Service” publication. The Trust has aligned its data to work towards this strategy's targets. There are two targets, one for the "NHS Carbon Footprint," which is for an 80% reduction by 2032 and a 100% reduction by 2040. The other target is the "NHS Carbon Footprint Plus," which has an expanded scope and a target of an 80% reduction by 2039 with a net zero emissions target for 2045, all against a 1990 baseline. The components of these two targets are shown in the diagram below as presented in the publication.



5.2 Delivering A Net Zero NHS

Notes on NHS and Mandatory Carbon Reporting Data

Baseline

The targets set by both the Climate Change Act and the "Delivering a Net Zero NHS" strategy are measured against a 1990 emissions baseline. There are two emissions targets set for the NHS:

- NHS Carbon Footprint to reach net zero by 2040, with an 80% reduction by 2028-2032;
- NHS Carbon Footprint Plus to reach net zero by 2045, with an 80% reduction by 2036-2038.

The Delivering a Net Zero NHS report was published in October 2020 and carbon emissions calculations were done for the whole NHS using 2019/20 data. Comparing the 2019/20 calculations against the 1990 baseline:

- NHS Carbon Footprint to be reduced by at least 47% by 2028-2032, achieving net zero by 2040;
- NHS Carbon Footprint Plus to be reduced by at least 73% by 2036-2038, achieving net zero by 2045.

Data Quality

We constantly review our data. We are always looking to improve the quality of our data, the accuracy of our calculations and increase the scope of what data is collected.

Any changes to our calculations are backdated to the 2019/20 baseline, so an accurate trendline is kept.

As a consequence, figures presented in this Green Plan may be different from previous Green Plans.

Historical data is subject to change as more data sources become available, and we will report this in the sustainability section of the Trust Annual Report each year.

Calculating the NHS Carbon Footprint and NHS Carbon Footprint Plus

There are two ways to calculate carbon emissions; activity-based and spend-based. Activity-based calculations - e.g. tonnes of waste generated, kWh of gas burned - are more accurate. Spend-based calculations are based on the average carbon footprint of an entire procurement category - e.g. electrical equipment, pharmaceutical products - and switching to a low carbon alternative that costs the same does not get shown as a reduction in carbon emissions in the calculations. The only way to show carbon reduction is to reduce spend in that procurement category. A further complication is that price increases inflates the carbon emissions total, even when the underlying products used remain the same.

The NHS Carbon Footprint is activity-based. The NHS Carbon Footprint Plus is currently mainly based on spend. The following charts focus on the NHS Carbon Footprint.

The NHS is working with its supply chain to get more accurate emissions data based on actual products and services used, not simply by procurement category.

5.3 Delivering A Net Zero NHS

2025/26 NHS Carbon Footprint

NHS Carbon Footprint Categories	tCO2e	%
Fossil Fuels	13,997	65.3%
Electricity	2,812	13.1%
Anaesthetic Gases	2,097	9.8%
Business Travel	976	4.6%
Inhalers	752	3.5%
Waste & Water	415	1.9%
NHS Fleet	393	1.8%
TOTAL	**21,441**	**100%**

This pie chart further breaks down the Trust's NHS Carbon Footprint into Greenhouse Gases Protocol (GHGP) Scopes. Scope 1 are emissions generated by the Trust's activities, scope 2 are emissions from grid electricity and scope 3 are emissions generated indirectly from the Trust's activity, e.g. emissions from patients' inhalers

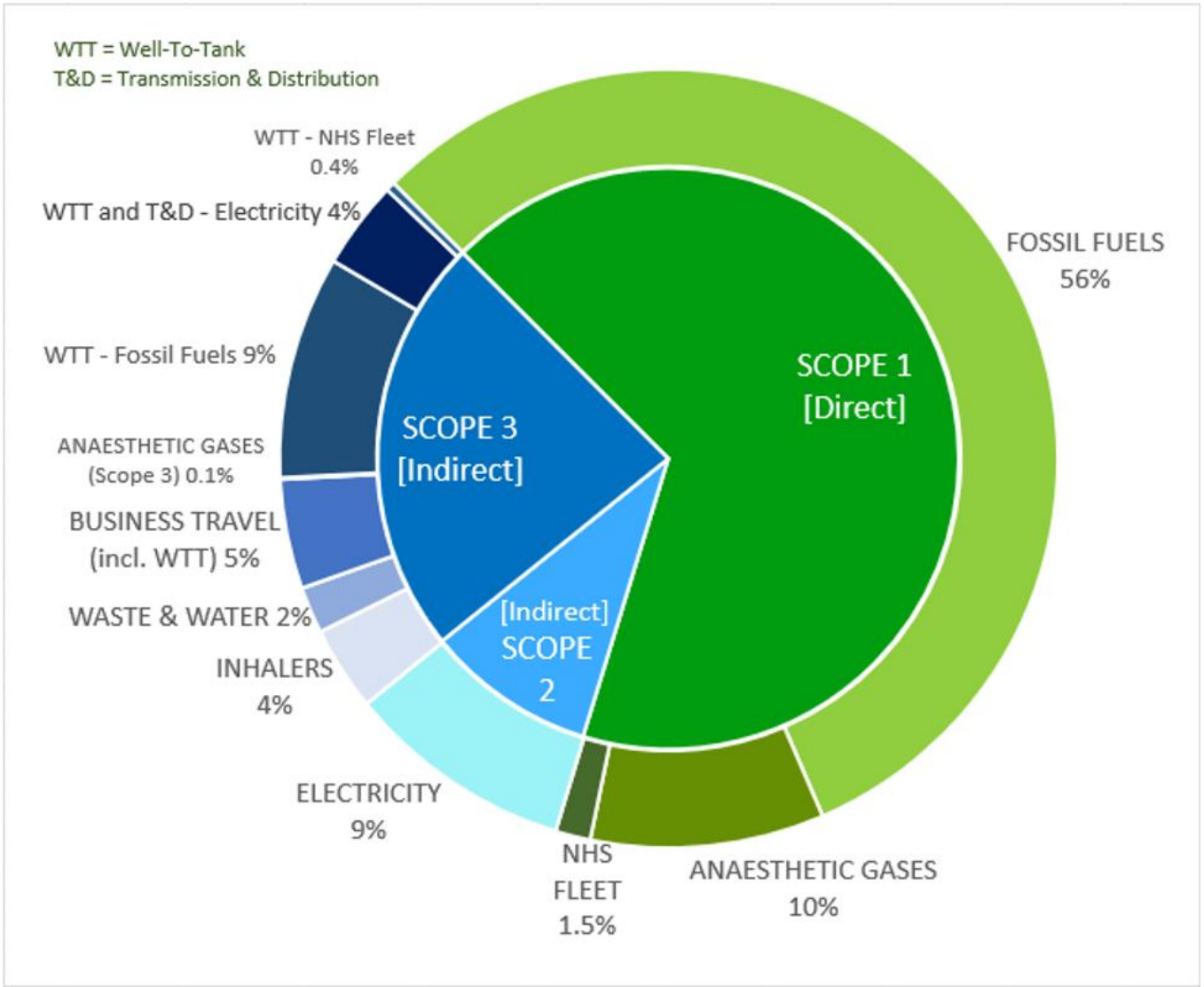


Chart 1: Trust carbon emissions for 2025/26 broken down into NHS Carbon Footprint categories & GHGP Scopes

5.4 Delivering A Net Zero NHS

NHS Carbon Footprint from 2019/20

NHS Carbon Footprint Overview

The Trust's NHS Carbon Footprint includes all scope 1 (buildings, fossil fuels, anaesthetics and the inhalational anaesthetic agents and nitrous oxide, including Entonox, NHS fleet vehicles) and scope 2 (grid electricity) emissions as well as business travel, waste, water and metered dose inhalers which are classified as scope 3. Also included in scope 3 are the emissions associated with the extraction, refining and transportation of raw fuel sources before they are used to produce energy ("Well-to-Tank").

These are areas that the Trust has significant influence over and the emissions are largely produced as a direct result of our activities.

Below is a table of our carbon emissions calculations since the baseline year of 2019/20.

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	tCO2e	tCO2e	tCO2e	tCO2e	tCO2e	tCO2e	tCO2e
FOSSIL FUELS	14,654	15,241	15,990	14,943	13,435	14,265	13,997
ELECTRICITY	2,679	2,167	2,057	2,292	3,222	3,391	2,812
WASTE & WATER	712	700	541	495	442	397	415
ANAESTHETIC GASES	1,842	1,827	2,232	2,208	2,034	1,794	2,097
INHALERS	849	576	859	805	809	857	752
NHS FLEET & BUSINESS TRAVEL	1,633	1,090	1,582	1,826	1,757	1,367	1,368
TOTAL (tCO2e)	22,369	21,601	23,262	22,570	21,698	22,072	21,441
		-3.4%	7.7%	-3.0%	-3.9%	1.7%	-2.9%

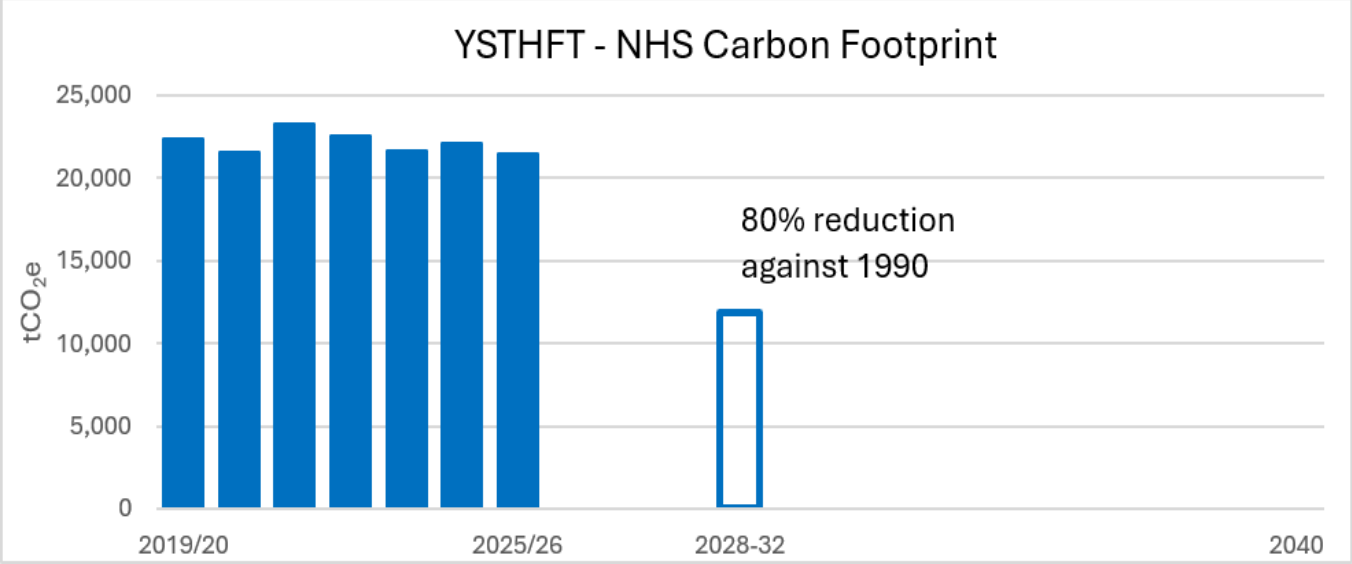


Chart 2: Changes in the Trust's NHS Carbon Footprint from 2019/20 to 2025/26

6.1 Carbon Reduction Progress

CO_2e Emissions 2019/20 – 2025/26

Carbon Emissions Reduction Progress

The table and chart below show that since 2019/20, the Trust's NHS Carbon Footprint has only dropped slightly since 2019/20 (-928 tCO2e).

However, the Trust has seen a massive increase in the number of patients treated. Around 422,000 additional patient contacts (+36%) occurred in 2025/26 compared to 2019/20.

An important metric to measure our progress in reducing emissions is the carbon intensity per patient contact (see yellow line). There has been a 30% drop from 19.2 kgCO2e per patient contact to 13.5 kgCO2e.

