York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 26th February
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 29 January 2025** To be agreed as an accurate record.	Chair	Report	**5**	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	**15**	
6.	**Chair's Report** To receive the report.	Chair	Report	**16**	9:35
7.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	**18**	9:45
8.	**Quality Committee Report** To receive the February meeting summary report.	Chair of the Quality Committee	Report	**48**	10:00

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Resources Committee Report** To receive the February meeting summary report.	Chair of the Resources Committee	Report	50	10:10
10.	**Trust Priorities Report (TPR)** January 2025 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	Chief Operating Officer Medical Director & Chief Nurse Director of Workforce & OD Chief Digital Information Officer Finance Director	Report	52 55 114 125 131	10:20
Break 11:10					
11.	**Maternity and Neonatal Reports (including CQC Section 31 Update)** To consider the report and approve the section 31 update.	Chief Nurse - Executive Maternity Safety Champion	Report	144	11:25
12.	**January CQC Inspection Update** To consider the report.	Chief Nurse	Report	162	11:35
13.	**Research and Innovation Strategy** To approve the report.	Medical Director	Report	165	11:45

Governance

Item	Subject	Lead	Report/ Verbal	Page No	Time
14.	**Emergency Preparedness Resilience and Response (EPRR) Core Standards Update Report** To approve the report.	Chief Operating Officer	Report	**191**	12:00
15.	**Committee Effectiveness reports** • Quality Committee • Resources Committee To consider the reports.	Committee Chairs	Report	**203**	12:10
16.	**Risk Management Strategy and Policy** To consider and approve the report.	Chief Executive	Report	**216**	12:20
17.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
18.	**Time and Date of next meeting** The next meeting held in public will be on 26 March 2025 at 9:00am at York Hospital.				
19.	**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.				
20.	**Close**				12:30

Minutes
Board of Directors Meeting (Public)
29 January 2025

Minutes of the Public Board of Directors meeting held on Wednesday 29 January 2025 in the Boardroom, Trust Headquarters, York Hospital. The meeting commenced at 9.30am and concluded at 12.30pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Mr Jim Dillon
- Mrs Jenny McAleese
- Prof Matt Morgan
- Ms Helen Grantham, Associate Non-Executive Director

Executive Directors
- Mr Simon Morritt, Chief Executive
- Mr Andrew Bertram, Finance Director
- Dr Karen Stone, Medical Director
- Mrs Dawn Parkes, Chief Nurse and Executive Maternity Safety Champion
- Ms Claire Hansen, Chief Operating Officer
- Miss Polly McMeekin, Director of Workforce and Organisational Development
- Mr James Hawkins, Chief Digital and Information Officer

Corporate Directors
- Mrs Lucy Brown, Director of Communications

In Attendance:
- Ms Jane Hazelgrave, Non-Executive Director designate
- Mr Mike Taylor, Associate Director of Corporate Governance
- Ms Paula Gardner, Insight Programme
- Ms Virginia Golding, Head of Equality, Diversity and Inclusion (For Item 13)
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 14)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- One member of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting with a particular welcome to Jane Hazelgrave, who would be joining the Board formally as a Non-Executive Director on 26 February 2025.

2 Apologies for absence

Apologies for absence were received from:
Dr Stephen Holmberg, Non-Executive Director

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 27 November 2024

The Board approved the minutes of the meeting held on 27 November 2024 as an accurate record of the meeting.

5 Matters arising/Action Log

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

BoD Pub 26 *Include in the Trust Priorities Report (TPR) unvalidated data on operations cancelled on or after the day of admission.*
Mr Hawkins advised that his team were working to align the methodology for calculating this metric with that of NHS England, to be introduced in a new version of the TPR in the spring. The due date was amended to May.

BoD Pub 27 *Ensure sub-divided data on attendances in ED is added to TPR.*
This data had been added to the TPR and the action was closed.

BoD Pub 28 *Provide further information to the Board on the categorisation of patients arriving at ED by ambulance.*
This information had been circulated by email to the Board and the action was closed.

BoD Pub 36 *Report back to the Board on waiting times for the Rapid Access Chest Pain Clinic.*
The waiting times had been added to the TPR and the action was closed.

BoD Pub 38 *Provide the Quality Committee with more detailed information about complaints.*
Mrs Parkes reported that the Mid-Year Complaints report had been presented to the Quality Committee at its meeting on 21 January 2025 and further information on the September position had been sent to the Chair. The action was closed.

Mr Barkley advised that the Council of Governors had requested further information about complaints, and he proposed adding both papers to the next Council of Governors' meeting agenda.

BoD Pub 40 *Investigate and report back on Community Response Team referrals and what proportion of these are urgent*.
Information on Community Response Team referrals had been circulated to the Board by email. The action was closed.

BoD Pub 41 *Investigate and report back via email on the figure for the fracture neck of femur patients treated within the gold standard timeframe.*

Mr Hawkins advised that the figure was a percentage; this had been clarified in the TPR. The action was closed.

BoD Pub 42 *Provide a further update on Neck of Femur pathways to the Quality Committee.*
An update had been provided to the Quality Committee. The action was closed.

BoD Pub 43 *Provide an update on the migration of the Estates Team's Computer Aided Facilities Management (CAFM) systems, including progress towards a post implementation review.*
Mr Taylor provided an updated on behalf of YTHFM colleagues which would also be circulated to the Board: the system had been implemented and used on a small number of asset types. Computer Aided Design drawings had been obtained for laser surveys at UECC, Bridlington, Malton and Selby sites but gaps remained at Scarborough and York. The target for full implementation was by September 2026 when a post-implementation review would be completed. The action was closed.

BoD Pub 44 *Ensure that more details are provided to the Board on the cost of compliance with waste management requirements.*
Mr Taylor provided an updated on behalf of YTHFM colleagues which would also be circulated to the Board: a Business Case to purchase additional waste management facilities was being drafted. The action was closed.

6 Chair's Report

The Board received and noted the report.

7 Chief Executive's Report

The Board received the report. Mr Morritt highlighted:

- the increase in operational pressures over the Christmas and New Year period which reflected the national picture;
- the National Planning Guidance for 2025/26 had still not been received although details had been released regarding plans to reform elective care and to recover the 18-week referral to treatment standard;
- the unannounced visit of the Care Quality Commission (CQC) to the York Hospital site on 14 and 15 January to inspect and re-rate Urgent and Emergency Care, and to review pathways as part of the wider York system; Mr Morritt explained that there had been some confusion over the nature of second inspection which was in fact an inspection to re-rate medical care; the CQC had subsequently issued an apology;
- the appointment of a new Managing Director for YTHFM: Mr Chris Norman would begin in post on 1 April;
- Star Award nominations.

8 Trust Strategy 2025-2030 "Towards Excellence"

Mr Morritt drew attention first to the summary paper which detailed the process by which the strategy had been developed. The final draft was now being presented to the Board for approval. A strategic scorecard would be developed, to be presented to the Board at its March meeting. Mr Morritt cautioned that, in approving the new strategy, the Board needed to be mindful of the evolving operating environment and as such the strategy would be reviewed annually.

Mr Morritt recommended the strategy to the Board of Directors for approval; directors were invited to send any minor amendments to content or format to Ms Brown after the meeting. There was a brief debate on the use of photographs in the document and on the process of communicating the new strategy to staff. It was noted that milestones for delivery of the strategy would be discussed at the Board Development Seminar in March.

The Board of Directors approved the Trust Strategy 2025-2030.

9 Quality Committee Report

Dr Boyd highlighted the key discussion points from the meeting of the Quality Committee on 21 January 2025:

- there had been discussion around the recent visit from the CQC; it was noted that there had been no immediate actions flagged during the visit;
- the senior leadership team from the Cancer, Specialist and Clinical Sciences (CSCS) Care Group had presented to the Committee and had highlighted new pathways in place for vulnerable patients to bypass Emergency Departments (EDs) and a concern regarding waiting times for Dermatology Services;
- the Deputy Director of Midwifery had reported the position against the Maternity Incentive Scheme safety actions and the Committee had reviewed the Maternity Section 31 submission;
- there had also been discussion around support for perinatal mental health; the Committee had been informed that Trust capacity was stretched in the context of an increasing number of referrals and there were long waiting times for the Mental Health Trust services; support from the ICB had been sought;
- there had been discussion about the Mid-Year Complaints report, particularly around the recurring theme of poor staff attitudes.

Mr Barkley commented that the fragility of the Dermatology service was concerning especially with regard to the significant gap between demand and capacity, although it was noted that solutions to the current issues were being explored.

10 Resources Committee Report

Mr Dillon provided a verbal report of the key discussion points from the meeting of the Resources Committee on 21 January 2025:

- performance in Urgent and Emergency Care was a focus of the meeting, with discussions around the targets set, for example, for 12 hour trolley waits which seemed unrealistic given the current level; Mr Barkley noted that the number in December was lower than that of the same period in 2023 but was clearly still unacceptable;
- there had been a reduction in the number of patients with No Criteria to Reside;
- the Cost Efficiency Programme was forecast to result in £40m in savings in 2024/25 which was an outstanding achievement but not sufficient to meet the target;
- the Trust had attained Level 4 in erostering, from Level 0 twelve months ago; this had resulted in significant savings in addition to benefits for patients and staff;
- there had been 350 graduates from the Health Care Academy and existing staff were also now being offered opportunities to benefit from the Academy's courses; retention rates of Health Care Support Workers had improved significantly.

Mrs Parkes noted that the impact of the Health Care Academy should not be underestimated: it provided firm foundations for new employees and resulted in improvements in quality.

Miss McMeekin clarified that the Level 4 attainment in erostering related to inpatient nursing staff; work was in progress to roll out erostering across the organisation.

11 Group Audit Committee Report

Mrs McAleese reported that the Group Audit Committee had met on 10 December 2024. The Committee recommended the corporate documents under Item 19 to the Board for approval. In relation to the regular review of the Board Assurance Framework, the Committee had discussed the number of areas in which the Trust was operating beyond its current risk appetite. The Committee recommended that the Board allocate time to discussing risk scores in context of the Board Assurance Framework.

12 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Mr Barkley noted that the number of patients waiting over 65 weeks had increased since September. Ms Hansen responded that this number was within the trajectory submitted to NHS England and that an increase in December in the number of patients waiting was not unexpected, due to the Christmas and New Year Bank Holidays. She added that NHS England was now not expecting the number to be zero at 31 March 2025. Mr Barkley asked if there were any specialities with more patients waiting longer than others. Ms Hansen explained that Neurology was particularly stretched but work was ongoing to support the service with new strategies. Neurology was an under pressure service nationally so the Trust could not look to system partners for support. Other services with small numbers of patients waiting over 65 weeks were Cardiology and Gastroenterology.

Mr Barkley queried whether the target metric for Emergency Care Attendance should be in the TPR. Ms Hansen responded that these metrics were needed for reporting purposes. Ms Grantham noted that strategies to manage attendances at Emergency Departments were discussed at length by the Resources Committee.

Mr Barkley asked Ms Hansen to send him the report on the timeliness of discharges which was referred to in the TPR.

Action: Ms Hansen

Mr Barkley requested that the Health Inequalities data on the average Referral to Treatment waiting times by Multiple Deprivation Quintile be checked for accuracy.

Action: Ms Hansen

In response to a question about waiting times for the Rapid Access Chest Pain clinic, Ms Hansen explained that workforce issues had led to a disparity in waiting times between the York and Scarborough sites. Recruitment was ongoing and job plans were also being reviewed. Ms Hansen would circulate the action plan.

Action: Ms Hansen

There was discussion on the metric for first outpatient appointments. Ms Hansen observed that she had no concerns.

Ms Hansen agreed to investigate the reason why the outsourcing of diagnostics led to longer reporting times than in-house diagnostics.

Action: Ms Hansen

Mr Barkley referred to the Diagnostics scorecard and queried whether the longer waits for the Audiology service were due to high patient numbers. Ms Hansen agreed that this was the case, as Audiology was a challenged specialty across the ICB; improvement plans were in place. This was also the case for Urodynamics. Ms Hansen advised that medical specialty workforce reviews were being undertaken to support improvement.

Mr Barkley highlighted the low occupation of virtual ward beds and questioned whether this service was of value to the Trust. Ms Hansen explained that the virtual ward beds were usually full by the end of each day: the timing of the reporting showed lower occupancy. It was noted that research demonstrated that virtual wards were more expensive to operate and did not guarantee better outcomes for patients. Use of virtual ward beds was, however, vital when hospitals had no available space to open an extra ward.

In response to Dr Boyd's question, Ms Hansen explained that the Community Response Team was being stretched by competing demands on the service. This was being discussed as a system issue.

Quality and Safety

Mrs Parkes highlighted that rates of *C.difficile* infections had been within the trajectory in December which, given the high number of patients, was a positive outcome. Care Groups had now established Infection Prevention and Control meetings, focussed on using data to drive improvement.

Maternity

Mrs Parkes advised that she had asked for the metric for the percentage of women smoking at the time of delivery at Scarborough Hospital to be investigated, as it did not seem accurate.

Workforce

Ms Charge noted that staff sickness absence resulting from colds and flu had risen significantly, which was very likely to be linked to the disappointing uptake of the flu vaccine. She questioned what could be done to improve take-up rates next winter. Mrs Parkes commented that she had received feedback that too many peer vaccinators had been deployed and that fewer peer vaccinators focussed on encouraging uptake might be more successful. In response to a query, Miss McMeekin advised that there were no published benchmarks for vaccination uptake, but anecdotally the Trust was not an outlier regionally in its vaccination rates. Mr Morritt observed that there was likely to be a response at a national level, given the significant reduction in vaccination rates, which was also reflected in the community.

