York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 4

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.

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Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Ms Rukmal Abeysekera
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Ms Helen Grantham
- Ms Jane Hazelgrave
- Mr 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

- 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.*

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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

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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.

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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.

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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.

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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

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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%,

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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.

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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

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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

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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.

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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).*

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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.

APPROVED

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.

APPROVED