Average Carbon Emissions per Patient Contact 2019/20 to 2025/26

Emissions in tCO_2e	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
NHS Carbon Footprint	22,369	21,601	23,262	22,570	21,698	22,072	21,441
Number of Patient Contacts	1,163,737	1,099,139	1,235,437	1,386,957	1,491,818	1,563,224	1,586,099
kgCO2e per Patient Contact	19.2	19.7	18.8	16.3	14.5	14.1	13.5

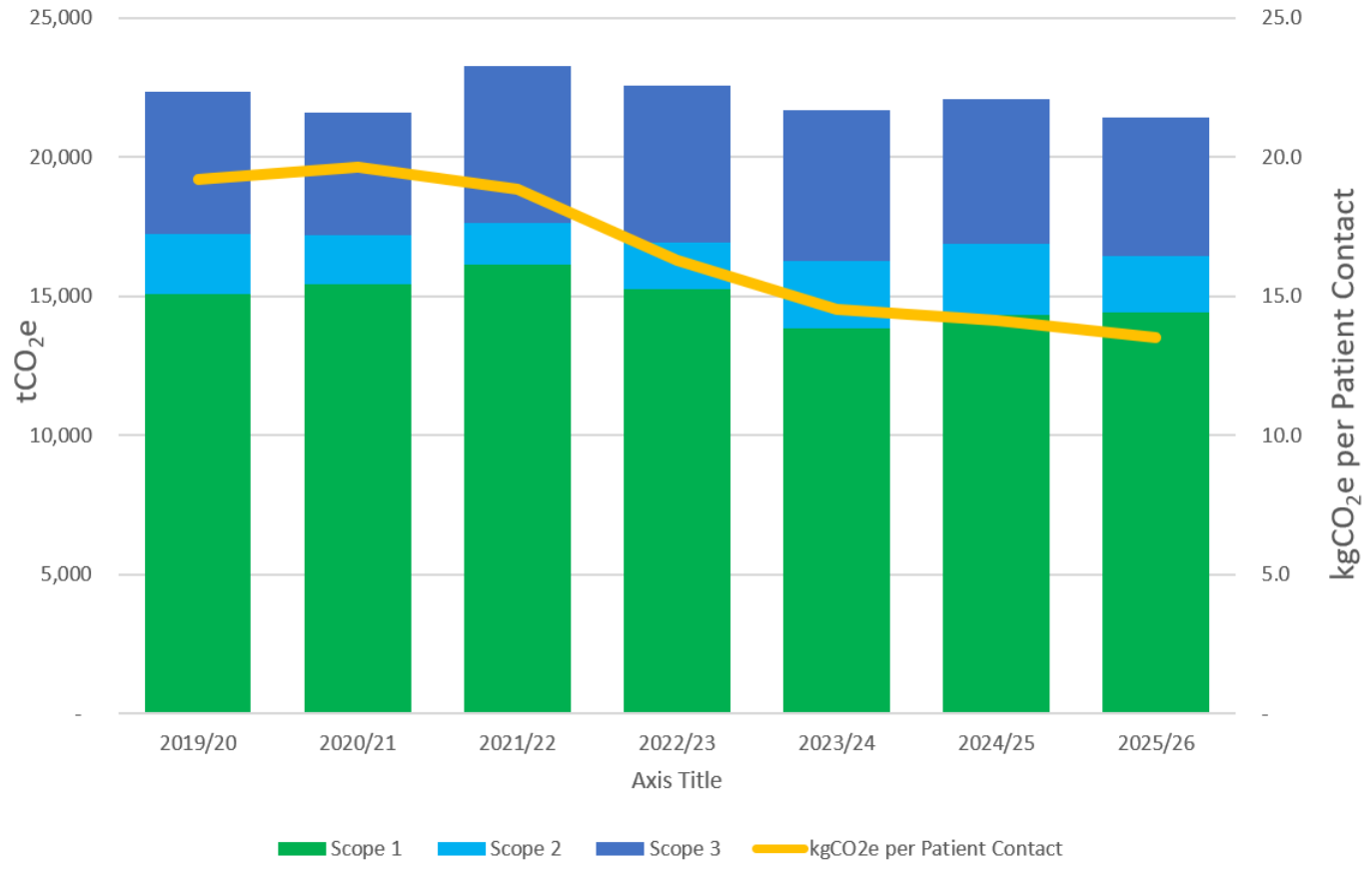


Chart 3: NHS Carbon Footprint 2019/20-2025/26 by GHGP Scopes and Carbon Intensity per Patient Contact

6.2 Carbon Reduction Progress

Annual Carbon Emissions Reduction Target

NHS Carbon Footprint - Targeting Net Zero

The NHS Carbon Footprint focusses on emissions that are directly produced by activities carried out by NHS organisations themselves. The government targets are to achieve an 80% reduction in the NHS Carbon Footprint by 2028-2032, and to reach net zero by 2040.

For this updated 2024-2028 Green Plan, we have calculated what are the average annual carbon savings required to hit our 80% reduction target by 2032.

After 2024/25, the Trust needs to cut its emissions by an average of 1,350 tonnes of CO2e for every single year to reach the 80% reduction target by 2032.

Annual Emissions Reduction Target

1,350 tCO_2e

This will be a huge challenge, requiring a wholesale shift from using fossil fuels to electricity and solar to heat, cool, and light our buildings, replacing our fleet with electrical vehicles, adopting sustainable travel options, reducing emissions from inhalational anaesthetic agents, nitrous oxide and metered-dose inhalers.

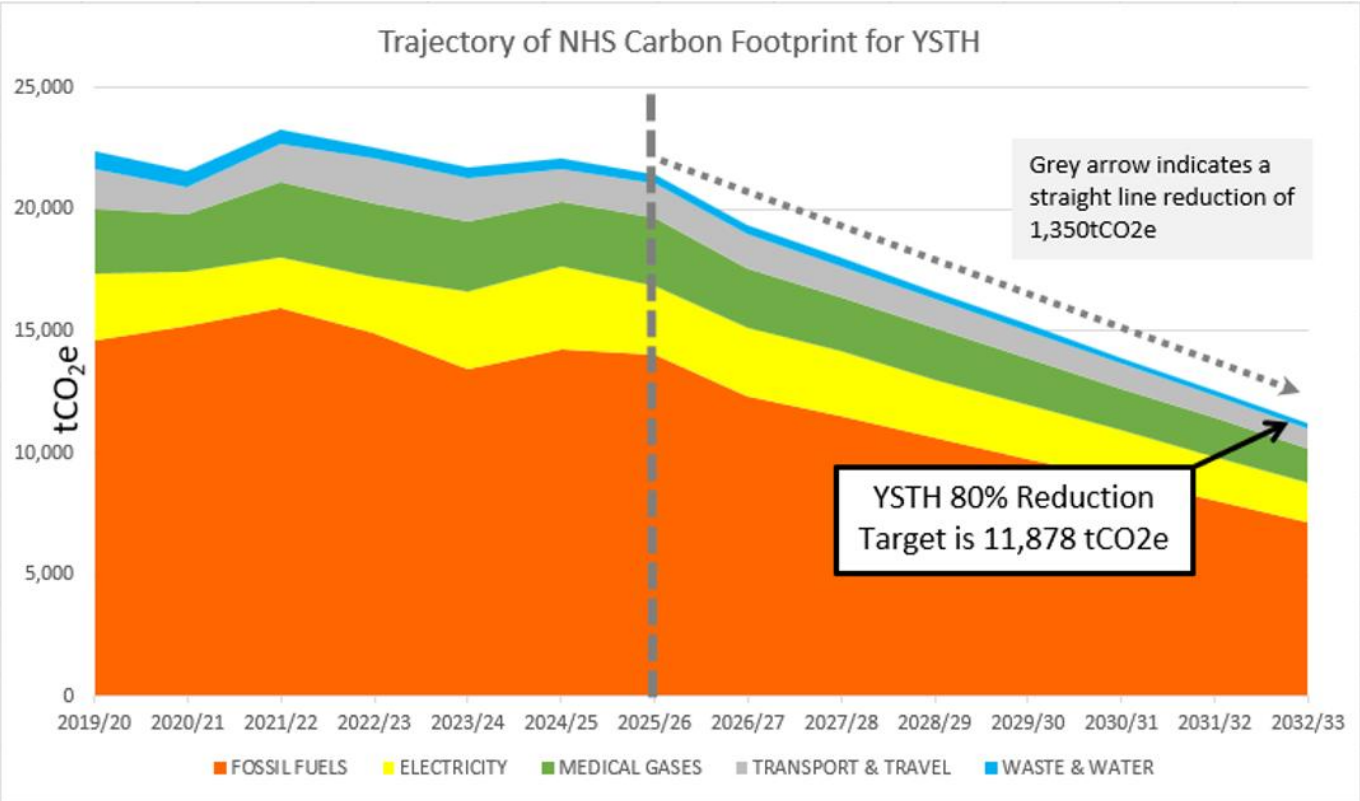


Chart 4: Trajectory of Trust NHS Carbon Footprint towards the 80% Reduction Target

7.1 NHS Sustainability Overview

Overview and UN Sustainable Development Goals

Overview

The NHS's Sustainability Areas of Focus are used to help NHS Trusts reach their sustainability goals. The tool divides objectives into a group of workstreams, outlined on page 30. Each workstream has the responsible to lead and deliver all agree work in the Trust's Green Plan and supportive plans, developing KPI's for the Trust to meet with the support from its partners and provides a lead who reports back on progress to the sustainability team and quarterly to the Sustainable Development Group.

The areas of focus cover measures that can reduce CO_2 emissions and more holistic initiatives such as improving the health of our staff and visitors, increasing access to green spaces, and mitigating and adapting to the impacts of climate change.

Several NHS Long Term Plan and Standard Contract requirements are also included here within the relevant workstreams to contextualise them and demonstrate how they fit into the "bigger picture". There is inevitably slight overlap, but this is kept to a minimum.

United Nations Sustainable Development Goals

The 2030 Agenda for Sustainability Development Goals, adopted by all United Nations Member States in 2015, provides a shared blueprint for peace and prosperity for people and the planet, now and into the future. At its heart are the 17 Sustainable Development Goals (SDGs), shown below which are an urgent call for action by all countries - developed and developing - in a global partnership. The Trust strives to improve its performance on these areas, many of which sit under the NHS Sustainability Areas of Focus.



7.2 NHS Sustainability Overview

Key Focus Themes

While there are several themes that the Green Plan is delivered through, the biggest and largest emissions are produced from our estates.

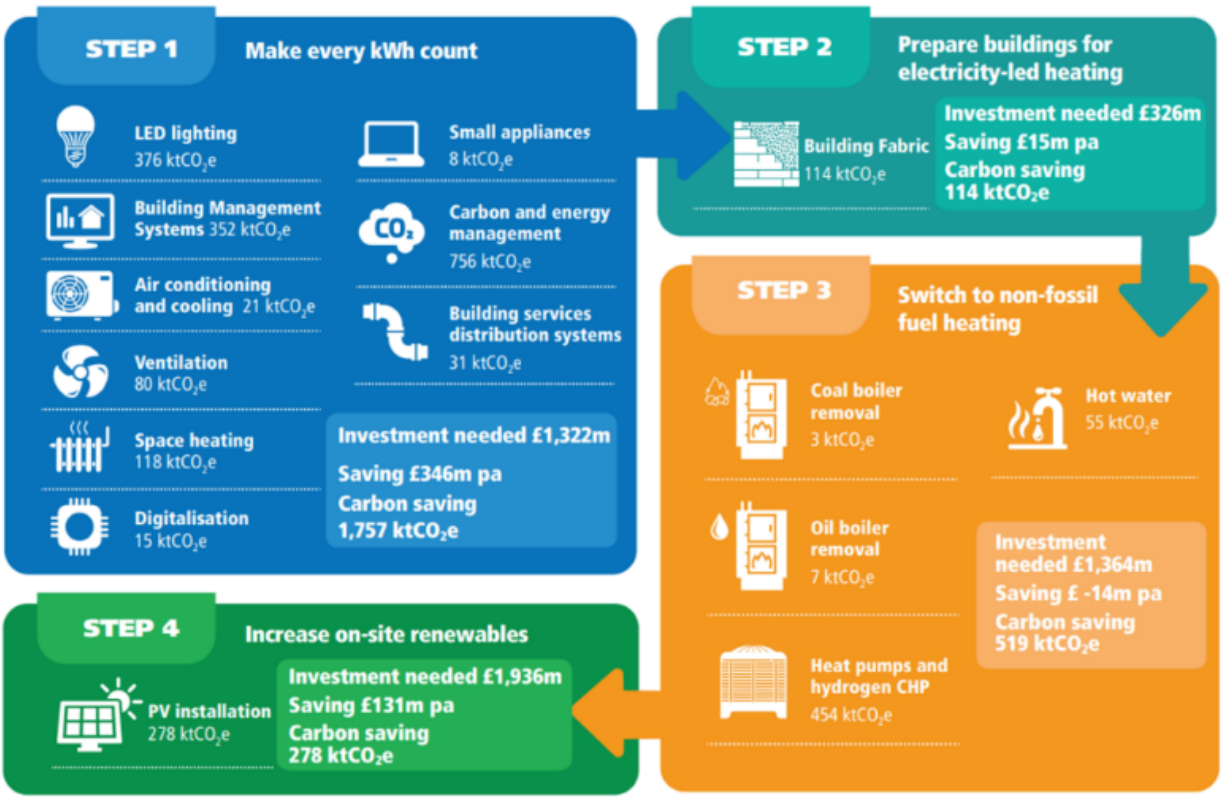
Our Estates and Capital teams are embedding the NHS England's (NHSE) guidance documents to inform current and future plans on how our buildings are maintained, refurbished, designed, and built to BREAAM excellence standards. These plans incorporate sustainable design measures and sophisticated equipment, whether that is increasing our LED lighting provision through to building management systems to monitor usage in real-time and identify further efficiencies in cost and CO2e emission reduction. Importantly adapting our estates for the increasing number of extreme heat events and wetter climates due to climate change.