Mr Barkley queried the number of administrative bank shifts undertaken in December. Miss McMeekin noted that the number had decreased from November and clarified that these were not agency shifts. The use of bank staff would continue to be monitored. Ms Hansen added that bank staff were being deployed to undertake extra work, for example, around Referral to Treatment waiting extra lists.

Digital and Information Services

Mr Barkley was concerned that the number of calls to the Service Desk which had been abandoned was high at 25% of the total number of calls.

In response to a question, Mr Hawkins outlined the reasons for the P1 incidents which had occurred in December.

Finance

Mr Bertram reported that, at Month 9, there was a £14m deficit against a planned deficit of £5m, so the Trust was £9m adrift of plan. This reflected the trajectory which would lead to a year end deficit of £23.7m. The ICB was forecasting a deficit of around £50m but had not invoked NHS England's Protocol, pending further discussions around available resources and cost cutting measures. The Trust was required to support recovery work by not spending outside of its budget and by making every effort to effect further savings. Mr Bertram advised that a further £2.3m of savings had been identified by Care Groups.

Mr Bertram reported that Elective Recovery Fund (ERF) activity was 121% of the 2019/20 baseline activity and income for the year was forecast to be c£21m. However, the ERF would be frozen as of mid-February for all activity from April to December 2024.

Mr Bertram highlighted that agency spend was at 2.9% of the Trust's overall pay bill in Month 9; the Trust had sustained a position below the cap of 3.2% for a number of months which was very positive. The Trust was also forecasting a £40m saving overall, driven by the Cost Efficiency Programme; around half of this total was recurrent savings. This was excellent performance but well short of the £53.3m efficiency target. Mr Bertram advised that the Trust was unlikely to need to request cash support this financial year.

In response to a query, Mr Bertram confirmed that the shortfall from the pay award funding would be around £1.6m.

Mr Barkley questioned why the Surgery Care Group was reporting a negative variance in part resulting from Resident Doctors on rotas over substantive budgets. Mr Bertram explained that this related to unfunded posts which were not in establishment. He agreed that this issue needed to be addressed through tighter financial governance. Miss McMeekin noted that not following Standing Financial Instructions could well be viewed as potential misconduct.

13 Equality Delivery System (EDS) Report

Ms Golding presented the report. She observed that implementing the requirements of the Equality Delivery System (EDS) had been challenging but would be ultimately worthwhile in its positive impact. She referred to the services chosen under Domain 1 *Commissioned or provided services* of the EDS and noted that there was no guidance on improving services which were underperforming under the EDS. Improvement would be led by service leads through plans which were locally developed and implemented.

Mr Barkley noted that, according to the report, significant improvement was needed under Domain 2 *Workforce health and well-being* and asked what form this would take. Ms Golding responded that more engagement was needed from the relevant staff networks; also, it would take time for the improvement actions in place to be fully embedded and take effect.

It was noted that the EDS report had been reviewed by the Resources Committee. It was agreed that the Committee would be kept apprised of the progress of the EDS action plans.

Action: Miss McMeekin

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

14 Maternity and Neonatal Report (including CQC Section 31 Update)

Ms Wells-Munro presented the report and highlighted:

- there had sadly been one antenatal stillbirth in November 2024, but no neonatal deaths;
- tragically there had been one maternal death in November; the Maternity and Neonatal Safety Investigation (MNSI) had begun and an After Action Review had been completed; the Trust continued to support the family and staff;
- a baby had been transferred out from Scarborough Hospital for therapeutic cooling; the case had been referred to the MNSI and an After Action Review and Duty of Candour had been undertaken; Ms Wells-Munro outlined the immediate actions put in place following this incident;
- the rate of postpartum haemorrhages (PPH) over 1500mls was 4.2% in November; Ms Wells-Munro referred to the metrics recorded in the Section 31 submission which showed that the Trust was not an outlier but would continue to make efforts to improve its position;
- there was improved compliance in Element 2 of the Saving Babies Lives Care Bundle Version 3;
- the CQC Maternity Services 2024 survey was published in December 2024 and showed an improvement from 2023; women were still reporting good support from the Trust's Midwifery Perinatal Mental Health Team despite capacity issues;
- efforts were being made to support the Mental Health Team and clinical supervision had now been secured;
- issues around GPs prescribing medications for pregnant women were becoming more prevalent; this had been escalated to the ICB by the Chief Pharmacist and mitigations were being put in place;
- work continued to review scrub nurse provision in maternity theatres with a view to reducing the number and investing instead in midwifery staffing;
- work continued to develop an action plan in response to the Perinatal Culture Score survey; the Board safety champions had commenced meetings with the Perinatal leadership team on a monthly basis;
- a visit from representatives of the Local Maternity and Neonatal System had been re-scheduled for 12 February.

Ms Wells-Munro referred to progress against the Maternity and Neonatal Single Improvement Plan which was detailed in the report, along with key achievements in December 2024. She highlighted that the Service did not have a substantive audit midwife which was a mandated post; this had been added to the Service risk register.

The Board approved the CQC Section 31 Update.

Ms Wells-Munro was thanked for her report, and she left the meeting.

15 CQC Inspection

<u>CQC inspection of York Hospital Emergency Department</u>
Mrs Parkes reported that the CQC had made an unannounced inspection on 14 and 15 January. There were two inspections, the first was to re-rate Urgent and Emergency Care pathways. The Trust was informed initially that the second was part of an informal review of patient pathways in the system, but after the inspection the Trust had been notified that this second inspection was in fact a re-rating of medical care. Mrs Parkes referred to the

letters received from the CQC, and the first response sent by the Trust. The second response letter would be shared after the meeting, as it was still being drafted at the time the meeting papers were published.

Action: Mrs Parkes

Mrs Parkes advised that no concerns had been raised by CQC inspectors during the inspections. Staff who they had spoken with had communicated the improvement work which was in progress and had managed these interactions well, given the operational pressures which they were under at the time. Mrs Parkes advised that the CQC had given no timeline for the report and her team were currently working through a large volume of data requests. The Board noted the change in CQC processes under its new inspection framework and the increase in requests for data. Mrs Parkes underlined that the Trust's relationship with CQC was open and transparent.

16 Mid-Year Complaints Report

Mrs Parkes presented the report, noting that communication was a core element of the Trust-wide improvement plan for patient experience and engagement.

Mr Barkley highlighted the timeliness of responses to complaints, which needed to be improved. Mrs Parkes responded that the policy had only just been amended and needed to be fully embedded to effect improvement in response rates. She reported that there had been some reduction in the number of complaints more recently and that Care Groups were working hard to improve the speed and the quality of responses. The average response time was reducing and most only just breached the 30 day deadline which was a significant improvement from a year ago.

It was noted that the report referred to complaints received from April to September 2024 and that it would be more valuable for the Board to receive more timely information.

Ms Grantham questioned whether staff were held to account if they exhibited an unprofessional attitude, which was a theme of a large number of complaints. Mrs Parkes explained how individual cases were managed. In addition she commented that one of the roles of Care Groups leaders was to set expectations and hold staff to account. She noted also that compassion shown to patients and families was often challenged in periods of high operational pressures.

Mrs Parkes was asked to confirm that the problems with the Head and Neck Service phone line were now resolved.

Action: Mrs Parkes

17 CT Mobile Scanner to Support Lung Screening Rollout Business Case

Ms Hansen presented the Business Case and advised that the Trust had been offered capital funds by NHS England to purchase a CT Mobile Scanner to support the rollout of targeted lung health checks.

The Board approved the Business Case.

18 Quarter 3 2024/25 Updated Board Assurance Framework

The Board received the Quarter 3 Board Assurance Framework.

Mrs McAleese drew attention to the risk scores which were outside of the Board's risk appetite. There was further discussion around risks PR6a *Failure to deliver financial balance to deliver the 2024/25 annual plan of the Trust's Strategy 2025-30* and PR1 *Inability to provide consistently effective clinical pathways leading to poor outcomes, experience and possible harm.* It was agreed that there were reasons for the target risk score being outside the Board's risk appetite and target risk scores would be reviewed in next year's Board Assurance Framework. It was agreed that a Board seminar session should be dedicated to a discussion on risk appetite.

Action: Mr Taylor

19 Corporate Governance Framework

It was noted that the Summary of Delegated Authority in the Reservation of Powers and Scheme of Delegation document mandated that expenditure should be within agreed budgets. It was suggested that procurement threshold amounts should be consistent throughout the document.

The Board of Directors approved the amendments to:

- **the Trust Constitution**
- **the Scheme of Reservation and Delegation**
- **the Standing Financial Instructions.**

20 Questions from the public received in advance of the meeting

There were no questions from members of the public.

21 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 26 February 2025 at Scarborough Hospital.

Item 5

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 26	25-Sep-24	5	Matters arising/action log	Include in the TPR unvalidated data on operations cancelled on or after the day of admission.	Chief Digital and Information Officer	Update 23.10.24: This would be included in the next version of the TPR to be presented to the Board in November. Update 27.11.24: Mr Hawkins advised that his team were working with Care Group colleagues to determine a method to represent this data in the TPR. The due date was deferred to January. Update 29.01.25: Mr Hawkins advised that his team were working to align the methodology for calculating this metric with that of NHS England, to be introduced in a new version of the TPR in the spring. The due date was amended to May.	May 25 from Oct 24	Amber
BoD Pub 45	29-Jan-25	12	Trust Priorities Report	Send Mr Barkley the report on the timeliness of discharges which was referred to in the TPR	Chief Operating Officer		Feb-25	Green
BoD Pub 46	29-Jan-25	12	Trust Priorities Report	Check that the Health Inequalities data on the average Referral to Treatment waiting times by Multiple Deprivation Quintile is accurate	Chief Operating Officer		Feb-25	Green
BoD Pub 47	29-Jan-25	12	Trust Priorities Report	Circulate the action plan for improvement in waiting times for the Rapid Access Chest Pain clinic	Chief Operating Officer		Feb-25	Green
BoD Pub 48	29-Jan-25	12	Trust Priorities Report	Investigate the reason why the outsourcing of diagnostics leads to longer reporting times than in-house diagnostics	Chief Operating Officer		Feb-25	Green
BoD Pub 49	29-Jan-25	13	Equality Delivery System Report	Keep the Resources Committee apprised of the progress of the EDS action plans.	Director of Workforce and OD		May-25	Green
BoD Pub 50	29-Jan-25	15	CQC Inspection	Share the second response letter to the CQC after the meeting.	Chief Nurse		Feb-25	Green
BoD Pub 51	29-Jan-25	16	Mid-Year Complaints Report	Confirm that the problems with the Head and Neck Service phone line are now resolved.	Chief Nurse		Feb-25	Green
BoD Pub 52	29-Jan-25	18	Quarter 3 2024/25 Updated Board Assurance Framework	Progress the use of a Board development seminar for a Board discussion on risk appetite.	Associate Director of Corporate Governance		Feb-25	Green

Report to:	Board of Directors
Date of Meeting:	26 February 2025
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 ☒ A Regulatory Requirement ☐

Trust Objectives

- ☒ Timely, responsive, accessible care
- ☒ Great place to work, learn and thrive
- ☒ Work together with partners
- ☒ Research, innovation and transformation
- ☒ Deliver healthcare today without compromising the health of future generations
- ☒ Effective governance and sound finance

Board Assurance Framework

- ☒ Quality Standards
- ☒ Workforce
- ☒ Safety Standards
- ☒ Financial
- ☒ Performance Targets
- ☒ DIS Service Standards
- ☒ Integrated Care System
- ☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

For the Board of Directors to note the report.

Report Exempt from Public Disclosure No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History Board of Directors only		
Meeting	**Date**	**Outcome/Recommendation**
Board of Directors	26 February 2025	

Chair's Report to the Board – February 2025

1. I have continued to visit various wards and services at Bridlington, York and Scarborough Hospitals as well as three services at the LNER stadium and the Trust's Healthcare Academy. Through conversations with colleagues during these visits I pick up valuable insight and issues which I share with relevant Executive Directors as appropriate

2. Paula Gardner has completed her attachment with us as part of the Insight programme. Along with the Chief Executive we will have an informal meeting with another candidate we have received from Gatenby Sanderson, again as part of the Insight programme.

3. With the Chief Executive we attended a meeting of the Humber & North Yorkshire System Chairs and Chief Executives at which the key topics were the end of year likely position (31st March 2025), and the plans and obligations required for 2025/26 year.

4. I spent a day as part of a two person panel interviewing five NEDs who have applied to join the NHSE Aspiring Chairs development programme with the aim of identifying those who are ready to be part of the programme.

5. I have continued to have 121 meetings with various colleagues including shadowing a Clinical Director.

Martin Barkley
Trust Chair

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 February 2025
Subject:	Chief Executive's Report
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Simon Morritt, Chief Executive

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ A Regulatory Requirement ☐

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- ☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

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	**Date**	**Outcome/Recommendation**

Chief Executive's Report

1. Planning guidance for 2025/26

NHS England's Operational Priorities and Planning Guidance for 2025/26 was published on 30 January.

The overall number of national priorities has reduced, and are as follows:

- reducing the time people wait for elective care.
- improving A&E waiting times and ambulance response times.
- improving patients' experience and access to general practice and urgent dental care.
- improving patient flow through mental health crisis and acute pathways, and improving access to children and young people's mental health services.

The key priorities in the guidance are:

- Improving health outcomes for all patients: ensuring better health and wellbeing.
- Enhancing patient experience: making services more accessible and patient-centred.
- Sustainable services: ensuring that health services can meet the needs of the population both now and in the future is crucial.
- Collaborative approaches: collaboration between health and local authorities is essential to address social determinants and improve community health.

In delivering on these priorities, partners must work together to:

- Drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future. ICBs and providers must focus on reducing demand through the development of Neighbourhood Health Service Models, making full use of digital tools to drive the shift from analogue to digital and addressing inequalities with a shift towards secondary prevention.
- Live within the budget allocated, reducing waste and improving productivity.
- Maintain our collective focus on overall quality and safety, paying particular attention to challenged and fragile services including maternity and neonatal services, delivering the key actions of the 'three year delivery plan', and continuing to address variation in access, experience and outcomes.

Specifically on elective care, cancer and urgent care, the requirements are:

- To reduce the wait for elective care, ensuring 65% of patients receive elective treatment within 18 weeks by March 2026, with each trust delivering a minimum 5% improvement.
- For cancer, systems should aim for 75% compliance with the 62-day diagnosis standard and 80% with the 28-day Faster Diagnosis Standard by March 2026.
- To improve A&E waiting times and ambulance response times compared to 2024/25.
- By March 2026, at least 78% of patients should be seen within four hours in A&E. Category 2 ambulance response times should average no more than 30 minutes throughout 2025/26.

For the first time there is explicit reference to the potential need for difficult decisions to be made in relation to reducing or stopping activity in order to live within our means as a system, and that local leaders will be supported by NHS England the Government in doing so. This is a reflection of the continuing pressures on NHS finances.

There is also a requirement to reduce unwarranted variation and maximise productivity and efficiency, and we are working with clinical and corporate teams to explore potential opportunities based on benchmark data.

Our teams have been working incredibly hard to develop our plan, balancing finance, workforce and operational activity and performance. Our draft plans have now been submitted to the ICB, and final plans are expected to be submitted in mid-March.

The guidance and supporting documents have been published on NHS England's website.

2. Anti-racism steering group established

An Anti-racism Steering Group has been established for our Trust, holding its inaugural meeting last month.

This group, which I chair, has been established to prioritise anti-racism and give a focus to the Trust's work on eradicating racism in our workplace, whether that comes from colleagues or patients. If we are to deliver on our priority of creating a workplace where everyone feels safe and welcome, then it is absolutely critical that we take meaningful action to tackle racism and deal with concerns appropriately.

3. Star Award nominations

Our monthly Star Awards are an opportunity for patients or colleagues to recognise individuals or teams who have made a difference by demonstrating our values of kindness, openness, and excellence through their actions. It is fantastic to see the nominations coming in every month in such high numbers, and I know that staff are always appreciative when someone takes the time to nominate them. February's nominations are in **Appendix 1**.

Date: 26 February 2025

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

February 2025

Anoop Mathew, Staff Nurse **Scarborough** **Nominated by colleague**

Anoop is one of a kind; nothing is ever to much trouble for him. He always gets stuck in and helps others when they are struggling. Anoop is newly qualified and shows enthusiasm to learn. He is a pleasure to work with.

Ellen Womersley, Advanced Practitioner Sonographer **York** **Nominated by patient**

We have seen Ellie twice in short succession and both times the care shown has been wonderful. The first was during an early pregnancy scan due to a scare. She was calming, kind, and genuinely happy for us once the outcome was confirmed as positive. The way she spoke showed she understood how we were feeling at the time and was extremely empathetic. We returned for our 12-week scan, and she once again showed incredible care and warmth and genuinely shared our joy.

Lynne Jackson and Claire Wise, Gynaecology Clinical Nurse Specialists **York** **Nominated by colleague**

We are experiencing difficult times in the Gynae Oncology department. Lynne and Claire have gone the extra mile in helping review clinics and speaking to and seeing patients. Their experience and in-depth knowledge of the patients has been highly valuable. Even though Lynne and Claire have a split role between surgery pathway and oncology pathways, they have been very supportive of the oncology teams, making themselves available for regular meetings and catch ups. I and the wider team really appreciate all the hard work and dedication they have to their role.

Sandra Brown, Audio Typist **York** **Nominated by colleague**

Sandra is always thorough with her work and goes out of her way to help anyone. She is meticulous with detail and takes great care to provide a positive experience to all our patients, going the extra mile when needed. She consistently works overtime to provide secretarial support to the team and always has a cheery demeanour. The team would be lost without her!

Christopher Page, ST3-ST8 **York** **Nominated by colleague**

Chris has gone above and beyond to support our on-call service since rotating to York Hospital in September 2024. Chris cancelled his plans over Christmas to ensure that the service was covered by working extra on the evening of Christmas Eve after his standard day, as well as working a long day on Christmas Day. Since this, he has stayed at work to cover multiple evening gaps.

Chris has shown a huge commitment to his job ensuring that patients are cared for and the service is covered safely. Not only this, but Chris also agrees to swap duties last minute to ensure that clinics are covered, and patients are seen. Thank you, Chris, for your dedication and flexibility recently, it really is appreciated.

Chemotherapy Department **York** **Nominated by colleague**

A couple of weeks ago, there was a serious medical emergency in the waiting room and the whole team, including haematology, chemo nurses, acute oncology, front desk receptionists, coordinators, HCAs, and doctors, were involved in helping this patient. Everyone played a part in helping this patient whether it was physically helping the patient come round and cannulating them under pressure, waiting at the end of the corridor for the Medical Emergency Team, or moving the other patients calmly out of the waiting room. Everyone communicated well in a difficult situation, and we all made sure each other were ok.

The team is a great department because individually they all have their own pressures, but as a team come together when they need to for the service of the Chemotherapy department. While this emergency was on going, the non-clinical colleagues also made sure the patients from the waiting room who witnessed it happening were OK, which I thought was so lovely and good of them, they were excellent, kind, and empathetic.

It was a tough couple of hours but even once the medical emergency team came, everyone worked together to get the waiting room back to normal and to carry on the flow of service as amazingly as it normally does. I want to say the biggest thank you to being a part of the team and I could not be prouder to work alongside them all!

East Coast Trauma and Orthopaedics **Scarborough** **Nominated by colleague**

I joined the team in November 2024, but it feels like I have been in the team for years because all members of the team have been so kind and supportive. They are always willing to help and answer my questions. Their unwavering commitment to excellence has had a profound impact on me. They made settling into my new role so easy and smooth. It is a privilege to work alongside such talented and compassionate individuals who not only strive for success, but also uplift and support each other along the way.

Helen Hope, Sister **York** **Nominated by patient**

Helen looked after me when I was having a miscarriage. Like many patients in hospital, we were in a situation we never wanted to be in. We did not know what to expect, and it often felt like decisions were being made quickly and were out of my control. In a busy and confusing department, while inevitably juggling several cases, Helen was unfailingly kind. She took the time to find me and my husband space to be on our own while processing difficult news, so we did not have to sit in a busy waiting room full of expectant mothers and was sympathetic to the situation we were in.

Helen was open and kept us updated so that we knew what we were waiting for, what needed to happen next, and were able to discuss decisions we were likely to have to make so that we could be prepared for these discussions with the doctors. She took time to listen to our concerns and championed our preferences when decisions were being made about my care, while still being realistic and open with us about the safety nets that needed to be in place and concerns the clinical team had.

Even on busy days, Helen always called if she said she was going to call. At a time of profound sadness, Helen's excellent, compassionate, and attentive care made a real and meaningful difference to us.

Robert Wotherspoon, Consultant **Scarborough** **Nominated by patient**

I attended an appointment this morning at Scarborough Hospital, and it was a worry for me for a couple of weeks. Dr Wotherspoon put me at ease straight away with his lovely manner and I felt relaxed in his care. He explained everything to me in a relaxed and friendly manner and I was impressed with his professionalism. A very nice man. Thank You.

Katie Smallwood, Administrative Assistant **York** **Nominated by colleague**

I had a parking issue this morning due to admin error regarding my number plate and that my contract banding had changed. The issue was that my Trust parking app was showing my car as owing a parking charge, which worried me. Katie was amazing at every turn, correcting the error on my file, making sure my permit and banding was up to date.

Katie demonstrated Trust values throughout by going that extra mile to put my mind at ease, demonstrating kindness in the email correspondence, and showing the excellence in the job she is in. I can imagine it is a demanding job, dealing with unhappy staff and visitors to the hospital who have parking issues. A little thank you goes along way, and I think Katie is truly deserving of a mention.

Same Day Emergency Care **York** **Nominated by patient**

Such a friendly, energised, and professional team! Every member of staff I came in contact with had a smile and a kind word, and it was lovely to hear staff laughing together. My medical treatment was adeptly done, and I always knew what was going on. I felt safe and heard, which are such important things.

I specifically remember nurses Joshua and Kinga, although many others were involved in my care. HCAs, doctors and students, the housekeeper, and reception were all so nice. Wendy and Elaine who, amongst many other things, looked after us with drinks and snacks, radiate kindness and compassion. It is not an easy ward to be a patient on, busy and not the comfiest chairs, but the staff are first rate. Thank you so incredibly much for looking after me, I am grateful.

Emme Dalton, Healthcare Assistant **Scarborough** **Nominated by relative**

Emme took her time to go the extra mile for a patient who was extremely confused but took comfort in Emme's presence.

Vivian Anakwenze, ST3-ST8, and Debbie Bargewell, Staff Nurse **York** **Nominated by relative**

Late at night, my sister and I drove from Scarborough Hospital to York Hospital with our other sister. She had a serious problem with her left eye. Vivian and Debbie were amazing with all of us. They had stayed late because of the seriousness of my sister's eye. They both went above and beyond, and we would like to thank them for their amazing treatment and how they made us all feel.

Blood Sciences **Hull** **Nominated by colleague**

On New Years Day, the Transfusion Department at Hull Royal Infirmary began this year with a MAJAX (Major Incident/Accident) call at just past 2AM. The staff on the night shift (Angela McClean and Charmaine Mariano) were quick to prioritise the oncoming traumas and follow the local policy for MAJAX. The Duty Manager (Alex Clubley) came in to work, as did additional BMS staff members (Hannah Bridge) to assist with the MAJAX.

This is a unique situation that we have not seen the like of in years within the department. The MAJAX activation began with a potential of eight patients being received into the hospital with a need for blood transfusions and a potential for multiple massive haemorrhage activations. Angela and Charmaine had to order in additional stock from NHSBT Barnsley on a blue light request.

The two MLA staff members on overnight (Paul Glover and Dean Aves) did an amazing job as well making sure to keep the reception area of the laboratory running while prioritising anything that the transfusion department required, including heading across to the first floor to help a clinical staff member get into the BSU to access emergency O negative RBCs. They also did all this in heavy rain! By the time the situation had been thoroughly assessed and the patients were on site, minimal blood components were ultimately required. The MAJAX was stood down and all issued emergency units were returned to stock.

This has been a learning experience for all involved, but the transfusion department wants to formally congratulate and thank all the staff that were on site (or came in to work at 3am on New Year's Day) for their incredible hard work and dedication.

Richard Booth, End User Compute Engineer **York** **Nominated by colleague**

I am delighted to submit this Star Award nomination for Rich, a colleague who consistently goes above and beyond to assist those around him. Since joining the DIS team and working alongside Rich, I could have nominated him every month without fail, as he consistently demonstrates the Trust values of kindness, openness, and excellence, even during stressful times.

This nomination stems from yet another instance of Rich's exceptional support. I had been grappling with a recurring IT issue for weeks, which had already undergone every attempted fix at my and my colleagues' disposal, to no avail. Unable to resolve the issue, I had to resort to varied, time-consuming workarounds each morning, which became a significant source of stress. After arriving early for his busy day ahead, Rich took the time to assist me before his workday began. He carefully listened to all the information I had on the previous attempts to resolve the issue and, drawing on his years of experience, identified the source of the problem. Rich successfully fixed the issue, eliminating the need for the lengthy morning workarounds, for which I am immensely grateful.

Rich has been instrumental in my training since my first day in DIS. Despite recent team and role changes, he continues to provide invaluable support to our colleagues and me. Rich exemplifies kindness, openness, and excellence, regularly offering help, support, and encouragement to all. He remains eager to assist where possible, even when faced with inquiries outside of his job description, team staffing and workload pressures, and my never-ending questions during training or assistance. Rich has been pivotal in setting me up for success in both my previous and current roles within DIS, sharing his knowledge and challenging me to think in different ways to get to the root of problems.

Electrical Services Team **York** **Nominated by colleague**

Day in and day out, the Estates team across the Trust work tirelessly to keep our buildings and services operational as best as possible with the limited resources and budgets they have, with their work often not acknowledged or understood.

I would like to nominate the Electrical Services Team in York for the action in dealing with a small electrical fire in York Hospital. Quickly seeing the fire, Dave and his team dropped everything and quite literally faced the fire head on. They made the area safe and shut down the power, stopping the fire. After dealing with the fire brigade, working with myself, all senior leads were called to an emergency meeting while the Electrical Services Team continued working in parallel to assess the cause of the fire, do additional checks, and rectify the problem within a matter of hours, when it could have easily taken more than a day.