NHSE documents are:-

- NHS Net Zero Building Standards
- Estates Net Zero Carbon Delivery Plan

Working alongside the Trust's Energy Manger and wider Sustainability team, the Estates and Capital teams will lead on this critical work that will provide the biggest emission reduction with the goal to develop a decarbonisation plan to accurately lay out the journey and measures the Trust needs to take in order to meet our net zero obligatory targets of 80% reduction by 2032, net zero by 2040 for our NHS Carbon Footprint and 2045 for our NHS Carbon Footprint Plus.



7.3 NHS Sustainability Overview

Climate Change and Adaptation

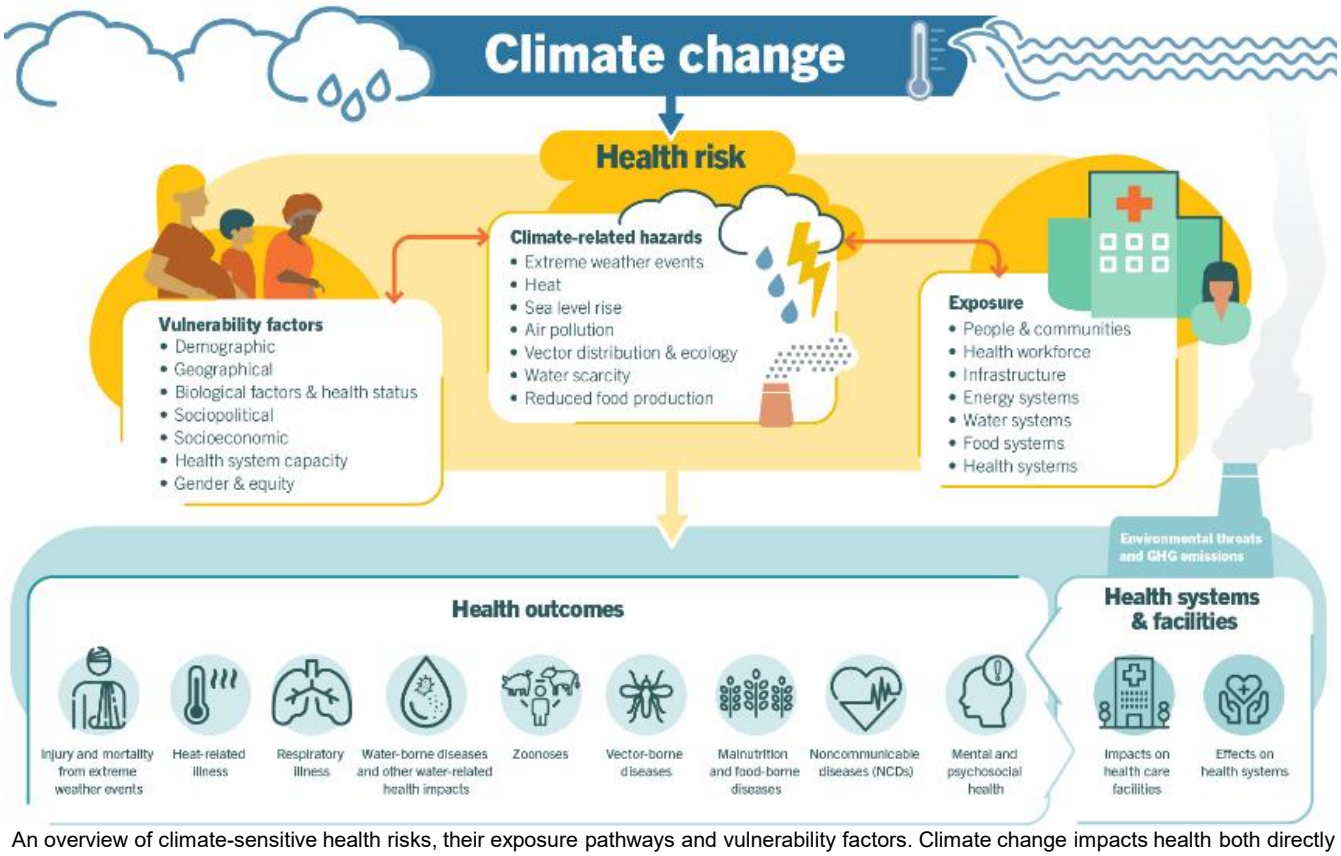
Climate adaptation means strategically changing how our health and care system operates to remain effective and resilient in the face of a changing climate. For healthcare, this translates into proactively preparing for the impacts of extreme weather events like heatwaves and floods, ensuring resilience against increased demand, service disruption, and evolving disease patterns driven by environmental shifts.

Adapting requires strengthening services, ensuring the continued operation and resilience of our buildings, operations, and vulnerable infrastructure to cope with acute and chronic climate impacts. This necessity is emphasised by the chronic climate risks identified in the National Risk Register, the recommendations of the Climate Change Committee, as well as meeting our responsibilities under the Civil Contingencies Act and other pertinent national guidance and directives.



To achieve this, we commit to playing an active role in all relevant emergency planning exercises. Working closely with our system partners, we must collectively build resilience and implement robust protective measures for the most vulnerable in our communities when health systems inevitably come under environmental pressure.

Throughout the themes in this Green Plan, each will be working to adapting our estate and services to the changing climate.



An overview of climate-sensitive health risks, their exposure pathways and vulnerability factors. Climate change impacts health both directly and indirectly and is strongly mediated by environmental, social and public health determinants.
World Health Organization. Climate change. 2023. **Licence:CC BY-NC-SA 3.0 IGO.**

8. NHS Sustainability Areas of Focus

Workforce and System Leadership
Engaging and developing our workforce and system partners in defining and delivering carbon reduction initiatives and broader sustainability goals.

Sustainable Models of Care
Embedding net zero principles across all our clinical services and considering carbon reduction opportunities in the way care is delivered.

Digital Transformation
Harnessing digital technology and systems to streamline service delivery and support staff while improving the use of resources and reducing emissions.

Travel and Transport
Reducing the carbon emissions arising from our travel and transport, including active travel, public transport, fleet vehicles, business travel and logistics.



Estates & Biodiversity
Reducing the carbon emissions from our buildings and infrastructure, including energy efficiency, building design and maintenance. Incorporating green spaces and biodiversity across our estate.

Facilities
Reducing the carbon emissions and waste from the Trust by working/educating all staff and the provision of services to ensure better waste segregation, year on year exceeding of national waste targets through reduction in general waste incineration and increasing in recycling.

Medicines
Reducing the carbon emissions related to our prescribing and use of medicines, medical equipment and medical products.

Supply Chain and Procurement
Using individual or collective purchasing power and decisions to reduce carbon embedded in our supply chains.

Food and Nutrition
Reducing the carbon emissions from the food made, processed or served within our organisation.

8.1 Sustainability Areas of Focus

Workforce and System Leadership



Progress

Governance – Sustainability is embedded into key governance processes e.g. it is a mandatory requirement for consideration for all new business case and policy developments

Staff Engagement – Ongoing and regular communications will continue to be delivered across the organisations various communications channels to highlight key areas of the sustainability agenda.

The relaunching of the 'Green Champions' network will be a key focus by the Sustainability Team. This will allow for sustainability to be discussed, promoted and further developed at a local area level across the organisation.

The Trust has appointed a Net Zero Carbon Data Analyst to measure and monitor progress on carbon reduction and NHS net zero targets.

Implementation of two internal online training courses has been established on the Trust Learning Hub and an apprenticeship designed for staff who wish to take their understanding for sustainability further.

The Trust Travel Plan encourages the take up of sustainable modes of transport for colleagues.

A recent survey from Deloitte shows the current generation of entrants to the workforce is extremely interested as well as anxious about environmental sustainability issues, with 28 per cent of Gen Z respondents (those born between 1997-2012) saying that climate change and safeguarding the environment is their top concern, and more than 2 out of 10 researching a company's environmental impact or policies before accepting a job. The study also directly linked business sustainability with staff retention of this generation. Gen Z employees who feel their employers are making efforts to reduce the company's impact on the environment are more inclined to stay with that employer for at least five years.

Partnership working - Our commitment to sustainability is also demonstrated through strategic partnerships with local councils and organisations, most of whom are also working towards the overarching goal of Net Zero between 2035 and 2050.

8.1 Sustainability Areas of Focus

Workforce and System Leadership

Strategic Objectives

- Support the Sustainability team to integrate sustainability throughout the organisation.
- Supporting the implementation and embedding of the Green Plan across the Trust to ensure the embedding of sustainability into everyday practice and decisions.
- Increase engagement across the organisation and encourage colleagues to become a Green Champion;

Sustainability Actions

- Support and promote staff to volunteer to become a Green Champion, with the Sustainability team;
- Ensure there is a monthly comms piece across all internal media with a view to encouraging further behavioural change and momentum.
- Review and support the Sustainability team around promotion of existing and expansion of new sustainability-related training.
- To support the Trust Travel plan to encourage take up in sustainable modes of transport for colleagues, ranging from cycling and bus use and greater promotion of salary sacrifice vehicles being EV, HEV and PHEV.
- Promotion of sustainability commitments and actions through appropriate employment milestones e.g. via Welcome Fairs.
- To continue to build strategic partnerships with local councils and other organisations who are also working to the goal of Net Zero between 2035 and 2050.

How We Will Measure Our Progress

- Monitor volunteer numbers in the Green Champions network;
- Increases is staff accessing the online sustainability training modules and apprenticeships;
- Staff benefits programme availability and uptake link to uptake in salary sacrifice schemes ranging from bus, cycles and EV/Hybrid vehicles;
- Establishment of sustainability being incorporated into the staff appraisal reviews and each sustainability item being recorded with the Sustainability team;
- Consideration of sustainability within our values, strategies, processes and procedures.

8.2 Sustainability Areas of Focus

Sustainable Models of Care

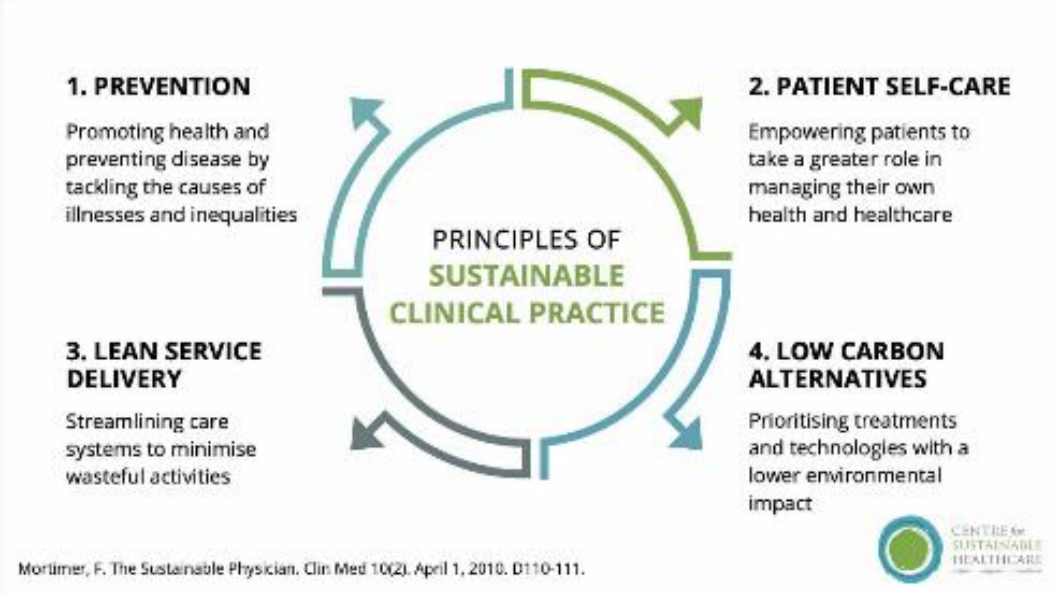
Progress

Sustainable models of care are crucial for the longevity of patient and planet health. Effective models increase resilience, performance and sustainability within the Trust, based on core principles of prevention, integrated care and optimising delivery of care in the right place, e.g. community or home with a net-zero focus supported through digital transformation of care.

Accelerated by the Covid-19 pandemic, the Trust has experienced a huge increase in teleconferencing, reducing unnecessary patient travel, air pollution and congestion. Thousands of patients use the service every month, but there is active encouragement across our organisation to continue the increase of virtual appointments and wards, supported by the NHS 10-year plan to increase care into the community and at home (where appropriate).

The Trust is taking forward a number of initiatives including a senior leader's group to tackle over-ordering of items in the clinical setting and driving forward a consistent approach ranging from reusable alternatives to single-use items, reduction in waste and better segregation of it, through to using oral forms of medication by default with less liquid forms of medicine that are most costly and have a shorter shelf-life

Key partners are strategically important in the enhancement of health and promotion of resilience within individuals and communities. The Trust will continue to nurture and develop strong relationships with healthcare partners and work together to reduce environmental and carbon impacts.



8.2 Sustainability Areas of Focus

Sustainable Models of Care

Strategic Objectives

- Implement an effective educational approach for all clinical staff to embed sustainable practice in healthcare.
- Measure financial and carbon benefits of care models to inform planning, policy and business case development.
- Increase walking-aid returns through prescriber engagement and equipment provider and collection services.
- Influence policies, such as the Trust's Clinical Strategy to reduce patient travel and staff time using virtual, local appointments and combining treatments and assessments where appropriate.
- Build partner-led innovations that reduce waste, packaging and single-use items.

Sustainability Actions

- Care Group's senior leadership and medical education teams to implement sustainability training to embed sustainable healthcare practices through to growing the Green Champion network across care groups.
- Improve walking-aid returns with prescribers and suppliers, targeting 10% year-on-year improvement.
- Embed WRAP-aligned procurement, stock reduction and just-in-time processes to reduce waste and spend across all the care groups
- Standardise reusable alternatives to single-use clinical items through clear guidance where possible.
- Support Care Group leaders to communicate and embed sustainability priorities across clinical areas.
- In line with the Trust's Clinical Strategy, streamline appointments by combining visits where appropriate, offering care closer to patients' homes, and using virtual appointments where practicable to reduce time, cost and travel.
- Reducing healthcare associated infections by reducing prolonged stays, returning to general deterrent cleaning and review of equipment, e.g. use of choline dioxide foam with non-plasticised wipes over cleaning wipes and better hand washing rather than overuse of PPE.

How We Will Measure Our Progress

- Track outpatient activity annually, including virtual, same-day and local appointments.
- Monitor walking-aid and equipment returns, targeting 10% year-on-year improvement.
- Assess financial, environmental and carbon benefits of care models.
- Use patient feedback and local/national data to measure experience and impact.
- Clinical Care Group assurances and reports
- Analyse clinical purchasing ledgers to identify savings and CO2e reductions.

8.3 Sustainability Areas of Focus

Digital Transformation

Progress

IT infrastructure is key to the sustainability and success of the NHS as an enabler, which allows for the effective management of resources, improvements in the quality of care and advanced reporting procedures.

This involves the streamlining and improvement of existing infrastructures, including moving on-premise hosted services to cloud-based systems that have direct reduced energy reduction and staff saving, as well as increased security and access. Examples of the cloud-based systems now being adopted are NHSmail, MS Teams and Sharepoint along with the Nervecentre EPR. Inefficient data centre equipment has recently been replaced with less energy consuming hardware, and there is the prioritisation of refurbishing existing IT equipment where possible.

Key achievements include the digitisation of nearly 50,000 patient case notes in 2025, resulting in significant cost savings (£50K), reduced paper and energy usage, and a clear roadmap to eliminate physical storage needs over the next eight years.

Use of Teams and other forms of tele and video conferencing is reducing the need for staff to travel as well as increases in online patient consultations, all of which enables home working and virtual appointments.

The Trust in now embarking on the implementation of a new Electronic Record Patient (EPR) system, Nervecentre. As well as the many benefits this will bring to patient care and their records, it will significantly reduce paper forms and records. First phase due to be complete by March 2026 with further phases later in the year.

While a Procurement initiative, a new system called Scan4Safety is being rolled out introducing barcoding for people, products, and places to enhance patient safety, improve operational efficiency, and ensure better use of NHS resources, including waste and capturing products and redistributing them before they expire and risk being thrown away unused.

8.3 Sustainability Areas of Focus

Digital Transformation

Strategic Objectives

- Factor new and emerging technologies into decision-making, including projects like EPR and Scan4Safety;
- Continue to increase the uptake of teleconferencing;
- Streamline and utilise effective management software;
- Enable efficiencies through the use of solutions such as AI and AVT (ambient voice technology)
- Implement and improve equipment distribution through referencing and reporting systems.
- Reduce on-premise systems and move to cloud-based solutions where possible

Sustainability Actions

- Evaluate the transfer of our server and data moves to cloud-based systems and report the overall savings including costs and energy consumption savings;
- Improve the distribution of already existing equipment by implementing a referencing and reporting system, enabling absolute control of IT assets;
- Streamline and develop the effective use of software, reducing the need for intensive hardware and paper-based processes, for example the digitisation of patient case notes
- Assess and report on the ongoing EPR savings on an annual basis and ensure this is pasted to the Data Carbon Analyst
- Continue to consider the potential for refurbished equipment when replacing legacy equipment and reporting on the cost savings of this to the Data Carbon Analyst to work out the Co2e savings.
- To constantly look out for new ways to reduce energy consumption and other savings, including staff time and paper use, for example review automated shutdown procedures on equipment such as computers and printers through to new IT software.

How We Will Measure Our Progress

- Outpatient appointment records across the Trust;
- Numbers of virtual case notes created
- Live equipment reports;
- Software assessment and evaluation reports;
- Energy consumption calculations;
- Staff surveys and reviews.

8.4 Sustainability Areas of Focus

Travel and Transport

Progress

The impact of travel and transportation on the local community is significant, and the Trust recognises its responsibility to implement effective strategies for reducing air pollution at York and Scarborough sites.



We have already executed a **travel hierarchy and plan** to encourage the uptake of public and active transportation methods, built a secure 1**00-cycle storage facility**, deployed a fleet of designated **low emission pool cars and nine electric vehicles**. The **salary sacrifice scheme** for bicycles has also seen good levels of uptake.

The Trust is continually expanding its **promotions of healthy and active travel online** and has increased accessibility to **electric scooters and bicycles**, with a new parking bay for patients and visitors in York. Over 14,000 journeys have been made since it was launched. Our SDG encourages and promotes active participation in **events like the 'National Clean Air Day'** and the NHS Supply Chain is working to **reduce the number of single supplier deliveries** and consolidate the transportation of goods to each site.

The Trust has also recently announced a new incentive to encourage staff to change their single occupancy car journey to work to public transport. In late 2023, the Trust began to fund a **£1 bus travel scheme for staff journeys** on the First York bus network and the number 10 bus service at Scarborough. This will help to support staff journeys to work at York and Scarborough hospitals.







8.4 Sustainability Areas of Focus

Travel and Transport

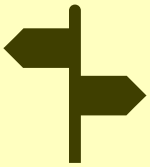


Strategic Objectives



- Evaluate EV infrastructure and encourage active engagement from local suppliers;
- Develop a plan to reduce staff (business and commute), patient and visitor emissions;
- Reduce air pollution by transitioning fleet to use exclusively Zero and Ultra-Low Emission Vehicles including the development of plans to install electric vehicle charging infrastructure fleet vehicles at the Provider's Premises
- Ensure that all new staff lease, salary sacrifice, and pool cars purchased/leased are ULEVs or ZEVs, and work towards purchasing vans meeting these requirements;
- Reduce fleet air pollution by using exclusively zero and ultra-low emission vehicles, including the development of plans to install electric vehicle charging infrastructure for fleet vehicles at the provider's premises;
- Implement a staff travel plan for the Trust and develop working plans from the staff travel plan to further encourage staff to travel more sustainability and provide opportunities for them to do so.

Sustainability Actions



- Review external and internal funding opportunities in support of the staff travel plan
- Ensure the Trust salary sacrifice schemes are in line with NHSE net zero targets;
- Review and reduce business lease and fleet lease CO2 limit for all new/replacement vehicles, e.g. through the adoption of EV and hybrid vehicles in the Trust fleet;
- Continue to increase provision of cycle storage, showers and lockers across sites;
- Continue to work with partners including all Local and Combined Authorities to promote and enable uptake in sustainable travel;
- To continue with the Trust staff bus travel scheme with bus operators and the Local and Combined Authorities , reviewing its effectiveness and find ways to continue this while reduce the financial burden on the Trust to support this;
- Implement agreed actions for the Trust staff travel plan, ensuring this is supportive of the NHS Net Zero strategy and aligned to the Trust's Green Plan, see travel plan for more details https://www.yorkhospitals.nhs.uk/seecmsfile/?id=8487.
- Implement yearly staff travel surveys.

How We Will Measure Our Progress



- Fleet composition and conversion to EVs, fuel use and mileage records;
- Outpatient appointment records across the Trust;
- Annual staff travel surveys (latest survey undertaken in November 2025);
- Take up of the staff bus travel scheme;
- Reduced emissions from business travel and grey fleet

8.5 Sustainability Areas of Focus

Estates and Biodiversity

Progress

Developing and managing the Trust estate sustainably is crucial to its success, as it not only reduces environmental impact, but ensures long-term financial stability and supports the well-being of staff and patients.

The NHS Net Zero Building Standards (Feb 2023) is a primary focus to incorporate this across all Estates and Capital teams staff to ensure sustainability is at the heart of our projects and maintenance. This outlines the procedures and sustainability checklists required to meet BREEAM, innovation credit and decarbonisation guidelines within sustainable new building designs and refurbishments. The Scarborough Urgent and Emergency Care development, for example, which began in 2022 was awarded BREEAM 'Excellent' status at the pre-construction stage. New buildings including the Scarborough CDC building is being built to this BREEAM standard. Whole-life costing is considered with all estate projects and consideration of the resilience of local biodiversity and green spaces has been of particular importance.

The Trust has won several external funding bids towards decarbonising our estate, including increase EV charge points for Trust fleet, winning another Public Sector Decarbonisation Grants in 2025 to de-steam Scarborough General Hospital and other bids aimed at increasing our LED lighting and Solar PV provision. Also complimenting the measures installed at Bridlington including a solar farm, roof PV through to air source heat pumps, battery storage that is predicted to reduce site carbon emissions by at least 53% that will be further supported by upgraded electrical switchgear, taking the site to becoming one of the first net zero hospitals in the UK.



The Trust has had numerous successes in winning external funding of well over £30million for the last few years ranging from investing installation of solar panels, air source heat pumps, and energy efficient fans, LED lighting and PIR sensors and various types of building insulation and cladding. This funding has been critical given the majority of our green house gas emissions come from our buildings.

8.5 Sustainability Areas of Focus

Estates and Biodiversity

Biodiversity and Green Space

The value of nature for mental and physical wellbeing must be accounted for in the strategic implementation of net zero and sustainability initiatives. Various studies outline the importance of green space in the reduction of stress, depression and anxiety, and the improvement of physical health through space for activities. Biodiversity also plays a crucial role in the maintenance of eco-system services such as pollination and soil fertility.

Where possible, green spaces have been actively considered in the development and refurbishment of the estate. As mentioned in this plan, partnership working is key where the Trust has engaged with Humber Forest and White Rose Forest to develop a comprehensive strategy and plan for Bridlington and Scarborough sites to provide better green space for our staff and visitors, support the increase in biodiversity across these communities and appropriate increases in tree and shrub planting.

Our green space and gardens provide opportunities for rehabilitation, space for reflection and interaction and improved habitat conditions. They were and will continue to be developed as part of a collaborative process between teams from estates, sustainability, charity funding, arts, capital projects and other partners.

Following the NHS Net Zero Building Standard, the Trust considers the potential benefits of green space, as well as the impact of construction on biodiversity. One notable success is the recent helipad development within close proximity of the Scarborough Urgent Emergency and Critical Care Department. 31 immature trees were dug out and replanted in Dalby Forest and on farmland in Staintondale. The area around the helipad was sown with wildflower seeds and “bee bombs” to encourage invertebrate populations, and hedgehog and owl boxes were installed.



8.5 Sustainability Areas of Focus

Estates and Biodiversity

Strategic Objectives

- Incorporation and following of the NHS Net Zero Building Standards across all teams in Capital and Estates
- Projected energy and carbon performance delivered within projects;
- All new builds to conform to BREEAM, innovation credit and decarbonisation standards, as detailed in the new NHS Net Zero Building Standards;
- All existing building maintenance, room/ward refurbishments to follow BREEAM standards and incorporating energy savings measures
- Renewable/low carbon technologies such as solar panels, Electrical Charging points, switchgear, LED lighting, Building Management Systems and ground/air heat pumps included in new builds and existing building buildings;
- Increase collaboration and contracting mechanisms with local and small businesses; Publish a Board approved green space and biodiversity plan;
- Encourage support from the local community to engage with our green spaces;
- Implement tree planting schemes and habitat improvements to support with the carbon offsetting of developments and support for the increase in biodiversity.
- Develop a biodiversity and green space strategy and plans for each main Trust sites to ensure food and shelter to support local biodiversity and improved green spaces to reduce maintenance and increase wellbeing spaces for staff and patients.