The sheer professionalism and calm approach by Dave and his team demonstrated in what can only be described as one of the most challenging situations any of us could have faced and putting a successful solution place, where initially being faced with a fire, is highly commendable and at least deserving of a Star Award. Without their quick action and troubleshooting, the situation could have been significantly worse, but the speed in which they put a solution in place meant clinical and other services were not as impacted as much as they could have so easily have been.

For me and other senior officers, they truly demonstrated the Trust values, showing true excellence and selflessness.

Melissa Cammish, Healthcare Support Worker **Scarborough** **Nominated by colleague**

Melissa greeted a new patient that was transferred onto the ward by saying, "Welcome to Cherry Ward, my name is Melissa and if you need anything, please let me know". I felt this was such an exemplary way to greet a new patient to the ward and very welcoming. The ward was extremely busy on that day, but this did not deter Melissa from being polite, kind, and welcoming. Melissa also made sure that the lady was provided with a table and a drink almost straight away.

ID & Car Parking **York** **Nominated by colleague**

Much maligned and overlooked, the team on duty on 22 January 2025 were kind, helpful, and supportive to me following a road traffic collision. They calmly and effectively reorganised car park access for my hire car so I could get back to work as soon as possible. This meant I had one less thing to worry about, which made a huge difference.

There are many overlooked teams who go above and beyond to keep the Trust running, and these staff should be recognised.

Martin Sainty, Palliative Care Clinical Nurse Specialist	**York**	**Nominated by colleague**

Martin Sainty is an exceptional team leader for the palliative care team at York Hospital and goes above and beyond to benefit his team and patients. He epitomises excellent leadership, being kind, clear, and full of knowledge. No question is ever too small or big to ask him, which helps his team grow in confidence, and his patients get the best care. Additionally, he treats colleagues equally and with fairness, leading to an excellent dynamic in the team. He prioritises staff welfare, through his open nature, kindness, and understanding of people's personal situations. He is open to supporting those with personal issues and will go above and beyond to try to support them at work through difficult times.

Martin is a fantastic representative of the service to external teams and constantly works towards improving the service we provide. Thank you, Martin, for everything you do!

Alexandra Dexter, Specialist Midwife	**York**	**Nominated by colleague**

Alex has worked hard to support multi-disciplinary training. She was central to helping put this package together despite incredible pressures.

Kim Hartnett, Bereavement Midwife	**Scarborough**	**Nominated by colleague**

Kim worked hard to put together important training for the Maternity team with little notice. She is incredibly devoted to her role in bereavement, and not only is her knowledge something to be admired, but also her endless compassion and kindness. Scarborough are so blessed to have her.

Emma McDonnell, Senior Healthcare Assistant, Tara Kadis, Lead Diabetes Specialist Nurse, and Joanne Gill, Diabetes Nurse Specialist **York** **Nominated by patient**

I am nominating Emma McDonnell, Tara Kadis, and Joanne Gill for star awards for their outstanding and life-changing support throughout my journey as a Type 1 diabetic.

From the moment I was diagnosed and struggling to come to terms with the changes in my life, these incredible individuals have been by my side every step of the way. Their unwavering patience, compassion, and encouragement gave me the confidence to reclaim my life. They provide not only medical guidance, but also emotional and psychological support, ensuring I never felt alone on this challenging path. Thanks to their dedication, I have been able to find a new sense of normality and purpose. I understand that some of my needs and challenges are time-consuming, but throughout my time, I have never felt that as if I was a pain and taking up their time.

Their impact has been so profound that I have been inspired to pursue a psychology degree with the ambition of becoming a clinical psychologist to help others, just as they have helped me. They did not just help me manage my diabetes, they gave me back my confidence, my independence, and my hope for the future. I start my degree this month and I really hope that, in the future, our paths will cross as NHS professionals. These three individuals are shining examples of the absolute best the NHS has to offer, and I cannot think of anyone more deserving of this recognition.

Maternity Education Team **York** **Nominated by colleague**

I would like to nominate my team: Charlotte Copson, Rosie Chapman, Rachel Collins, Rachel McCormack, Lois Bennet, and Kelly Ann Dobbin. I am always grateful to be in such a supportive team. They all know exactly what to say to an endless and varied list of complaints or concerns. They are kind and compassionate and think not only of our small team, but of the wider maternity/neonatal family, including a host of other specialities.

New annual training starts every January, and it can feel that the festive period is taken over by simulation prep and navigating the hurdles of acquiring faculty, space, and equipment. We eat sleep and breathe training prep for months before we even start to deliver it and the stress at times can be overwhelming, causing niggling night-time ear worms. I had a difficult year last year and I have felt nothing but love and support from these people. I think at times they have had to carry me despite their own heavy loads, and I am forever grateful.

After the first week of training, which has been accompanied by inevitable tweaks as well as emotional exhaustion, I wanted them to know how well they have done, how proud of them I am, and how appreciated all their work, support, and devotion to the safety of our families is. What a team!

Lucy Nicholson, Pump and Education Administrator **York** **Nominated by colleague**

While the whole Diabetes Team are excellent and always give their all at work, Lucy deserves a special mention. Lucy works as our Pump and Education Administrator. She is amazing at dealing with all the healthcare professional and patient requests that come through and she always responds in a timely and friendly manner, even though it feels overwhelming at times.

Lucy's organisation skills are second to none and she ensures that all education sessions, virtual and face-to-face, are arranged and facilitated smoothly, always being on hand for support as required. She has been responsible for submitting the recent National Diabetes Audit Insulin Pump data, which has been a huge body of work. She is also responsible for all the pump and CGM orders for York and Scarborough, which again is a massive undertaking.

Nothing is ever too much trouble for Lucy and the pump and education service would not run as effectively without her. She deserves a Star Award as a small token of our appreciation, along with a great big thank you for being amazing!

Operating Department Practitioners **York** **Nominated by colleague**

The Operating Department Practitioners (ODPs) at York are a passionate multiskilled team of dedicated individuals who constantly deliver unflustered highly skilled support across the Trust, where and when it is needed most. In venues such as delivery, surgery, anaesthetics, resuscitation and trauma, ODPs are often involved in dynamic situations where, despite the traumatic environments they encounter, they display resourcefulness, enthusiasm, professionalism, and the high level of care that the people of Yorkshire deserve.

The team deserves recognition for their openness, kindness, and excellent unstinting work that continues 24/7.

Williams Acholonu, Healthcare Support Worker **York** **Nominated by colleague**

I was unfortunate enough to have to attend ED in December with my mum. It was busy and there a wait to see a doctor. William came onto the night shift and straight away began making patients' drinks, offering sandwiches, and finding people seats. He was like a breath of fresh air and continued to do anything he could to ease the waiting times with a smile on his face, nothing was too much trouble. We watched as William assisted people to the toilet, reassured the waiting room that we would be seen eventually, and generally made sure everyone had what they needed while they sat and waited.

My mum suffers from a brain condition and William made this time much more bearable and was so kind and attentive to every patient in the department. He treated every single person as an individual, not just a number on the board, and went above and beyond his role despite the shift being busy and the department being understaffed. He truly is a credit to your Trust.

Marta Watson, Occupational Therapist | **Nelsons Court** | **Nominated by colleague**

Marta has demonstrated her commitment to her AHP team, wider MDT, and patients through her willingness to support numerous different wards while staffing has been particularly challenging throughout winter. On regular occasions, over a working week, she will be supporting four different wards on different sites. Marta does this without complaint, with a positive attitude, and with a smile on her face.

Marta has been supportive of her colleagues and demonstrates great team behaviours that we should all aspire to. Thank you, Marta!

Helen Harrison, Haemophilia Specialist Nurse | **York** | **Nominated by colleague**

The team have recently started using a different system for recording bone marrow procedures in the department, which has caused confusion and been difficult to adapt to. Having used this system before, Helen took the time to provide detailed screenshot instructions and to walk her colleagues through the easiest way to navigate this, saving the team a lot of time.

Helen stepped up (as she always does) and took responsibility for this issue when it was causing problems for the wider team. Without her help this could have been much more difficult to resolve.

Sarah Gallagher, Maternity Quality and Governance Lead | **York** | **Nominated by colleague**

I want to acknowledge how amazing my line manager, Sarah Gallagher, is. Despite being based on the opposite site to me and having her own work pressures, she is always present and visible to me (this has also been recognised by others not in our team). She leads with the compassion, and nothing is ever too much hassle.

I was feeling overwhelmed with my workload, and she recognised something was not right and probed me about it. When I explained that I had a heavy workload, she came over straight away to look through it with me and help me prioritise and reallocate some of my work.

Sarah is always supportive of work issues and personal issues, and, thanks to her, I have completely and utterly fallen in love with my job role. I aspire to lead like her one day. Thank you, Sarah, you are a huge support and inspiration, and words will never be enough to explain how grateful I am for you.

Jennifer Ellis, Healthcare Assistant | **York** | **Nominated by colleague**

Jenny looks after patients with care and dignity. She goes above and beyond. She cared for a patient with learning disabilities with the upmost kindness in line with Trust values, caring for the patient as a person and providing person-centred care. She is an asset to the bank.

Katy Hogg, Healthcare Assistant | **White Cross Court** | **Nominated by colleague**

Katy looks after patients with care and dignity. She goes above and beyond. She cared for a patient with learning disabilities with the upmost kindness in line with Trust values, caring for the patient as a person and providing person-centred care. Katy often banks on the acute stroke unit and is an asset to the bank. She is a breath of fresh air; the kind of employee that sets an example, who you would want to care for you and who brings joy. She is an excellent team player.

Anthony Simpson, Charge Nurse | **Scarborough** | **Nominated by colleague**

Tony has gone out of his way to develop a survey to collect feedback for staff to help us make their experience better at work. He has done this with the intention of seeing if he can start any QI projects to help with staff wellbeing, resilience, and retention.

Marie Wilde, Staff Nurse | **Scarborough** | **Nominated by colleague**

Marie is a huge team player and supports all the staff on the unit. Colleagues say nothing is too much trouble for her and she will help anyone with anything. She shows kindness and compassion to patients, relatives, and colleagues alike. She is an asset to the team and is a role model for the Trust values. She is always positive and takes any opportunity to learn, support, and provide high standards of care.

Sheeba George, Deputy Sister | **Scarborough** | **Nominated by colleague**

Sheeba is a kind and compassionate leader. She is caring and put her heart and soul into everything she does. She is reflective and always aims to strides towards exceptional practice. She goes above and beyond for her patients and motivates staff by giving them patience, empathy, and the time they need to feel supported and cared for. Sheeba is a true role model for the Trust values. She is an exceptional nurse.

Zoe Lang, Clinical Educator | **Scarborough** | **Nominated by colleague**

Zoe is an inspirational role model for this Trust. She has shown such dedication for the critical care service, helping optimise standards, support for staff, the quality of care for patients. She is highly regarded by her team. She shows kindness, compassion, and empathy to her colleagues and supports the team going above and beyond to support their learning, wellbeing, resilience, and mental health. Her leadership has helped all bands within the nursing team. Zoe's hard work makes such a difference to critical care within the Trust, which has benefited both staff morale and the quality of care given to those critically unwell.

Zoe has put so much work towards the new critical care, QI projects, and the care given to patients. She has dedicated her time not only to Scarborough, but also supporting cross-site working, enhancing the education, service, and patient/relative experience for all. She is a true advocate for the Trust and critical care, and we are so proud to have her on our team! We are profoundly grateful and thankful for all that she does.

Christine Cosheril, Staff Nurse **Scarborough** **Nominated by colleague**

My elderly and frail mother had to attend for eye surgery. As Mum was unable to remember everything explained to her in the Outpatient Clinic several months before, she had been provided with information leaflets to read at home. As it happened, these were the wrong leaflets and led us to believe that Mum would be having a different surgical procedure to the one that was planned and consented to. Mum was extremely nervous. We discovered the error on the day of surgery during the admission process causing Mum's anxiety to increase significantly. Mum was afraid that she would have to lie flat for longer than she could manage, and that the position would induce coughing due to a chronic lung condition. Mum was embarrassed and upset believing the mistake was hers.

Chrissy admitted Mum. Chrissy recognised the problem and quickly worked to resolve mine and my Mum's anxieties, and to reassure my Mum that she had not done anything wrong. Chrissy spent time to listen to Mum and I and understand the situation from our perspective. She apologised for the systematic error in a kind and empathic way that put my Mum at ease, and Chrissy offered to take it up with the appropriate teams to prevent it happening to others. Chrissy then explained in detail the correct procedure that we were booked in for. She made it easy to understand for us both and was so friendly and warm that she soon won my Mum's trust. Although Chrissy had other duties to attend, she stayed with my Mum and ensured that Mum was settled. Chrissy offered to ask the surgeon to go through everything and re-consent Mum, but she had explained everything so well, that my Mum was happy to proceed.

Chrissy made accommodations for Mum's individual difficulties, listening specifically to Mum's anxieties to find ways to resolve them, for example about the change in atmospheric temperature in the theatre which may induce Mum's coughing, and her comfort whilst being laid for an extended period, and where Chrissy was unable to complete such accommodations personally, she ensured that others were aware.

The team on Willow Ward acted with kind and well-organised professionalism and are a credit to the Trust, but Chrissy went above and beyond, in listening and taking the time to understand an individual's personal anxiety and limitations, to resolve the anxieties and to ensure the safety and comfort of that individual. Mum and I are forever grateful. Thank you, Chrissy.

PACS Team **York** **Nominated by colleague**

The PACS team must receive hundreds of requests a week from various teams within the hospital, requesting scans to be sent from and received from here, there, and everywhere. The team work with pace and urgency, while never losing any politeness or professionalism, and I know we can always rely on them to get the job done. They send us updates on our transactions which is amazing as it means we can make sure that important images and reports have arrived in time for appointments. Super grateful for all their hard work!

Lisa Etherington, Administrative Assistant | **Bridlington** | **Nominated by relative**

Lisa is the best NHS receptionist I have come across in years. I was impressed in how she spoke to me as soon as I arrived at her desk. I was enquiring about the disabled parking system as I did not know how it worked. I had parked in a disabled bay and was displaying a Blue Badge but had then noticed a sign in a hospital corridor about cameras and asking disabled drivers to register their car registration number. I had not known what to do, so I enquired at reception.

Lisa was very pleasant, efficient, and professional. She went out of her way to explain the disabled parking arrangements which are in operation at hospitals in the York NHS area, making it clear it did not just operate at Bridlington. She imparted the information clearly and concisely.

I returned with the Blue Badge to register our vehicles, and she gave additional information at that point, about what to do in the event of changing vehicles or when renewing the Blue Badge. Lisa's help was very much appreciated, and her pleasant disposition brightened the day.

Sharon McDade, Waiting List Coordinator | **Scarborough** | **Nominated by colleague**

Sharon has always been a very thoughtful and skilled coordinator and have we have worked together to ensure our day case patients have a wrap-around care from start to finish.

In December, Sharon rang one of our elderly patients to ensure they were coming in for their procedure. The patient told her they would be spending the festive period and Christmas Day alone, they would be having a microwave meal for Christmas Dinner, and that they were incredibly lonely and often felt like giving up. We both had a similar conversation with him so set about thinking what to do for him, it was difficult as he lived quite far away, and services were limited due to Christmas.

I came to work the following day on Christmas Eve to a wonderful phone call from Sharon to say she had managed to contact a colleague and arranged for a Christmas food package and card to be delivered to the patient’s home address. The patient said, "This is one of the kindest things anyone has ever done for me".

Sharon is an absolute pleasure to work alongside and a true asset to the NHS. She constantly exemplifies Trust values, and for this she should be recognised.

Andrew Emmerson, Orthoptist | **Scarborough** | **Nominated by patient**

The whole department has been brilliant, but Andrew has gone out of his way in my time of need.

Elaine Dixon, Service Manager **Scarborough** **Nominated by colleague**

We recently had quite a complex complaint from a relative of a patient who had died unexpectedly at Scarborough Hospital. The patient was no local but had been on holiday locally. A comprehensive response was sent, but the relative was still unhappy and needed more answers. A meeting was therefore arranged with the relative and the Clinical Director, and Elaine was present to take notes of the discussion. Action points were agreed, and Elaine made sure that everything that was discussed was followed up so that lessons could be learnt by all the teams involved.

Elaine kept the relative updated and received the following response, which clearly demonstrates the compassion that Elaine shows and her dogged determination to make things better for our patients and their relatives:

"Thank you so much for the update and, to be honest, I think you have done more than I expected at this point. It is really comforting to us that it was taken seriously by all departments and that our experience will now benefit staff and patients in the future. EOL is not an easy situation for anyone, but those in healthcare recognising a deteriorating and dying patient efficiently can make such a significant impact on families and patients, especially when it happens suddenly. I am pleased that extra support and teaching for staff is now in place around this.

"I am grateful for how positive this process has been, and it has helped us come to terms with events and find some closure. I understand it was the cancer that caused my relative's death and not the hospital. I am pleased the hospital are prioritising being open and honest and am confident (through professional experience) that doctors and nurses having the difficult conversations early on will improve experiences for everyone involved in these cases. Thanks again for all your time and support through this and to all of you for meeting with me and listening."

I had further contact with the relative when asking for permission to share her response as part of this nomination, and she wanted to add this to her statement:

"Elaine has made an unexpected and painful experience a little bit easier for me and my family. I will be forever grateful for her caring, empathetic, and proactive attitude throughout. It is clear to me that Elaine is focused on improving patient and family experience at Scarborough Hospital which is all I can ask. I wish her all the best."

Georgia Bowlby, Staff Nurse **Community** **Nominated by colleague**

Georgia is an asset to our team. She is caring and patients are at the heart of everything she does. She goes above and beyond to see patients when they need extra support. Georgia goes the extra mile and works so hard, always with a wonderful attitude. It is such a privilege to work with Georgia, she is a wonderful nurse, and I feel lucky to be her colleague.

Bryony Alexander, Nursing Associate **Selby** **Nominated by colleague**

I am nominating Bryony as she has excelled with patient care and managed a difficult situation while supporting a deteriorating patient. She has shown compassion and empathy towards a patient in the last stages of life and given unprecedented care to both the patient and their family.

Bryony is a very valued member of our team and will always go the extra mile for both her patients and the team she works with. Nothing is ever too much trouble. She always demonstrates warmth and empathy within the team and is such an asset to our service. In her current role, she shows great flexibility and has a wealth of experience between the band 3 and 5 roles. Bryony is also willing to share her knowledge and experience with nursing students, supporting the nursing team.

High Dependency Unit **York** **Nominated by relative**

My mum was admitted to HDU via ED on 13 July and had to have emergency surgery for a trapped bowel. The operation was successful, but she deteriorated quickly, and she sadly passed away on 15 July.

We want to recognise the team who were looking after her. They always treated her with respect and care and were visibly shocked at the turn of events after the operation went well. We were allowed to be with her at all times, even though I am sure we were in the way. We had always promised my Mum that she would not be alone if such a situation arose, and we were able to fulfil this promise. The main nurse who looked after her, Ema, was brilliant, as were the other members of the nursing staff (sorry, I do not have all the names). The consultant on duty, I believe he was called Steve, was on duty the whole time and tried everything possible to stabilise her.

When we were told that there was nothing more that could be done, Ema managed the situation with respect and care, making sure all the family were able to be present and explaining what would happen. The gestures of the card for my dad and the knitted hearts for all the family were particularly lovely, and while the situation was distressing and upsetting, these kind tokens helped.

Joanne Hamilton, District Nurse **Community** **Nominated by colleague**

Jo is a credit to her team. We have been quite short-staffed with senior members recently, and Jo has worked tirelessly to keep the community service going. It has not gone unnoticed that she works extra hours every shift to ensure the smooth running of the department and never asks for anything in return. She never complains, always remains calm, and works above and beyond every day.

We would be totally lost without Jo, and recognition for her hard work is completely justified. Thank you, Jo, for keeping us afloat with your hard work and dedication. Keep up the hard work, but please remember to take some relaxation time for yourself, you deserve it.

Sarah York, Lead Nurse for Hysteroscopy and Colposcopy **York** **Nominated by patient**

I was anxious about my first colposcopy, but from the moment I walked into the room and met Sarah, she made me feel at ease and relaxed. She genuinely listened to my concerns, showed kindness and compassion, and offered reassurance. She explained what she was doing in a way that was easy to understand and made sure I had full control of the process to ensure my comfort. I am currently still too young to be offered smear tests, so did not know what to expect from colposcopy but I knew it was an appointment lots of women can fear or put off.

Because of Sarah's professionalism and kindness, I now have a positive experience of women's healthcare and will carry this throughout the future when it comes to booking my eventual appointments for smears. I will always remember her effortless ability to make me feel comfortable at my appointment.

Laura Wilkinson, Generic Support Worker **Selby** **Nominated by colleague**

Laura demonstrated great kindness and compassion when supporting a deteriorating patient and family. The patient was quite unwell, and Laura acted with professionalism and escalated quickly to a senior member of staff. She stayed with the patient and family for several hours to ensure they were well supported. She ensured the patient received the correct treatment and medical support. Laura used her expertise and compassion to give the patient and family such excellent care at a very difficult and overwhelming time.

Beth White, Speech and Language Therapy Assistant **York** **Nominated by colleague**

Beth is a new member of our team who has already demonstrated an ability to take the multiple demands of the role in her stride. She has a genuine interest in the speech and language therapy field and is already seeking opportunities for professional development.

I am nominating her for a Star Award as we recently had some significant challenges with staffing within our admin team due to sickness which was impacting on our ability to adequately support our training offer. Despite only recently starting with us and being busy building her own caseload, Beth was happy to get stuck in and help with managing the significant volume of email enquiries we receive about our training sessions. Thank you so much for all your help and hard work Beth!

Lucy Hogarth, Staff Nurse **Scarborough** **Nominated by colleague**

I worked my first bank shift as a nurse in more than 10 years, and Lucy was supportive, kind, and caring. She helped me understand the processes and routine of the ward and was a brilliant mentor for the shift. Her passion for her job was apparent and she has a keen eye for detail which really made a difference to the whole ward, both patients and staff, on that shift. It was a pleasure to work alongside her, and I was grateful for her support during the shift. Thank you, I am looking forward to booking more shifts now and this is mainly down to the support Lucy gave me.

Chelsie Miller, Phlebotomist **Scarborough** **Nominated by colleague**

Chelsie was working in the outpatient phlebotomy department when a parent arrived with their child for a blood test. The patient had severe learning difficulties and required assistance with the procedure.

During this time, Chelsie observed that the parent appeared fatigued, confused, and anxious. Concerned about the parent's wellbeing, Chelsie kindly inquired if they needed any assistance. The parent responded in an abrupt manner, expressing a range of health concerns affecting both themselves and their child. Recognising the parent's distress, Chelsie became increasingly concerned about their physical and mental state, as well as their ability to care for their child. Chelsie promptly raised a safeguarding concern with me, not only regarding the parent's welfare but also the potential impact on their child, for whom they were the primary caregiver.

Thanks to Chelsie's empathy, diligence, and professionalism, appropriate measures were swiftly taken. The learning disabilities nurses were contacted, and both the parent and child were referred to the emergency department for further assessment. Safeguarding procedures were put in place, and they were both able to return home after a few hours, having been checked over by medical staff. Chelsie's patience, kindness, and understanding during this difficult situation ensured both the parent and child were well cared for and safe.

Felicity Welburn, Midwife **York** **Nominated by patient**

The whole maternity team at York were supportive, but I want to single out Fliss in maternity triage as she provided exceptional care every time we encountered her.

I needed additional monitoring in the later stage of pregnancy, and she provided clear explanations and reassurance about the results. She remembered the names of my husband and me and put us at ease. We were touched when we came in after the birth to a tongue tie clinic that she rushed over to say hello and meet the baby. Her kindness and patience shone through, and we want to express how grateful we are to her and the wider team who cared for us.

Claire Gardiner, Specialist Nurse, Claire Gray, Staff Nurse, and Samantha Ashurst, Staff Nurse **York** **Nominated by patient**

Claire Gardiner's presence when contacting me for a cardioversion procedure was impressive. She was able to overcome admin issues with my address and did not give up on making phone calls to ensure I was booked in for the procedure. This dedication was backed up by the day unit team including the receptionist, the nurses and the doctors.

Clare Gardiner, Claire Gray, and Sam Ashurst made the visit to the day unit a pleasant experience. They were kind and reassuring and their care was professional, knowledgeable, understanding, and efficient. Everything they did was meticulous, clearly explaining each stage of the process, putting me at ease. Nothing was too much trouble, and this was highlighted in recovery where their attention was on all patients' needs, serving hot drinks and food. More importantly they performed their duties with a smile and a softness of voice.

Katie Graver, Physiotherapist **York** **Nominated by relative**

Since my son started his physiotherapy in October, Katie has been fantastic. She shows great care and compassion as well as drive to get my son back to playing the sports he loves.

My son has had some conflicting information and tough decisions to make regarding future surgeries, however Katie has helped find us the best information available to help us make the right decisions for him. She also put us in touch with an expert surgeon in Sheffield to seek a second opinion as we as a family were still unsure how to proceed. Katie has always been there for advice on email and gives such great advice and support.

Kim Rose, Associate Educator **York** **Nominated by colleague**

Kim consistently demonstrates our Trust values. Kim strives to keep up staff morale, especially during the more challenging recent months. She is always available to give advice, to simply listen, or to provide additional training, whether this be within ED or within the Healthcare Academy.

I hope Kim realises how much her kindness, honesty, and commitment to all staff is appreciated.

Karen Cooper, Senior Work Based Learning Facilitator **York** **Nominated by colleague**

I would like to nominate Karen for her positivity and fun approach when teaching new healthcare support workers within the Healthcare Academy. Karen ensures that the content she is teaching is not only relevant but engaging and relatable. She is an asset to the team.

Daniel Burton, Specialist Radiographer, and Faith Young, Clinical Imaging Assistant | **Scarborough** | **Nominated by colleague**

I am nominating Dan and Faith for going above and beyond for an MRI patient, showing outstanding patient care and compassion. When an elderly patient arrived in the department, it quickly became clear that they were frail and immobile and that their communication was severely impaired. They attended via ambulance transport from their home, unaccompanied, unable to recall their medical history, and unable to stand safely, although they attended in a wheelchair. Unfortunately, their next of kin was also frail and quite unwell and unable to inform Dan and Faith of the contact details for their carers, which meant the only history available to them was on CPD. It was clear from the last clinic attendance that their condition had rapidly deteriorated.

Following MRI safety policies, the patient required a series of x-rays which caused a delay to their scan, meaning they would be travelling home via patient transport out of hours. Due to communication errors, the patient was not collected by suitable transport until late at night. Despite their shift finishing at 8pm, Dan and Faith stayed with the patient to care for them until they were collected. They managed to reach the care company to establish that the patient was a choking risk and carefully gave them some food and drink. Unfortunately, the patient was also incontinent, so Dan and Faith cleaned and changed them so that they were comfortable before their return journey and making them comfortable on a bed while they waited.