Sustainability Actions

- Develop a decarbonisation plan (HDP) by 2028, which, for example, include:
    - identifying and prioritising the phasing out of all existing fossil-fuel primary heating systems by 2032 and seeking to remove all oil primary heating systems by 2028
    - considering Local Area Energy Plans and opportunities from local heat networks and other low-carbon solutions
- Ensuring that the BREEAM process is followed carefully to ensure ‘Excellent’ category is achieved;
- Electrical submetering in new builds to measure against projected performance and linked to the BMS;
- Sustainability and carbon reduction, and measures supporting this, are factored into all Capital projects and Estates PPMs and backlog maintenance;
- Actively encourage and consider tenders from small and local contractors to achieve Social Value;
- Plan in all desired sustainability capital projects to align with likely NHSE funding windows to ensure integration with Trust capital programme and Estates/Capital staff.
- Sustainability to be a tender requirement for all new builds to include CO2e reductions of at least 10% weighting;

8.5 Sustainability Areas of Focus

Estates and Biodiversity

Sustainability Actions

- Full embedding of NHS Net Zero Building Standards documentation across all Estates and Capital teams and recording in training records by the end of 2026;
- Expand the coverage of BMS sensors across the Trust by the end of 2027 and ensure reported savings recommendations are implemented and data is sent to the Trust Net Zero Data Carbon Analyst;
- Factor in the effects of climate change when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions
- Implementation of biodiversity and green space improvement plans across all identified sites, ensuring a mix of tree types and planting to support biodiversity. This to be completed by the end of 2027 across all identified sites.
- Improved green space planting to reduce grounds maintenance and improved wellbeing green spaces for staff and patients, supported by improved seating and shelters. This to be ongoing and form part of the ground maintenance but in line with the above action.
- Consideration of differing types of planting and gardens including healing and sensory as well as accessible garden types. This to be in line with the above two actions.

How We Will Measure Our Progress

- Carbon monitoring from new builds and refurbishments where BMS sensors and submeters are installed.
- BREEAM and innovation credit assessments;
- BMS reporting and 100% of efficiency recommendations being reviewed and implemented.
- Increases in planting of a diversity of trees and shrubs and improvements in accessible green space. Notable reduction in grounds maintenance.

8.6 Sustainability Areas of Focus

Facilities Management

Progress

Waste

YTHFM Waste Management has already achieved significant improvements to waste management and waste segregation at the point of origin across the Trust's operational sites currently achieving a ratio of 57% , 22% and 21% against an NHS England target of 60%, 20% and 20% by the end of fy2026/27. Our food waste is recycled via anaerobic digestion for redistribution within the local community and ash from our clinical waste incineration is used within road building.

The Trust also uses a re-use portal called Warp It which allows staff to redistribute unwanted furniture and equipment within the Trust. It is estimated that this has saved the Trust just over £30,000, stopped 6 tonnes of waste and avoided 14.3 tCO_2e of carbon emissions.

Laundry & Linen

Reducing unnecessary laundry consumption at ward level directly supports the Trust's Green Plan by lowering waste generation, cutting carbon emissions, decreasing water, chemical, and energy consumption associated with textile processing.

Cleaning

The introduction of microfibre cleaning systems and the rollout of dilution control units has significantly reduced chemical use and water consumption across Domestic Services. These innovations support safer working environments whilst lowering environmental impact and operating costs.

Support Services

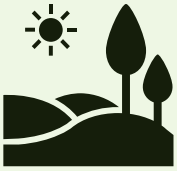
During fy2025/26 YTHFM implemented 2nd class post as the default mailing option, driving a substantial shift away from carbon-intensive first-class postage. As a result, first-class volumes reduced by approximately 50% in January 2026. Consolidation of items going to the same address, particularly for high-volume areas such as Audiology reduced excess packaging, collections and delivery miles.



8.6 Sustainability Areas of Focus

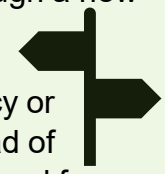
Facilities Management

Strategic Objectives



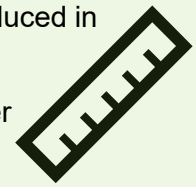
- Ensure improved waste segregation at point of source is sustained.
- Strengthen circular economy practices across uniform management.
- Advance the Domestic Services sustainability agenda through modern cleaning technologies, resource-efficient practices and workforce development.
- Develop a Trust Bed Changing Policy to reduce excessive usage and to improve overall operational efficiency and service quality.

Sustainability Actions



- Continue to work to increase our recycling volumes and %s of wastes rates through a new waste contract due to commence in the autumn of 2026.
- Ensure reusable returned uniforms are laundered and redistributed as emergency or second-hand stock. Introduce a site-to-site new uniform exchange system instead of purchasing new stock and ensure uniforms no longer suitable for reuse are returned for recycling.
- Explore the feasibility of introducing robotic cleaning machines in high-footfall areas in our acute sites to improve service delivery and to help overcome staffing shortages.
- Conduct a comprehensive review of the current inpatient bed linen usage to understand the variances at ward/department level, identify opportunities to standardise bed changing practice where needed and reduce unnecessary activity where feasible .

How We Will Measure Our Progress



- Review the % of waste recycled for each financial year against the total volumes produced in line with a target of 30% overall waste tonnage being recycled.
- Review the proportion of uniforms reused, reductions in ordering volumes, the number of uniforms recycled and budget performance during fy2026/27.
- Monitor our cleaning scores/KPIs alongside our staffing volumes, rotas fulfilment and budgets during fy2026/27.
- Review and amend ward or department daily standards where necessary and monitor linen usage in line with our contract and budgets during fy2026/27.

8.7 Sustainability Areas of Focus

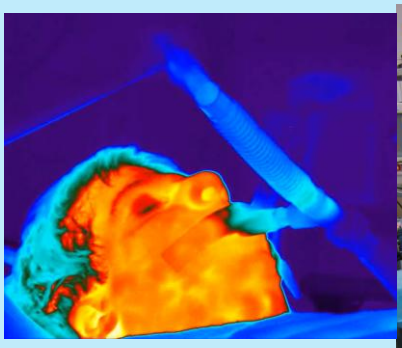
Medicines

Progress

Changes continue to be implemented across the Trust's clinical landscape to make metered dose inhalers a secondary consideration over Dry Powder inhalers and the recent addition of an inhaler recycling service in partnership with the Leeds Trust.

Anaesthetic gases remain the highest clinical emission. As these emissions depend on agent choice, fresh gas flow and pipeline leakage as well as surgical activity, growth in activity need not increase them proportionally, it is therefore not just a case of reducing the use of gases that have a high CO2e emission but change of practice to injectable forms of anaesthesia. As a result, a new Anaesthetic department led working group has been established with key stakeholders to reduce high-emitting CO2e gases, decommission piped gas and manifolds and using total intravenous anaesthesia (TIVA) where clinically appropriate.









8.7 Sustainability Areas of Focus

Medicines

Strategic Objectives



- Minimise use of metered dose inhalers with dry powder inhalers as the primary source
- Investigate alternatives to single use products
- Reduce emissions from inhalational anaesthesia across the Trust by decommissioning nitrous oxide manifolds (with point-of-use cylinders where clinically required), avoiding high-GWP agents and increasing use of TIVA where clinically appropriate over the next 3 years. Where gas is required, this will be moved to portable cylinders.
- To continue to disseminate pharmaceutical sustainability education to clinicians to better inform prescribing.
- Complete the RPS Greener Pharmacy Checklist

Sustainability Actions



- During inpatient admissions, pharmacists to review use of metered dose inhalers and influence prescribers to use dry powder inhalers instead. Respiratory Pharmacist to educate clinicians during directorate meetings.
- Continue to identify single use plastics and explore alternative products via bi-monthly Pharmacy Improvement Group.
- Recycle plastics where this is not possible e.g. inhaler recycling scheme.
- Through the monthly Drug and Therapeutic Committee and HNY Area Prescribing Committee, investigate new and emerging medicines / technologies that reduce the need for single-use products and a transition, where viable, to pill forms of medication away from IV forms
- Anaesthetic led working group to be established to review current policies and procedures to support increased use of TIVA and the decommissioning of nitrous oxide manifolds. Speciality Pharmacists to educate clinicians on pharmaceutical sustainability during directorate meetings
- Document evidence of initiatives that meet the criteria on the RPS Greener Pharmacy checklist

How We Will Measure Our Progress



- Annual review of Pharmacy report on number of MDI inhalers supplied
- Annual review of Pharmacy Improvement Group notes to identify number of single use plastic items replaced
- Bi-monthly review of minutes from Anaesthetic working group to identify progress against actions and agent-use data (e.g. CO_2e per anaesthetic).
- Annual staff survey to identify time spent by Pharmacist's educating clinicians on pharmaceutical sustainability
- Annual completion/ review of RPS Greener Pharmacy Checklist

8.8 Sustainability Areas of Focus

Supply Chain and Procurement

Progress

Procurement equates to approximately 67% of the Trust's overall carbon footprint (NHS Carbon Footprint Plus). A sustainable NHS Supply Chain will therefore substantially decrease greenhouse gas outputs, improve patient outcomes and support the local economy. As a national framework, it is essential that the NHS advocates for environmentally-conscious purchasing behaviours, with much already being done to demonstrate this.

The Trust's reuse portal Warp-It has been notably successful. The system has enabled a cost saving of £16,600, a reduction of 9 tCO_2e and 3,100kg of waste avoided. There have also been vast improvements in the procurement of fabrics across the Trust, with uniform and furniture overhauls of recycled fabrics and Better Cotton Initiative in the pipeline.

NHS Supply Chain has also begun to develop a tier of scoring for suppliers and products based on their sustainability credentials, allowing for more informed decision-making in respect to overall product impact. Within this remit, the Trust has asked all NHS large suppliers to conduct a full carbon audit.

Over the past 12 months, the Trust also begun to procure and utilise remanufactured surgical devices, where previously devices would be discarded. All wooden furniture is FSC certified; and a large portion of suppliers are accredited to ISO standards.

The Trust has partnered with Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust to create the Humber and North Yorkshire Procurement Collaborative, a new organisation created to support the sustainable provision of clinical and non-clinical services and be a centre of procurement and commercial excellence.

8.8 Sustainability Areas of Focus

Supply Chain and Procurement

Progress

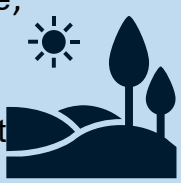
A procurement sustainability gap analysis has been completed to establish a baseline of current practice. Training has been delivered to procurement and contract teams on social value and sustainability contract management, supported by the development of practical tools including a sustainability checklist and a bank of tender questions by category of spend.

These tools are currently under review by the Contract Management team to assess their practical value and usability. This includes the sustainability checklist and the bank of tender questions by category of spend. Feedback from contract teams will be used to refine the tools prior to wider rollout, supporting improved consistency, tracking, and delivery of supplier sustainability commitments.

8.8 Sustainability Areas of Focus

Supply Chain and Procurement

Strategic Objectives



- Embed sustainability and social value into all stages of the procurement lifecycle;
- Improve supplier accountability for carbon reduction and environmental impact;
- Strengthen skills, awareness, and consistency across procurement and contract teams;
- Expand the use of Warp-It reuse portal;
- Support circular economy principles and reduce waste across the supply chain - through a targeted review of high-volume and high-impact single-use items to identify safe and appropriate reusable or lower-waste alternatives (e.g. couch roll, tourniquets, PPE where clinically appropriate, reusable sharps containers)

Sustainability Actions

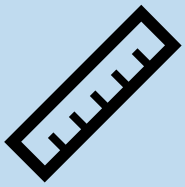


- Increase the online repository of sustainability related training within the procurement industry;
- Implement changes to fabric use to include recycled fibres and renewable materials for chair coverings and uniforms e.g.. 100% recycled chair fabric for operator chairs and Better Cotton Initiative cotton by using the NHS uniform contract from 2024;
- Implement procedures to limit access to non-environmentally friendly supplies and reduce over-ordering and effective environmentally friendly disposal of items, such as recycling, auctioning of to charities.
- Enhance energy efficiency analysis in procurement decisions on energy-intensive equipment to reduce energy demands;
- Maximise the use of the Trust Warp-It portal to reduce waste and unnecessary procurement;
- Only use of suppliers on Framework Agreements who have Carbon Reduction Plans in place and on or working towards the use of Evergreen Assessment. This to be adopted by the end of 2027.
- Reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects (see Net zero clinical transformation and Annex B of the NHSE Green Plan Guidance: selected resources for additional support tools) e.g. Reusable PPE, Reusable tourniquet, glove off, EP catheters, reusable sharps containers and any others

8.8 Sustainability Areas of Focus

Supply Chain and Procurement

How We Will Measure Our Progress



- % of new tenders including sustainability and/or social value requirements.
- % of new contracts containing at least one measurable sustainability or social value KPI.
- % of applicable suppliers with a compliant CRP in place.
- Number of contracts with carbon or environmental KPIs.
- Evidence of supplier sustainability reporting through contract reviews.
- Number and % of procurement and contract staff trained.
- Attendance and feedback from training sessions.
- Uptake and usage of sustainability tools and templates.
- Number of contracts including circular economy requirements.
- Number of reuse or waste reduction initiatives implemented.
- Supplier commitments relating to packaging reduction or reuse.
- CO2 and financial savings from the warp-It system

8.9 Sustainability Areas of Focus

Food and Nutrition

Progress

Catering across the localities continues to strengthen its alignment with the Trust's Green Plan through sustainable procurement that reduces waste volumes, augments our greener logistics coupled with a real shift away from single-use plastics within the services.