Although they both got home after midnight, both Dan and Faith arrived promptly for their shift the next day at 8am and communicated to the appropriate teams, to highlight their concerns for their patient and to ensure that this patient's care package was reviewed.

York Plumbers, Joiners, and Electricians | **York** | **Nominated by colleague**

The plumbers, joiners, and electricians who work at York answer our online reports quickly and come to our department friendly and ready to help with any job. Everyone is always polite and asks what rooms they are allowed to go in as our department is a sensitive area, so they are thoughtful about our patients having chemotherapy. They clean up after themselves if they make a mess (which is not often).

Just some of the team is Mick Andrews, Paul Helm, David Garnett, Aaron Garnett, Chris Rook, and Nigel, as well as all the others. The electricians, plumbers, and joiners are superb, and the Hospital would not run properly without them. Thank you!

Rad Humenczyk, Clinical Imaging Assistant **Scarborough** **Nominated by patient**

I attended Scarborough Hospital for an MRI. I was stood at the entrance to Radiology with my husband debating whether to go in. My anxiety was through the roof after pacing back and forth and I did not if I could even walk up to reception to tell them I was here for my appointment.

Rad happened to walk out the department, noticed me looking a bit distraught, and asked me if I was OK. I told him I was due in for MRI but was terrified and that I did not think I could even walk into the waiting room, let alone the scan room. He stood and explained he was the radiographer and said he was just on his break and will be back very soon and will help me through it. He continued to chat to me, explaining everything. This put me at ease, made me feel human, and gave me the courage to go in. That he spent at least five to 10 minutes of his own time during his break to reassure me just says everything.

I went in, registered my arrival, and waited. No sooner had I got comfortable, he came back and called me in and there was no way he took his full 30-minute break. He sat next to me went through the paperwork with me all the while making me feel so relaxed and even made me laugh. If it was not for this man, I would not have gone through with it. What a patient, caring professional. He made me feel so much better over something that was so scary for me.

Rad, you should be proud of the job you do, and Scarborough Hospital should be proud to have you on your team. You are the kindest man I have ever met, thank you.

Kirsti Daniells, Deputy Team Leader **York** **Nominated by colleague**

During a challenging emergency case in maternity theatres, Kirsti showed that she exemplifies Trust values and is a highly knowledgeable, efficient, and caring practitioner. Kirsti's knowledge allowed for quick identification of deterioration with the patient and her organisation of the multidisciplinary team allowed for the best possible intervention to be given to the patient during a difficult and stressful case.

Kirsti also showed her care and compassion as a team leader, staying well beyond the end of her shift to ensure the members of her and other teams were OK and had the appropriate debrief. Overall, Kirsti's actions showed what a dedicated and caring practitioner she is, always going above and beyond for patients and staff.

Marie Dring, Healthcare Assistant **York** **Nominated by colleague**

Marie constantly excels in her job role. She is kind, caring, and supportive to all. She works hard and her care and compassion always shine through.

What stands out about Marie is her dedication to the role, especially when it comes to caring for those receiving end-of-life care. She ensures the patient and their loved ones are cared for at a high level and that everything is in place and the best it can be for each individual.

Brian De-Alker, Assistant Facilities Manager | **Scarborough** | **Nominated by colleague**

Brian is the most kind and genuine employee that I have ever met at this Trust. He is friendly and outgoing. He goes above and beyond for his colleagues on a consistent basis, and he will work past his contracted hours to help everyone when needed and to complete his tasks.

Vascular Surgery Team | **York** | **Nominated by patient**

I was struggling and visibly upset while being prepared for my procedure. All the operating theatre staff were amazing. Sam, the Anaesthetist, was calming and caring and so was Pippa when she arranged for me to stay the night so the procedure could still go ahead. Also, Dr Garg was considerate of how the procedure was affecting me and how he could accommodate me. The whole team in the theatre were concerned with my welfare and wellbeing. I could feel their genuine care for me. Thank you.

Lisa Allen, Sister | **Scarborough** | **Nominated by patient (1) and relative (2)**

Nomination 1:

Lisa is an amazing nurse. She has been a game changer for me, and she deserves recognition for how incredible she is. When I was seen by her in ED, she was subtle but firm in how she spoke to me. This is the best thing she could possibly have done for me and the best thing someone has done for me so far. She really has changed my attitude and made me feel emotion which I have not felt before; it was a light switch moment, and I needed that. She deserves recognition for this. She does not know how much this helped me. She also linked back to her personal life, which was great, as it made me feel like I was not alone.

Lisa was so good to me, I felt like we had made a good connection with each other, and she offered me and my mum a drink and something to eat. Please make sure she gets recognition because she certainly deserves it. She goes above and beyond to help others.

Nomination 2:

Lisa told my daughter what she needed to hear. She was harsh but fair.

Rainbow Ward | **Scarborough** | **Nominated by relative**

We were admitted to Rainbow Ward with my child. As a first-time mum, this was extremely scary. From the moment we got onto the ward, we were well looked after. The staff nurse was efficient despite being busy, the doctors were very thorough, and we got transferred quickly to Hull as an emergency.

I had no spare clothes, phone charger, or any other useful belongings with me and the staff went above and beyond to find a pumpkin parent pack (a bag of essential items for parents containing items such as a charging cable, a hairbrush, toiletries, a pen, a notebook, a children's book, and more) for me to take to Hull Royal. They kept us informed of everything that was happening next, which put my mind at ease. Nothing was too much to ask.

Laura Wilson, Sister **Scarborough** **Nominated by relative**

We came into ED with our 10-month-old, and as first-time parents this was worrying and stressful for us. Laura was amazing; nothing was too much trouble, and she was extremely thorough. Although she was rushed off her feet, she ensured both my partner, my little girl, and I had everything we needed, no question was too much. Thank you, Laura!

Lucy Hindle, Staff Nurse **Scarborough** **Nominated by colleague**

I am nominating Lucy for a Star Award as she has gone above and beyond anyone's expectations to help with the care of a critically unwell young patient. Even though the patient was not on Lucy's ward, Lucy had previously cared for this young adult and built a great rapport with them. They felt safe and reassure with Lucy, which allowed for them to have bloods and cannula under less stress, despite their severe needle phobia.

Lucy gave her time and care to attend the ward where this patient was at their request, as they knew Lucy would make the experience a better one. This patient was critically unwell and Lucy's calm, caring, and reassuring nature allowed the patient to have these essential bloods, cannula, and treatment to save their life.

Lucy was amazing and made such a difference, not only to the patient, but to their condition and to their distressed family. Lucy holds all the values of an exceptional nurse and is a role model. The Trust and her usual ward, EAU, are lucky to have her.

Sarah Waites, Deputy Team Leader **York** **Nominated by colleague**

While working on the Day Unit, Sarah led a team that due to cancellations, had no patients. She contacted the Acute team to cover emergencies, coordinated with multiple agencies, and arranged for afternoon children to have their operations early saving time, recourses, and improving the expectations of the relatives and patients.

Sarah is a hardworking asset to the Trust who is a positive role model in difficult circumstances. She follows Trust values and needs to be recognised, not just for today, but for her many years of hard work and service.

Azariah Smith, Patient EDI Facilitator **York** **Nominated by colleague**

Azariah is an asset to the Trust and her exemplary empathy and kindness means she goes the extra mile for everyone, every time. As one of the committee members of the ENABLE network, she has a vital role in the support and representation of staff with disabilities, neurodiversity, and long-term health conditions.

In the most recent network meeting, Azariah chaired and led the meeting with great success, amplifying colleague voices and making sure everybody had a chance to speak and was heard. You can tell Azariah has great passion for what she does and strives to make the Hospital accessible for patients, staff, and volunteers.

Shannon McGovern, Nurse Educator **York** **Nominated by colleague**

Shannon is committed to her role. She goes above and beyond to help people and ensure things get sorted to make her area safe as can be. We would be lost without her when dealing with issues on the children's wards at both sites. She is our amazing source for knowledge as she is always informative, proactive, and helpful.

Our jobs in the Medical Device Safety Team would be far more difficult without her to call upon due to her enthusiasm and specialist knowledge. My advice would be to keep her at our Trust at all costs.

Annette Jarvis, Cleaning Operative **York** **Nominated by colleague**

Annette goes above and beyond anything you ask her to do, she just gets on and does it. Annette's personality is professional. She offers to help on our ward even though it is not her designated area.

Susan Jackson, Staff Nurse, Belinda Smale, Nursing Band 7, and Paula Smith, Imaging Support Assistant **York** **Nominated by patient**

When I was admitted to ED, Sue looked after me to start with and then Belinda Swale took over. Belinda examined me and sent me to x-ray. Paula could not have been more understanding and sympathetic, as I was in considerable pain. The whole team deserve the highest recommendation for going that extra mile.

I was treated with respect and professionalism by all the staff, and they were understanding as to my level of pain. I was informed by Belinda Swale that I needed a new knee. This was not the news I wanted to hear, but at least I can now understand why I am in such pain.

The wonderful team in this department do not get enough appreciation from the public. I can only say a sincere thank you to the whole team.

Reece Dodsworth, Charge Nurse **York** **Nominated by patient**

During a recent unexpected visit to ED, Reece cared for me as part of the triage process and throughout my ED visit. Reece was caring and friendly and explained the plan to me well, as well as the wait times and importance of not leaving. The department was extremely busy, however he made me feel exceptionally well cared for and ensured I was given pain relief as needed.

Reece is an exceptional member of staff and a credit to ED. I have visited numerous departments in the last few weeks and Reece has had a massive positive impact upon my care and treatment. Thank you so much, Reece.

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

I unfortunately had to bring my daughter to ED as she was unwell. Jason was the first healthcare professional that we saw, and he was brilliant. My daughter was feeling unwell, was frightened to be in hospital as she has never been before and is incredibly shy. Jason was lovely, kind, reassuring, and friendly. He did magic tricks for my daughter and within no time at all she was far more relaxed and was looking forward to the next time he came into the bay. She was put completely at ease by Jason, so by the time the nurse and doctor came to examine her she was relaxed, and her nerves had gone.

Jason is an asset to the team, and I want to say a massive thank you. Without Jason, my daughters experience would have been very different and the effort he took to put her at ease was lovely.

Yvonne Heaps, Outpatient Service Administrator **Scarborough** **Nominated by relative**

My husband received a letter for an appointment with Dr John Patterson at the stroke clinic. We came in for the appointment, bringing our letter. My husband had some tests earlier and had seen Dr Patterson previously. Yvonne read the letter and told us that the appointment had been cancelled because we had already seen Dr Patterson previously. We explained that he had asked for blood pressure readings to be taken, and he needed to see them. Yvonne immediately said that she would go to the relevant nurse and see if we could be fitted in that afternoon. She did that and Dr Patterson saw my husband immediately.

Yvonne was so friendly, caring, and understanding. She realised how upsetting it would have been to return home and wait for another appointment. She went out of her way to help us, and we realised when thanking her afterwards that she must have taken time out of her lunch hour to do so. A real star!

Ian Chapman, Urology Cancer Care Coordinator **Scarborough** **Nominated by relative**

During a stressful time concerning my husband and while waiting for different appointments, I have received emails from Patients Know Best. We are not registered with this app and find receiving the emails that we do not understand stressful. On two separate occasions, I have spoken to Ian. He calms me and puts my mind at rest immediately, before looking on the system, giving me the appointment date, and offering to post a letter.

Ian is calming and understanding, which during this stressful time is appreciated. This may seem a small thing, but it was just what we needed.

Jo Chambers, Midwife **Scarborough** **Nominated by patient**

I first met Jo when pregnant with my third child. I suffered with depression throughout my pregnancy, and without Jo and the support she showed throughout my pregnancy I do not know how I would have got through it. Even with the restrictions due to COVID, she never failed to be there.

A few years later I became pregnant with my fourth baby, and from the moment I fell pregnant, Jo took over my care. She showed respect and compassion to me and my family. After my fourth was born, they ended up needing care in SCBU, but Jo still came to see me in SCBU and supported me throughout. I could never thank Jo enough for everything she has done for me and my family. Jo is an absolute credit to maternity at Scarborough, and I think all midwives should look up to her and the compassion and care she showed throughout my pregnancies.

Georgina Rowe, Deputy Programme Manager **York** **Nominated by colleague**

Georgina has been a highly valued member of the maternity and neonatal team for over two years. There is no task that she is not willing to help or contribute to. Her sense of optimism, fun, and enthusiasm are infectious, and the team loves having her around.

Georgina consistently displays the Trust values and is always willing to go the extra mile. She is committed to excellence and ensures that all team members are recognised and included. Thank you, Georgina, for all you do.

Eleanor Katsarelis, Recruitment Advisor **York** **Nominated by colleague**

Eleanor is being nominated for a Star Award to acknowledge the support she provides in relation to recruitment queries. She is always available for advice or support, and quick to respond to enquiries. She consistently displays the Trust values and is incredibly patient. Thank you, Eleanor, from all in maternity.

Tracey Butterfield, Maternity Support Worker **York** **Nominated by colleague**

Tracey has been nominated for a Star Award in recognition of her consistent kindness, caring nature, and willingness to help. She is a highly valued member of the maternity team and is regularly featured in the Star Award booklet!

A couple who had experienced concerns with their care met with the Head of Midwifery, and while their care had not met the standard we would aim for, they were full of praise for Tracey. Tracey had provided them with reassurance when it was lacking elsewhere and stood out to them for her compassionate approach and genuine willingness to help. This feedback is regularly received about Tracey, and she is a huge asset to the Trust. Thank you, Tracey, for all you do.

Daniel Emmott, Head of Operational Estates, David Baker, Electrical Services Manager, Phill Fletcher, Electrical Services Technician (AP), Michael Andrews, Electrical Manager, Graham Titchener, Head of Sustainability, and Matt Tyrer, Electrical Services Manager

York

Nominated by colleague

This team responded to an electrical fire on Ward 8 and electrical issue on Ward 5 during January. Great leadership was demonstrated as it was not known how many other areas on the wards could be affected and would be at risk. We also had a fire watch in place from Security.

The team worked as a solid unit, working long hours to ensure safety and minimal disruption to clinical services. The team used engineering excellence by using thermal imaging, which is non-invasive testing, to identify if there were any other hot spots or issues to be addressed. They identified another problem and prevented a further electrical incident. The York team also called on support of the Electrical Manager at Scarborough, showing great collaborative working.

All the Trust values were demonstrated and the just culture they have meant everyone in the team had an equal voice. This incident was managed on top of responding to Storm Euan. I feel the team need recognition as often the work behind the scenes and the great team ethos can go unnoticed.

Item 8

Committee Report

Report from:	Quality Committee
Date of meeting:	18th February 2025
Chair:	Steve Holmberg

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

ALERT
Echocardiography – c300 examinations needing to be repeated due to competency concerns involving outsourced support. Risk identified promptly and risk held to be minor and mitigated
ASSURE
Committee Reporting – To improve assurance, the Committee will receive additional reports on: Follow-up on audit report actions in terms of quality improvement and safety mitigations Quality impact of performance metrics Quality improvement achievements that underpin overall quality performance metrics **IPC –** Headline rates of HAIs still running above trajectory but Committee noted successes in work to address fundamentals e.g. focus on ward leadership, matron visibility and increasing accountability within CGs for IPC performance **Clinical Effectiveness –** Committee noted improvements and assurance around handling of external reports and advice e.g. NICE, GIRFT etc.

ADVISE
Maternity – Committee approved Section 31 submission. In-month metrics provide assurance that improvement trajectory is being maintained although evidence of service being under increasing pressure. Work progressing to try and identify opportunities to fund essential staff recruitment principally through reorganisation of education and theatre functions. Rates of PPH noted to be 'in middle of pack' nationally and work continues to reduce risk. Security at SGH remains a concern due to impending building works; mitigations in place. Continuing concerns relating to challenges in mental health support for new mothers. Maternity Safety Champion initiative moving forward and gaining traction **Safeguarding –** ED coding remains a concern but risk now being mitigated through attendance at ED team meetings. 2 Domestic abuse advisers appointed. Intention to move towards 'perinatal' safeguarding as opposed to current division between maternity and neonatal **UEC –** Committee advised that level of demand had fallen as peak of respiratory and noro virus infections had passed. Few escalation beds required. 12 hour trolley waits still high but Committee

received assurance that for many patients (especially frail/elderly) this was a technical designation as care was being provided in a 'ward-equivalent' area with appropriate staffing levels and care arrangements e.g. electronic prescribing. Senior leadership presence in team meetings was having a positive impact with increased benefits seen with Continuous Flow and use of Discharge Lounge

BAF Deep Dive – Committee discussed risks associated with working arrangements and partner organisations. Received assurance that active steps were being taken to enter into joint meetings and to find ways to become more proactive in driving agendas e.g Place Directors. Committee accepted Risk Scores and acknowledged that some controls were outside the Trust's direct ability to manage

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Family Health CG – ED (CQC concern): Improvement work in progress to upskill ED staff to improve flexibility of team to care for children

Autism assessment: Committee discussed rapidly increasing demand and plans to mitigate risk that children might not complete assessment prior to transfer of care to CAMHS. Committee acknowledged that, even during lengthy waits for full assessment, children received significant input e.g. SaLT and that further mitigations were being explored

Paediatric Mental Health Nursing: Concern over withdrawal of funding for second post. CG reviewing possible solutions

Community Teams: Committee discussed challenges associated with significant increase in demand. Pathways being reviewed to ensure that the 'right person' attended for every visit and additional ways to optimise use of staff skills and time

Gynaecology: Committee advised that there had been a sustained improvement in waiting times for patients at York and that Scarborough was being supported by an external provider. Ovarian torsion pathway had been agreed between all relevant clinical teams. Colposcopy pathway experiencing new challenges due to loss of key staff members. CG actively investigating solutions

Committee Report

Report from:	**Resources Committee**
Date of meeting:	**18/02/2025**
Chair:	**Jim Dillon**

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

ALERT
▪ **January Emergency Care Standard position was 63.1% against a target of 69.3%** ▪ **Ambulance handover target of 36 mins and 32 secs not achieved with actual at 44 mins and 14 secs however this is an improvement on last months performance of 58 mins and 20secs** ▪ **Ambulance arrivals continue to rise in ED with an average of 151 per day compared to 140 a year ago.** ▪ **Proportion of all attendances seen by a doctor within 60 minutes is 28.9% against a year end target of 55%** ▪ **CIP savings expected of £40m however only around half of this is predicted to be recurring** ▪ **Expected shortfall of £34.4m with £18m of which is accountable to the trust has been accepted for the ICB by the centre for this year. However this will increase the pressure on next year when this deficit with have to be recovered.**
ASSURE
▪ **Use of Agency staff continues to decrease** ▪ **An "Engagement Room" established in York ED to help improve patient flow with a similar facility planned within the new facility at Scarborough** ▪ **Beds taken up by NCTR currently at 12.4% is high but better than previously however issues remain with occupants remaining longer** ▪ **Recruitment planning of nursing staff at all levels in a positive position with career opportunities and competency initiatives being put in place** ▪ **Initiatives supporting Compassionate Leadership being developed and delivered**

ADVISE
▪ Discussion on the need for a baseline assessment of Health and Wellbeing support for staff. ▪ Referral for treatment performance sees a 17% improvement with the Trust now the second most improved in its cohort ▪ Staff absence continues to be high at 5.9% ▪ Trust confirmed in Tier 2 for Cancer and Diagnostics with system in Tier 1
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
No new significant risks identified

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

TRUST PRIORITIES REPORT

Item 10

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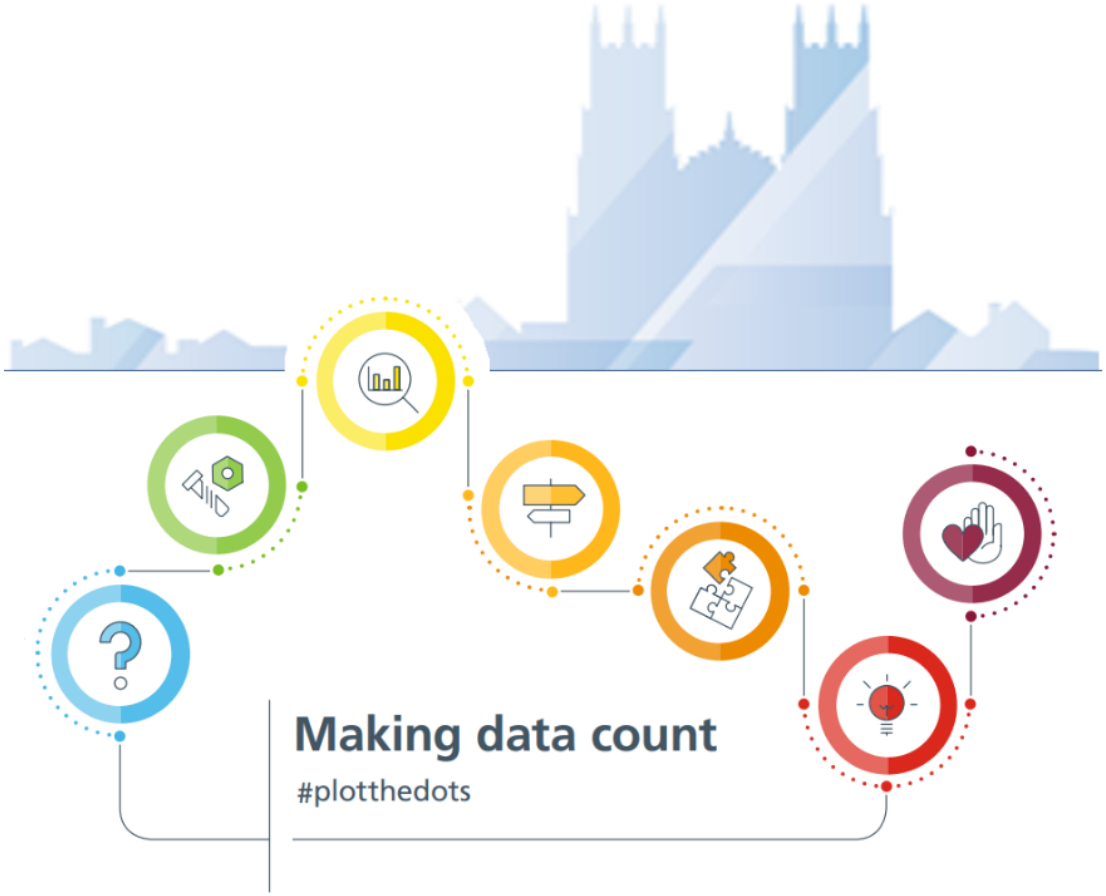


Executive Summary

Priority Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Ambulance average handover time (number of minutes)	2025-01			44	37	50
ED - Proportion of Ambulance handovers waiting > 60 mins	2025-01			21.3%		10%
ED - Median Time to Initial Assessment (Minutes)	2025-01			4		18
ED - Emergency Care Standard (Trust level)	2025-01			63.1%	69.3%	78%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-01			22.2%		7.5%
ED - 12 hour trolley waits	2025-01			949		0
Cancer - Faster Diagnosis Standard	2024-12			72.3%	70%	77%
Cancer - 62 Day First Definitive Treatment Standard	2024-12			66.4%	63.1%	70%
RTT - Total Waiting List	2025-01			42554	45072	44663
RTT - Waits over 65 weeks for Incomplete Pathways	2025-01			34	0	0

Executive Summary:

The January 2025 Emergency Care Standard (ECS) position was 63.1%, against the monthly target of 69.3%.

The Trust did not achieve the January 2025 average ambulance handover time target of 36 mins 32 seconds with performance of 44 mins 14 seconds. Average ambulance handover time is calculated by taking the total combined handover times divided by the number of ambulances that attended the Trust's Emergency Departments.

Please note; in line with national reporting deadlines cancer reporting runs one month behind. The Cancer performance figures for December 2024 saw an improvement in the 28-day Faster Diagnosis standard (FDS) to 72.3% (compared to 70% in November 2024) achieving the monthly improvement trajectory of 70%.

62 Day waits for first treatment December 2024 performance was 66.4% a reduction on the 71.7% seen in November 2024 however the monthly improvement trajectory of 63.1% was achieved. The Trust has, as part of the 2024 Operational Planning, submitted trajectories to achieve the national ambition of 77% for FDS and 70% for 62 Day waits for first treatment by March 2025.

At the end of January 2025, the Trust had thirty-four Referral To Treatment (RTT) patients waiting over sixty-five weeks. The Trust's RTT Waiting list position is ahead of the trajectory submitted to NHSE as part of the 2024/25 planning submission, 42,554 against the trajectory of 45,072, a reduction of 798 (-2%) on the end of December 2024 position (43,352).

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

February 2025

Headlines:

The January 2025 Emergency Care Standard (ECS) position was 63.1%, against the monthly target of 69.3%.

The Trust did not achieve the January 2025 average ambulance handover time target of 36 mins 32 seconds with performance of 44 mins 14 seconds.

Factors impacting performance:

- Ambulances arrivals at our Emergency Departments (ED) continue to rise (January 2025 average of 151 per day against the January 2024 average of 140, a rise of 8%). The acuity of ambulance arrivals has also continued to increase.
- Total number of ambulances arrived at both acute hospitals in January 2025 was 4691 compared to 4604 in January 2024; an increase of approximately 2% contributing to the pressure on our EDs. Across the York and Scarborough sites there were 10,008 ED Major, 1,762 ED Minor Injury, 111 ED Minor Illness and 1,475 GP Minor Illness attendances.
- This winter both acute hospitals experienced higher rates of flu compared to last winter and January showed similar pattern compared to the last January.
- 2hr Urgent Community Response (UCR) continues to face challenges around capacity.

Regional context provided by NHSE on 21st January 2025:

- Attendances, emergency admissions and ambulance arrivals dropped significantly in week commencing 6th of January 2025, likely due to widespread snow and ice in the region. Volumes of ambulance handover delays also decreased, reflecting lower demand.
- The region remains under a similar level of pressure to this time last year, with several metrics moving away from the desired position.
- 4-hour performance remained low at ~68%, 5% lower that the same week last year which was unusually strong. Department wait metrics remained high.
- Beds closed to IPC improved slightly across most ICBs but remained high in NENC. Volumes of beds occupied by patients with No Criteria To Reside or a 14+ day LOS increased significantly, though not to earlier peaks.

Actions:

Please see following pages for details.