The services have prioritised suppliers with strong environmental commitments, for example Catering suppliers are now selected not only for cost efficiency but also for the strength of their sustainability and carbon-reduction strategies. A new supplier is the first national wholesaler to set verified science-based targets to cut Scope 1 & 2 emissions by 27.5% by 2030. The supplier is also investing heavily in zero-emission multi-temperature vehicles, each saving approximately 52 tonnes of CO_2 per HGV per year.

Another new supplier was selected for regional sourcing, reducing food miles and supporting the local economy.

There has been a sustained focus on reducing single-use plastics, minimising food waste, improving recycling, and promoting plant-based, low-carbon food options. For example, the introduction of "No Disposable Cup Day," Vegware packaging, and reusable alternatives supports the Trust's Green Plan and NHS Net Zero objectives.

Food-waste reduction schemes and discounts have also strengthened performance against the NHS England waste targets, while daily plant-based dishes further reduce the carbon footprint of our catering operations.

Other achievements include:

- Plastic cutlery & straws have been completely removed in line with the NHS Plastic Reduction Pledge.
- The introduction of Vegware packaging, made from compostable Vegware, to sustain our 100% non-plastic food packaging usage.
- Our last-hour hot food discount is now on track to reduce food waste in line with the NHS England food waste reduction scheme objectives.
- 100% of our coffee grounds waste are segregated from the general waste stream and collected for recycling by our supplier.
- Recycling stations have been strategically installed within our restaurants facilities to further improve our food waste segregation and to avoid food waste contamination.

8.9 Sustainability Areas of Focus

Food and Nutrition

Strategic Objectives



- Improve the compliance of food waste management in line with new regulatory requirements within section 57 of the Environment Act which prohibit the use of food waste macerators in 2026.
- Expand the inclusion of plant-based food dishes to patients to at least two within each menu.
- Implement a digitised meal ordering system for patients Trust-wide that will modernise the process and support further reductions of food wastage.

Sustainability Actions



- Explore the feasibility of introducing SMART bins to collect and measure the food waste collected in readiness for recycling.
- Implementing digital meal ordering Trust wide for our patients that will lead to improvements in forecasting of our supplies and improve service delivery.
- Increase the local catering suppliers list to 70% thereby supporting the local economy and reducing food miles.
- We are working towards a Food for Life Bronze Award. The award criteria strengthen our approach to buying and serving food that is better for the environment and health, such as increasing freshly prepared meals, improving the quality and provenance of ingredients, and promoting seasonal choices, while also encouraging reduction of food waste and better engagement with patients, staff and visitors around healthier, more sustainable menus.

How We Will Measure Our Progress



- Compare fy2025/26 and fy2026/27 ERIC data with previous financial years to highlight efficiencies achieved in terms of costs savings through reductions in food purchasing and stock levels.
- Analyse digitised patient meal ordering data each month against the previous system to identify food waste reductions during fy2026/27.
- Comprehensive monthly budget reviews will indicate real progress against the objectives and actions described above during fy2026/27.

9. Communications and Tracking Progress

Communications

As an essential part of driving change throughout our organisation, we take a considered approach to communications about sustainability. By communicating what we are doing both within and outside the organisation, we can engage staff with key priorities and ensure sustainability is part of the conversation.

We communicate sustainability information through various channels, including our weekly and monthly staff communications and a group of staff who act as champions on various sustainability goals.

We aim to provide a resource of accessible sustainability information for staff on our Trust Intranet site, complete with a waste guide and advice on reducing utility consumption/carbon emissions.

Tracking Progress

We will be measuring the progress of this strategy using a range of qualitative and quantitative methods including:

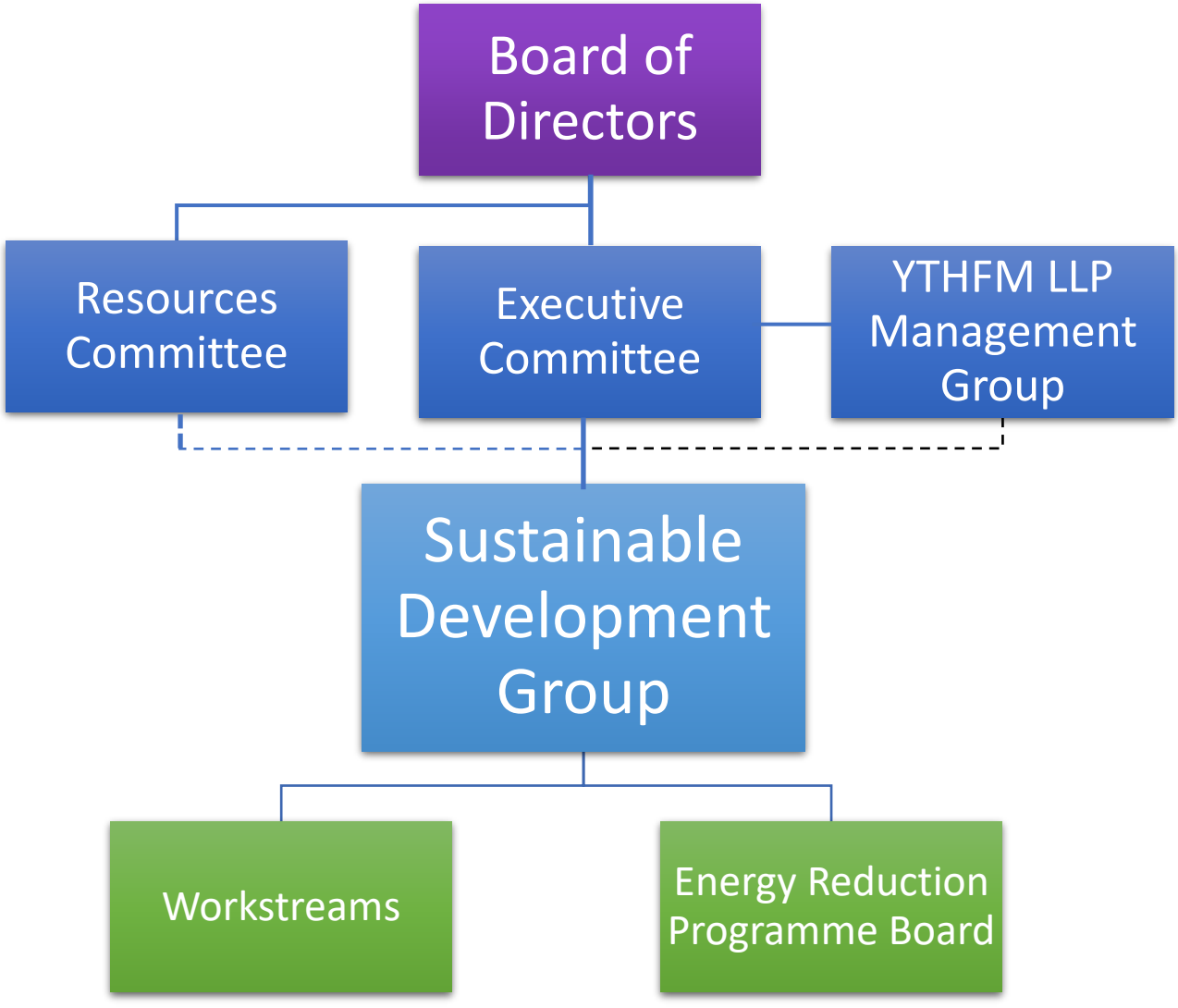
- Our annual NHS Sustainability Areas of Focus Scores – We are aiming for an overall percentage of 75%+ by 2026
- Consumption of utilities - We aim to improve our reporting ability, access to real time data and invest in sub-metering throughout the lifetime of this plan.
- Travel and transport data – e.g.. mileages, fuel consumption, travel surveys
- Waste volumes
- Inhalational agent and nitrous oxide use (CO_2e per anaesthetic; nitrous oxide procured vs clinically used).
- Organisational carbon footprint as measured and reported annually in line with official guidance
- Procurement data

10. Governance

Governance

The Trust has operated a Sustainable Development Group (SDG) since 2009. The group, which meets every quarter, includes key senior staff from various departments and facilitates both clinical and non-clinical and interdepartmental working on sustainability projects. The Travel and Transport Group and Energy Reduction Programme Board were established to provide more specific workstreams and feed into the SDG.

The SDG feeds items into individual work programmes for the Executive Committee, Resources Committee and the York Teaching Hospital Facilities Management (YTHFM) LLP Management Group, who in turn can bring items to the attention of the Trust Board of Directors.



11. Reporting

Reporting

The reporting of the Trust's sustainability performance is provided through multiple systems at an operational, organisational, regional and national level. Following CQC advice 'good' looks like the Trust's leaders demonstrate a commitment to environmental sustainability. The Trust has appropriate governance and support from leaders, with a board member who is responsible for approving and delivering their net zero targets and Green Plan.

The Trust can demonstrate that it has taken all reasonable steps to minimise the adverse impact of climate change on health. It does this through processes and interventions to simultaneously improve patient care and reduce carbon emissions and environmental harm, while tracking their progress. The trust communicates these actions to its workforce, patients and partners in the system.

The Trust makes its workforce aware of their individual carbon footprint in the context of their role and enables and supports them to reduce this.

As a responsible organisation we adopt an open and transparent approach to the information collected, making it available to all and have a duty to provide information that is accurate and is recorded within the systems below;

Monthly

- Data collection from utilities, waste and transport used to identify levels and trends.
- Reports and monthly figures reviewed at the Energy Reduction Working Group (ERWG).

Quarterly

- Internal reports produced by the Head of Sustainability are provided to the Trust's Resource Committee, LLP Management Group and Executive Board.
- A brief escalation report from the Sustainable Development Group is sent to the Resources Committee who escalate key issues to the Trust Board of Directors.
- Greener NHS Quarterly Data Collection Return.

Annual

- ERIC (Estates Return Information Collection).
- Greener NHS Transport Data Collection Return.
- Complete assessment on NHS Sustainability Areas of Focus to identify sustainability development work, measuring progress and enabling the Trust to make plans for the future from the previous year's actions.
- Annual Sustainability report identifying progress against the Green Plan and highlighting the main activities delivered throughout the year and presented in the Trust's Annual Report.

12. Risk

Risk

Risks to the delivery of our Green Plan are identified through a series of committees and groups illustrated within our Governance structure (p.48). Escalation of risks is conducted through the SDG and placed onto the York Teaching Hospital Facilities Management (YTHFM) Risk Register where, depending on severity of the risk, is progressed up to the Resources Committee, and then on to Trust Board of Directors.

The register is reviewed by the SDG on a quarterly basis include the following key risks:

1. Risks of changing climate – increasing costs and impact of adverse weather and climate change which includes heat waves and overheating buildings increasing deaths from air pollution, increasing likelihood of flooding events, disruption to services and communities and longer-term changing disease patterns.

2. Specific risk of overheating putting patients and vulnerable groups of visitors and staff.

3. Risk of failure to reduce air pollution and failure to meet requirements of NHS standard contract 2023/24 which requires Trusts to have a plan to transition fleet to Zero and Ultra Low Emission Vehicles, install EV charging for fleet, and establish policies which exclude high emission vehicle use and promote sustainable travel choices.

General risks include:-

1. Risk of insufficient engagement/support of the Trust's workforce.

2. The financial challenges the Trust and indeed much of the public sector is experiencing, reduces investment resulting in slower progress being made to reduce greenhouse gases emissions

13. Finance

Finance

Sustainable development schemes and activities will provide multiple benefits for the Trust over the coming years. As patient numbers, utilities and transport costs rise there will be a focussed approach towards reducing costs and improving services, through changing working practices and identifying beneficial cost reduction schemes.

Financial constraints within the Trust require sustainability improvements to either find external funding, partnership working or go through the Trust's business case (BC) process, indicating the benefits of the improvement, costs, return on investment and effects on the environment. The Trust's charitable funds are available if the improvement fits in with the criteria for accessing the funds.

The Sustainability Team seek to minimise and reduce financial burdens whilst at the same time seeking to achieve a balance between carbon and cost savings. It is increasingly difficult to achieve financial pay backs of five years or less, and greater levels of investment are now needed to achieve carbon reduction in line with Net Zero NHS targets. The Trust works with local, regional and national organisations to seek technical and financial support.

Utilities are procured through a tendering process to deliver the best value for money, provide energy from renewable sources and capture data that monitors and records information to identify high usage areas. This allows the Trust to identify areas where improvements can be made and alternative options for delivery considered.

Refurbishment to our estate provides an opportunity to invest in equipment and buildings that incorporate whole life cycle materials, heating, ventilation and adaptation to help cope with the predicted changes in climate change and reduce our carbon impact on the environment. Aligning and embedding cost-benefit analysis tools alongside ISO 19650 and the NHS Net Zero Building Standards to inform capital programs, business cases and funding applications and seeking to develop a Trust-wide decarbonisation plan, will help to draw up a detailed plan to meet our Net Zero targets and sustainability ambitions.

Funding had previously been secured for submetering and telemetry for the York Hospital site. More recently, the Trust was successful with our Public Sector Decarbonisation Scheme (PSDS) application, allowing further decarbonisation works to be undertaken. Further work is planned to develop a capital investment programme to contribute to the achievement of carbon reduction targets.

The predicted global impacts of an increase of greater than two degrees Celsius have been widely modelled and documented. Only a short window of time is available to reduce emissions to a level that can prevent potentially irreversible changes to the climate.

Currently there are changes to the existing external funding streams ranging from PSDS to Low Carbon Skills Funds, but it is hoped new funding sources will become available, including through the Combined Authorities, who the Sustainability team are actively working with to support the financial aspect of the transition to net zero. Cost savings will also bring sustainability savings themselves. The Trust must establish the most cost-effective way to deliver the required works to meet net-zero and contribute to the global effort to solve the climate emergency.

Appendix 1: Glossary

Air Pollution: Levels of pollutants in the air such as particulate matter, nitrogen dioxide (NO_2), ozone and sulphur dioxide (SO_2). This is measured on the Air Quality Index, which has a scale of 1-10. Air pollution can negatively impact health outcomes for local communities

BREEAM (Building Research Establishment Environmental Assessment Method): A method of assessing, rating and certifying the environmental, social and economic sustainability of buildings

Carbon Footprint: The total amount of greenhouse gases produced directly and indirectly as a result of human activities, usually expressed in tonnes of carbon dioxide equivalent (CO_2e)

Climate Change: A long term shift in weather patterns and average temperatures, caused by the emission of carbon dioxide and other greenhouse gases into the atmosphere

Climate Change Adaptation: Changes made to allow for future weather patterns. Examples include storm drains to help cope with increased flooding and improved quality road surfaces to withstand higher temperatures

CO_2e – Carbon Dioxide Equivalent: Whilst CO_2 is the most common greenhouse gas, other gases contribute to climate change, often at much higher levels per tonne. One tonne of methane has the global warming potential of 28 tonnes of CO_2. Whilst one tonne of desflurane (a potent anaesthetic gas) is equivalent to around 2500 tonnes of CO2 (100-year global warming potential (GWP100)". Desflurane is ≈2,500 (IPCC AR6: ≈2,590). The CO2e figure allows us to factor in the impact of these other gases within our overall carbon footprint

Combined Heat and Power (CHP): The generation of electricity (usually through consumption of natural gas) with the heat utilised as a by-product

Electric Vehicle (EV's): Vehicles driven by an electric motor. EV's have zero tailpipe emissions (CO_2/air pollutants) and do not contribute to local air pollution

Estates Return Information Collection (ERIC): A central reporting portal where NHS organisations report key information (such as waste and utilities usage)

Greenhouse Gases (GHGs): Gases that reduce the amount of infrared radiation that can escape through the atmosphere, thereby contributing to global warming. Examples include CO_2, methane, nitrous oxide and, in healthcare, the fluorinated volatile anaesthetic agents (desflurane, isoflurane and sevoflurane)."

Hybrid Vehicle: A vehicle that uses fossil fuels, assisted by electric motors

Appendix 1: Glossary

KPI: Key Performance Indicator

Low Emissions Vehicle (LEV): Vehicles that meet current 'Euro Standards'. Euro 3 for motorcycles, mopeds, motorised tricycles and quadricycles; Euro 4 for petrol cars, vans, minibuses and other specialist vehicles; Euro 6 for diesel cars, vans and minibuses and other specialist vehicles; Euro VI for lorries, buses and coaches and other specialist heavy vehicles (Correct as of July 2020)

Net Zero: The point where total CO_2e emissions minus offset emissions is less than or equal to zero

Patient Contacts: The number of patients that visit the Trust in a given time or have a remote consultation (telephone or video)

Payback Period: The length of time required for the cost of an investment to be recovered

Sustainable Development Assessment Tool (SDAT): The SDU's Sustainable Development Assessment Tool (SDAT) was designed to help Health and Social Care organisations assess progress in sustainable development and identify how local action is contributing to the UN Sustainable Development Goals. The tool is now superseded by the Green Plan Support Tool and the NHS Sustainability Areas of Focus.

SDG: Sustainable Development Group where all workstreams report into, that is chaired by the Head of Sustainability

Staff Travel Plan: A package of actions put in place by an employer to encourage staff to use alternatives to travelling alone in their cars, both for environmental and health benefits

Ultra-Low Emissions Vehicle (ULEV): Vehicles that emit tailpipe emissions of less than 50g CO_2/km. Electric vehicles (including battery electric, plug-in hybrid electric or hydrogen fuel cell) all meet these criteria

Warp It: A material reuse portal, which assists the Trust in redistributing assets such as furniture

Whole-life Costing: Sometimes called 'life-cycle cost', this approach assesses the absolute cost of a product or service over the course of its lifetime, from its conception through to its end of life, taking into account purchase, maintenance, repair, training, utilities and disposal

Zero Emissions Vehicle (ZEV), Electric Vehicle (EV), Fully electric vehicles that produce zero tailpipe emissions

Appendix 2: References

1. Delivering a Net Zero National Health service https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

2. How to Produce a Green Plan https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf

3. Committee on Climate Change, *Net Zero: The UK's contribution to stopping global warming,* 2 May 2019 www.theccc.org.uk/publication/net-zero-the-uks-contribution-to-stopping-global-warming/

4. NHS Standard Contract Service Conditions 2023/24 https://www.england.nhs.uk/wp-content/uploads/2023/04/03-nhs-standard-contract-fl-scs-2324.pdf

5. NHS Long Term Plan 2019 https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

6. Fourth Health and Care Adaptation Report 2025 https://www.england.nhs.uk/long-read/4th-health-and-climate-adaptation-report

7. "Well-led" single assessment framework The CQC integrates Green Plan leadership and environmental sustainability into its "Well-led" single assessment framework for evaluating trusts. https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/well-led

Item 20

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Emergency Planning Resilience and Response (EPRR) – Annual Self Assessment
Director Sponsor:	Accountable Emergency Officer – Claire Hansen
Author:	Head of EPRR – Richard Chadwick

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The Trust's 2026/27 EPRR annual self-assessment reports an overall rating of "Partially Compliant", with 52 of the 62 applicable core standards graded as fully compliant (84%). In 2025, 51 standards were fully compliant (82%). The small improvement in compliance does not upgrade the organisational rating as that remains as PARTIAL.

Outstanding compliance gaps concern EPRR resources, countermeasures and excess fatalities plans, incident communications and business continuity assurance. CBRN &

HAZMAT and Cooperation have improved, while Excess Fatalities and Business Continuity audit have been downgraded. Incident response, major Trust change programmes, staffing challenges and constraints on staff release for training continue to limit delivery of core business.

Recovery milestones include expected data protection and security toolkit compliance in Q4 2026, and proposed Countermeasures Plan publication in Q2 2027. Delivery depends on team capacity and external dependencies, including the Council's Mass Fatalities Plan. On governance, Appendix 1 records the Accountable Emergency Officer's agreement to the Partial rating, pending submission to the Board/governing body. Section 3 references the action plan at Appendix 2 and progress reporting throughout 2027 to the Resource Committee on behalf of the Accountable Emergency Officer.

The report will be submitted to the Emergency Preparedness, Resilience and Response Policy mandated governance and assurance processes as follows:

- Emergency Planning Steering Group – 24 Nov 2026.
- Executive Committee – 2 Dec 2026.
- Board of Directors – 27 Jan 2027.

Recommendation:

The Board is asked to:

- Note the 2026/27 self-assessment outcome of "Partially Compliant", with 52 of 62 applicable core standards fully compliant (84%).
- Note the planned governance and assurance submissions for the report.

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Resource Committee	17 Feb 26	Noted
Resource Committee	18 Aug 26	Noted

EMERGENCY, PREPAREDNESS, RESILIENCE AND RESPONSE CORE STANDARDS – ANNUAL SELF ASSESSMENT

1. Introduction and Background

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHSE funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

NHS England obtains assurance through an annual provider self-assessment against the core standards. The Integrated Care Board (ICB) EPRR Team then conducts a check and challenge process to confirm that assessment. The Local Health Resilience Partnership, chaired by the ICB Accountable Emergency Officer, endorses the provider gradings before submission to NHS England.

There are 62 core standards to be achieved split into 10 domains of governance, duty to risk assess, duty to maintain plans, command and control, training and exercising, response, warning and informing, cooperation, business continuity and HAZMAT/ Chemical Biological Radiological and Nuclear (CBRN). Overall gradings are achieved for full compliance against the standards as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

The governance and assurance timetable for finalising the Trust submission with the Integrated Care Board and NHS England is set out below. The table presents the submission deadlines and scheduled review and sign off stages; it does not, by itself, confirm completion of each stage.

HNY Core Standards 2026 Timeline	
Core Standards letter received	1st July 2026
Revised process discussed with providers	13th July 2026
Health Assurance Group Meeting (Sign off revised process)	29th July 2026
Initial self-assessment submission	31st August 2026
Peer Reviews	September 2026
Health Assurance Group Meeting	11th September 2026
Final self-assessment submission **Hard deadline for evidence submission (for Tier 3 standards)**	30th September 2026

ICB EPRR team to meet with providers to assess Tier 2 standards, finalise evidence review and feedback	To be completed by end of September 2026
ICB EPRR Team to review any evidence for Tier 3 standards not already reviewed and provide feedback	To be completed in advance of AEO meetings w/c 12th and 19th October
ICB and Provider AEO meetings	14th October 2026
NHSE NEY request dip-sample information	w/c 19th October 2026
Health Assurance Group Meeting	21st October 2026
Deadline for ICBs to send full assurance returns to NHSE	30th October 2026
Deadline for ICBS to submit dip-sample evidence to NHSE	2nd November 2026
Dip-sample check and challenge (if required)	w/c 16th November 2026
LHRP Confirm and Challenge	23rd November 2026
Regional Sign off – ICB, Provider and Regional Returns	26th November 2026
Executive Committee Submission	2nd December 2026
Board of Directors Submission	27th January 2027

Only evidence provided in Tiers 2 and 3 is eligible for NHS England's "dip sample" of evidence provided by acute trusts. This pragmatic approach has been adopted to make the governance and assurance process manageable for Trusts. The table below sets out the type of standard, and assurance or evidence required for each tier.

Tier	Type of Standard	Assurance/Evidence Required
Tier 0	Standard is non/partially compliant for this submission	No evidence required.
Tier 1	Standard moved to compliant last year and evidence was reviewed in 2025 and agreed by the ICB	No evidence required.
Tier 2	Standard is fully compliant and has been since before the 2025 submission	Pragmatic assurance discussion with provider. Providers should be prepared to submit evidence for dip sample to NHSE if required.
Tier 3	Standard was non/partially compliant and is moving to fully compliant this year	Evidence supplied in folder as per normal process, outcome included on the WIP sheet.

2. Core Standard Self-Assessment Observations

In 2025, the Trust was assessed as "Partially Compliant", with 51 of the 62 core standards graded fully compliant (82%). This year, the Trust remains "Partially Compliant", with 52 of the 62 standards graded fully compliant (84%). Competing demands on the Emergency

Preparedness, Resilience and Response Team—incident response, contributions to major Trust change programmes and staffing challenges have contributed to only a small improvement in compliance.

The domain review below identifies partial compliance in Governance, Duty to Maintain Plans, Warning and Informing and Business Continuity. Duty to Risk Assess, Command and Control, Training and Exercising, Response, Cooperation, Business Continuity and HAZMAT/CBRN are reported as fully compliant. The observations distinguish outstanding compliance actions from pressures on sustaining compliant arrangements.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	0	4	0
Cooperation	4	4	0	0
Business Continuity	10	7	3	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	52	10	0

To better understand the progress made in each domain, observations and comments are as follows:

2.1 Governance

The governance domain has 5 x fully and 1 x partially compliant standards.

EPRR Resources (Standard 5) is partially compliant because the scale and scope of the portfolio remain challenging for a team of two staff. The standard requires confirmation that the Trust has sufficient resources to discharge its EPRR duties. Increased time spent responding to incidents and contributing to major Trust change programmes, together with staffing challenges, is delaying completion of core business. A paper setting out these challenges and options to mitigate the resource shortfall has been submitted to the Accountable Emergency Officer.

2.2 Duty to Risk Assess

All standards in the duty to risk assess domain are fully compliant. This compliance is expected to be maintained over the next 12 months; the rating does not, in itself, establish that the domain is free of risk.

2.3 Duty to Maintain Plans

The duty to maintain plans domain has 9 x fully and 2 x partially compliant standards.

Countermeasures Plan (Standard 14) is partially compliant. The plan covers arrangements for the administration, reception and distribution of prophylaxis and mass vaccination. It remains in draft: circulation was due in early 2026 but did not take place. Publication is now proposed for Q2 2027, with stakeholder training to follow.

Excess Fatalities (Standard 19) has been downgraded from compliant to partially compliant. The standard comprises two plans. The Trust owns the Excess Deaths Plan, which is compliant. City of York Council owns the Mass Fatalities Plan, which has not yet been written. The Head of Emergency Preparedness, Resilience and Response has met the Council Planning Officer responsible for that plan. Production is envisaged in 2027; the Trust's response to the Council plan can then be written.

2.4 Command and Control

All standards in the command and control domain are fully compliant. This compliance is expected to be maintained over the next 12 months; the rating does not, in itself, establish that the domain is free of risk.

2.5 Training and Exercising

All standards in the training and exercising domain are fully compliant. Sustaining those arrangements remains challenging: operational pressures and financial constraints limit the release of large numbers of staff for contingency-plan training and testing. The Emergency Preparedness, Resilience and Response Team will continue working with Care Groups to support staff release, use training formats that require fewer staff, such as tabletop exercises, and increase the use of internet-based learning.

2.6 Response

All standards in the response domain are fully compliant. This compliance is expected to be maintained over the next 12 months; the rating does not, in itself, establish that the domain is free of risk.

It should be noted that the Incident Coordination Centre SOP was published post the Emergency Preparedness, Resilience and Response Core Standards Self-Assessment deadline of 30 September 2026.

2.7 Warning and Informing

The warning and informing domain has 4 x partially compliant standards.

Four standards remain partially compliant: warning and informing (Standard 33), incident communications plan (Standard 34), communication with partners and stakeholders (Standard 35), and media strategy in an incident (Standard 36). A draft Incident Communications Plan has been produced and reviewed by the Communications Team. Publication of the finalised plan was intended to address all four standards, but the planned publication in 2026 did not take place because work was reprioritised. Publication is now expected in 2027; this remains a planned improvement rather than a completed change in compliance.

2.8 Cooperation

The cooperation domain has 4 x fully compliant standards.

This is an improvement on last year with Local Health Resilience Partnership engagement (Standard 37) being upgraded due to attendance compliance by the Accountable Emergency Officer and Deputy Chief Operating Officer.

2.9 Business Continuity

The business continuity domain has 7 x fully and 3 x partially compliant.

The partially compliant standards are data protection and security toolkit (Standard 49), Business Continuity audit (Standard 51) and the assurance of commissioned providers business continuity plans (Standard 53).

The data protection and security toolkit is owned by Y&S Digital and is currently under development. The Emergency Preparedness, Resilience and Response and Y&S Digital teams are collaborating on it's development and it is expected to be compliant in Q4 2026.

The Business Continuity audit standard has been downgraded following NHS England's confirmation of the annual audit requirement. In previous years, the Trust treated an audit by its auditors every other year, with self-assessment in the intervening years, as sufficient for compliance. The requirement is now for an audit every year by audit-trained personnel, such as Audit Yorkshire. The previous approach therefore does not meet the annual requirement, and the standard is graded partially compliant.

Assurance of commissioned providers' business continuity plans remains partially compliant. Growing concerns about NHS supply chain resilience have prompted work to review providers' plans. The Emergency Preparedness, Resilience and Response Team is working with the Integrated Care Board Procurement Team to secure its involvement in that process. Further progress is expected in 2027, but the number of historical contracts requiring assurance means that the standard may remain partially compliant for at least a further 12 months.

2.10 Hazardous Material (HAZMAT) and Chemical, Biological, Radioactive and Nuclear (CBRN)

All standards in the CBRN & HAZMAT domain are fully compliant. This compliance is expected to be maintained over the next 12 months; the rating does not, in itself, establish that the domain is free of risk.

It should be noted that the York Hospital CBRN LIVEX took place on 04 November 2026 due to postponements for heat wave restrictions and availability of staff. This date is post the Emergency Preparedness, Resilience and Response Core Standards Self-Assessment deadline of 30 September 2026.

Decontamination Capability Availability 24/7 (Standard 59) 24/7, Waste Disposal Arrangements (Standard 62), HAZMAT/CBRN Training (Standard 63) and HAZMAT/CBRN Training (Standard 66) have been improved from partial compliance to full compliance. This has been achieved through:

- Internal audit to verify that shifts over a protracted period contain staff in ED who are trained to deliver the capability.
- The tendering of a contract to a national waste disposal company to be on call to identify a contaminant and remove it for disposal from site post incident.

- The Chief Instructor Chemical, Biological, Radiological and Nuclear has adopted the training resources as directed by the YAS Chemical, Biological, Radiological and Nuclear lead.
- Chemical, Biological, Radiological and Nuclear LIVEXs have been conducted this year on both sites to prove the capability.

3. Action Plan

The action plan at Appendix 2 covers two types of work: actions to address partially compliant standards and any outstanding actions carried forward from the previous action plan.

Progress reporting will be conducted throughout 2027 by the Head of Emergency Preparedness, Resilience and Response to the Resource Committee on behalf of the Accountable Emergency Officer.

4. Conclusion

Progress over the last 12 months has been limited, and the Trust remains partially compliant. Competing priorities have constrained the Emergency Preparedness, Resilience and Response Team's delivery of core business. Further progress is possible in 2027, but the rate of improvement will depend on the time the small team can devote to that work.

Appendices:

1. EPRR Core Standards Assurance – Statement of Compliance.
2. EPRR Core Standards Assurance – Action Plan 2027-2028.

Date: 10th November 2026

Appendix 1 – EPRR Core Standards Assurance – Statement of Compliance

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2026-27

STATEMENT OF COMPLIANCE

York and Scarborough Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, York and Scarborough Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

I confirm that the above level of compliance with the core standards has been agreed by the organisation's Accountable Emergency Officer (AEO) pending submission to the Board/governing body.

Signed by the organisation's Accountable Emergency Officer:



Date signed: 15 October 2026

Date of Board/Governing Body meeting: 27 Jan 27	Date to be presented at public Board: 27 Jan 27	Date published in Annual Report: In board report 2027

Appendix 2 – EPRR Core Standards Assurance – Action Plan 2026/27

Ref	Domain	Standard name	Standard Detail	ICB Final Grading 2024	ICB Final Grading 2025	ICB Final Grading 2026	Trust Action 2027	Actionee	Target Date	Assessed Grade 2027	Remarks / Updates
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	A	A	A	1 - Await direction from Accountable Emergency Officer on response to EPRR Resource paper (R)	RC	Q2 - 27	A	
14	Duty to Maintain Plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	R	A	A	2 - Draft plan to be circulated internally and externally to achieve final draft. To Executive Committee in early 2027.	RC	Q2 - 27	G	
19	Duty to Maintain Plans	Excess Fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	A	G	A	3 - Await publication of City of York Mass Fatalities and then draft Trust response to that plan.	RC	2027	A	This plan has been an outstanding action for the LA for the last 7 years.
33	Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	A	A	4 - RC to meet Comms Team to finalise draft and takge through governance and assurance	RC	Q3 - 27	G	
34	Warning and Informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	A	A	A	4 - RC to meet Comms Team to finalise draft and takge through governance and assurance	RC	Q3 - 27	G	
35	Warning and Informing	Communication with Partners and Stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	G	A	4 - RC to meet Comms Team to finalise draft and takge through governance and assurance	RC	Q3 - 27	G	
36	Warning and Informing	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	A	A	4 - RC to meet Comms Team to finalise draft and takge through governance and assurance	RC	Q3 - 27	G	
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	G	A	5 - Await Y&S Digital submission of toolkit to achieve compliance	AC	Q3 - 26	G	May require handover to CR
51	Business Continuity	BC Audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	G	G	A	6 - Gain agreement for annual Yorkshire audit ot tolerate every other year. Take to Emergency Planning Steering Group.	RC	Q3 - 26	A	Paper would be required to Exec Committee if toleration of every other year selected as the option.
53	Business Continuity	Assurance of Commissioned Providers / Suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	A	7 - Develop attendance in WG with Lisa Farley to reassess compliance and develop system for contracts going forward.	CR	Q3 - 27	A	

Report to:	Board of Directors
Date of Meeting:	25 November 2026
Subject:	Board Committee Terms of Reference Amendments
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.
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Board Assurance Framework

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

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

☐ Yes
☐ No
☒ Not Applicable

Executive Summary:

In September 2026, the Board approved the establishment of the Culture and People Committee as a standing committee of the Board. Its remit includes the Culture and People Plan, strategic workforce requirements, organisational culture, staff experience, equality and diversity, staff health and wellbeing, leadership development, workforce metrics and associated strategic risks.

Consequential amendments are now required to the Terms of Reference of the Resources Committee to remove workforce-related responsibilities that will transfer to

the Culture and People Committee. This will provide clearer accountability and avoid duplication between the two committees.

It is also proposed to amend the Group Audit Committee Terms of Reference to permit the appointment of Associate Non-Executive Directors as members of the Committee and, where determined by the Board, as Committee Chair.

Recommendation:

1. Resources Committee: remove the workforce and people-related elements of its remit, these responsibilities now falling within the remit of the Culture and People Committee; and

2. Group Audit Committee: amend the membership provisions to permit Associate Non-Executive Directors to be appointed as members of the Committee and, where determined by the Board, to serve as Committee Chair

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

Meeting/Engagement	Date	Outcome/Recommendation
Board of Directors	30 September 2026	Approval of Culture and People Committee Terms of Reference

Board Committee Terms of Reference Amendments

1. Purpose

This paper seeks formal Board approval of amendments to the Resources Committee terms of reference, following removal of workforce-related responsibilities that will transfer to the Culture and People Committee after approval at its terms of reference at the September Board meeting.

In addition, it is proposed for the Board to approve the Group Audit Committee terms of reference to allow membership of Associate Non-Executive Directors and to fulfil the role of Committee Chair subject to compliance with applicable NHS governance requirements.

2. Proposed Changes

The following changes are formally proposed:

Committee	Proposed Amendment
Resources Committee	Remove workforce and people-related responsibilities from the Committee's remit, with these responsibilities being incorporated within the remit of the Culture and People Committee. The Resources Committee will retain responsibility for financial, estates, operational performance and other resource matters remaining in its Terms of Reference.
Group Audit Committee	Amend the membership provisions to allow Associate Non-Executive Directors to be appointed as members of the Committee and to permit an Associate Non-Executive Director to be appointed as Committee Chair by the Board, subject to appropriate skills, experience, independence and constitutional eligibility.

The changes clarify the respective responsibilities of the Resources Committee and Culture and People Committee and support clear accountability, escalation and assurance reporting to the Board. Membership of the Group Audit Committee is subsequently clarified to enable its responsibilities to be discharged effectively.

3. Governance and assurance arrangements

All Committees are standing committees of the Board and will operate within the Trust Scheme of Delegation. Each will undertake an annual effectiveness

assessment, review its Terms of Reference at least annually and present an annual report to the Board.

4. Recommendations

The Board of Directors is asked to:

1. Resources Committee: remove the workforce and people-related elements of its remit, these responsibilities now falling within the remit of the Culture and People Committee; and
2. Group Audit Committee: amend the membership provisions to permit Associate Non-Executive Directors to be appointed as members of the Committee and, where determined by the Board, to serve as Committee Chair.