ECS Performance by Site and Type – January 2025

Site	Type	ECS Performance (Jan 2025)
Scarborough	Type 1	44.4%
	Type 2	100.0%
	Type 3	95.3%
	Overall	**56.2%**
York	Type 1	42.5%
	Type 2	100.0%
	Type 3	93.6%
	Overall	**57.3%**
Malton	Type 3	100.0%
Selby	Type 3	99.6%
Trust	**All**	**63.1%**

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

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT	* ED - Median Time to Initial Assessment (Minutes)	* ED - Emergency Care Attendances * ED - A&E Attendances - Types 2 & 3	* ED - Proportion of all attendances having an initial assessment within 15 mins
COMMON CAUSE / NATURAL VARIATION	* Proportion of SDEC admissions transferred to downstream acute wards	* ED - A&E attendances - Type 1 * ED - Proportion of Ambulance handovers waiting > 60 mins * ED - Proportion of Ambulance handovers waiting > 240 mins * ED - Ambulance average handover time (number of minutes)	* ED - Proportion of all attendances seen by a Doctor within 60 mins * ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - 12 hour trolley waits * ED - Emergency Care Standard (Type 1 level)
SPECIAL CAUSE CONCERN			* ED - Emergency Care Standard (Trust level) * ED - Proportion of Ambulance handovers within 15 mins * ED - Proportion of Ambulance handovers waiting > 30 mins

Acute Flow (1)
Scorecard

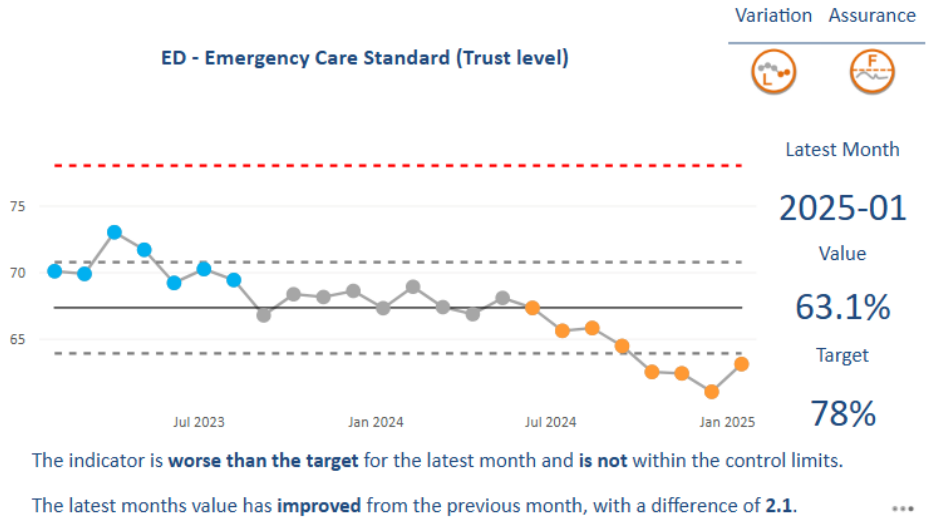
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Proportion of all attendances having an initial assessment within 15 mins	2025-01	H	F	66.9%		66%
ED - Proportion of all attendances seen by a Doctor within 60 mins	2025-01		F	28.9%		55%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-01		F	22.2%		7.5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2025-01			2250		
ED - 12 hour trolley waits	2025-01		F	949		0
ED - Emergency Care Attendances	2025-01	L	?	16074	17807	17807
ED - Emergency Care Standard (Trust level)	2025-01	L	F	63.1%	69.3%	78%
ED - A&E attendances - Type 1	2025-01		?	10119	10425	10423
ED - Emergency Care Standard (Type 1 level)	2025-01		F	43.3%	51.1%	66%
ED - A&E Attendances - Types 2 & 3	2025-01	L	?	5955	7382	7384
ED - Median Time to Initial Assessment (Minutes)	2025-01	L	P	4		18
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-01			46.5%		
Proportion of SDEC attendances transferred from ED	2025-01			60%		
Proportion of SDEC attendances transferred from GP	2025-01			26.5%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-01			54.5%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-01		P	16%		20%

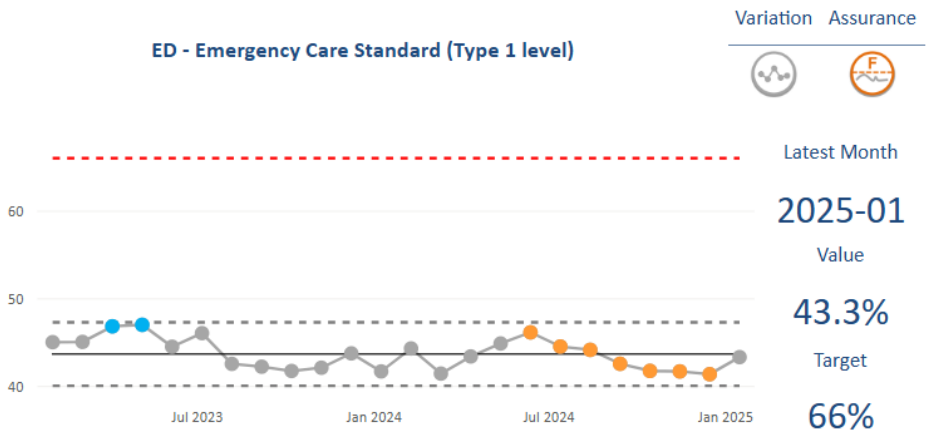
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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 **2.1**.



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 **2.0**.

Rationale: To monitor waiting times in A&E and Urgent Care Centres.
Target: SPC1: NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025. **SPC2:** Modelling showed that to achieve 78% as a Trust Type 1 performance needs to be at least 66%.

Actions:

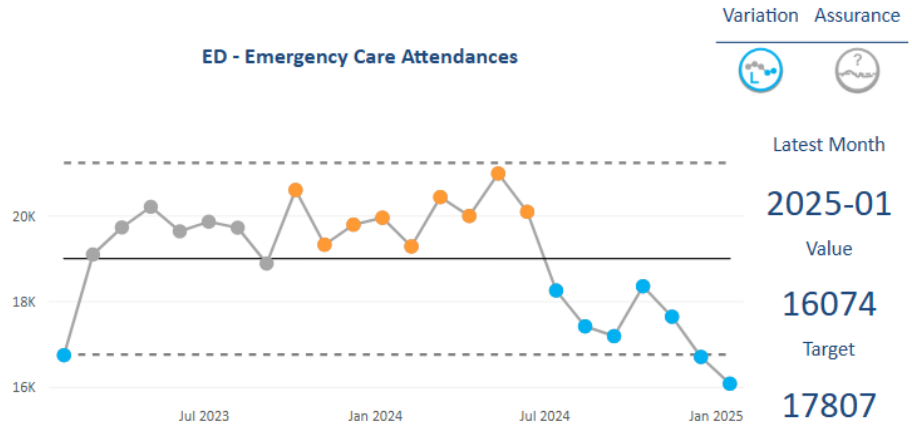
- The ECS performance for both Optimal Care Service (OCS) sites was above 93% in January 2025. The focus continues to be on maximising the number of patients seen appropriately on this pathway; Data modelling suggested that 185 patients per day could go through the OCS at York and 120 at Scarborough. January average was 62 patients per day in York and 40 at Scarborough – almost all were patients going to the pre-existing minor injuries and minor illness services (UTC).

- An ED Consultant has carried out an audit of Scarborough ED attendances to create a stronger evidence base for boosting the Optimal Care Service by moving some resource from ED Majors to support non-Majors. The findings have been presented to Clinical Navigators at Scarborough, and this session resulted in uncovering some 'myths' about the patients who can be streamed to various pathways. Further work is underway to support the team, including a number of planned coaching-style training sessions in February.

- An Engagement Room was established on 23rd January 2025 within York ED, with plans to replicate in the new build at Scarborough. This space provides an opportunity for frontline teams to learn about the full Unscheduled Care Improvement Programmes (UCIP) and encourages colleagues to respond to questions posed on a big whiteboard. The first 40 responses have been received; the responses will be considered for onward action by the Programme and Care Group teams.

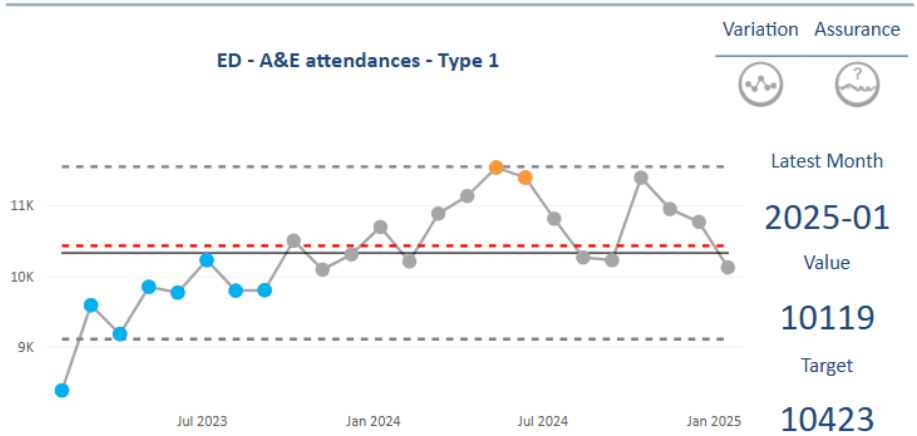
Executive Owner: Claire Hansen

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 **improved** from the previous month, with a difference of **624.0**.



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

The latest months value has **improved** from the previous month, with a difference of **644.0**.

Rationale: SPC1: To monitor demand in A&E. **SPC2:**
Target: SPC1: Monthly activity plan as per chart. **SPC2:** Monthly activity plan as per chart.

Actions:

A Community UEC Improvement Group brings together partners from across the system November 2024, to understand the alternative pathways being developed to support reducing attendances in our Emergency Departments.

North Yorkshire and York Coordination Hub (Formerly known as Integrated Care Coordination)

- The Hub team, led by YAS, takes calls from crews and gives advice about appropriate alternatives to conveying a patient to the Emergency Department.
- Since going live in mid-November 2024, the team has taken over 400 calls. 67% of those have resulted in an avoided ambulance dispatch.
- A full evaluation is currently underway which should inform a decision on whether to extend the pilot, which currently runs to the end of March 2025.

Frailty Crisis Hub

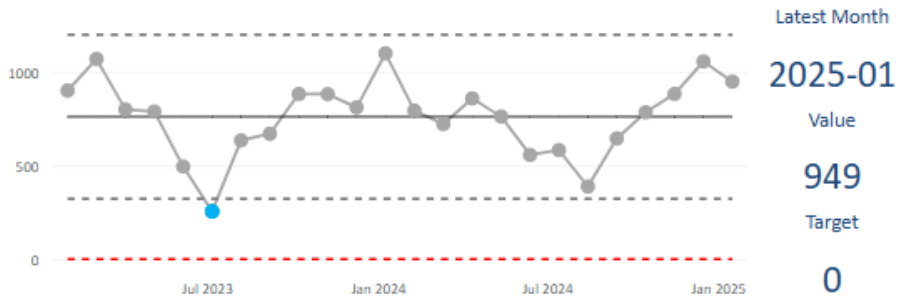
- Nimbuscare lead this service and are finding that the number of conveyances it is possible to avoid in a month is capped at around 300, due to the capacity in York Community Teams already been fully utilised. Trust colleagues who lead the 2-hour Urgent Community Response service are reviewing capacity and demand, with a view to potentially creating a business case for expansion.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

ED - 12 hour trolley waits

Variation Assurance



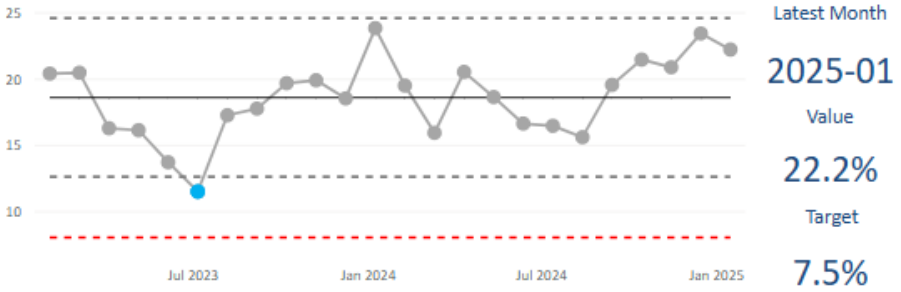
Latest Month
2025-01
Value
949
Target
0

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 **108.0**.

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

Variation Assurance



Latest Month
2025-01
Value
22.2%
Target
7.5%

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

The latest months value has **improved** from the previous month, with a difference of **1.2**.

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 7.5% of patients should wait more than 12 hours.

Actions:

- Continuous Flow policy implementation continues; the Continuous Flow SOP has been recently updated to reflect lessons learned.
- A new Temporary Escalation Spaces (TES) SOP draft has been finalised and going through internal governance. This includes further bed escalation capacity. Currently there are spaces identified as Green (1st escalation spaces) and Amber (2nd escalation spaces). The TES SOP additionally includes Red escalation spaces identified in extremis supported by a proactive risk assessment. The core triggers include any ambulance handover delay more than 45 minutes or any patient waiting with a Decision To Admit more than 10 hours in the ED.
- Effective use of this SOP should support a reduction in 12-hour spells in our Emergency Departments.
- Building work is underway to change the layout of York Emergency Department as part of the work enabled by the ACTIF fund. Linked to this is the new Acute Model of Care, being developed to ensure that there is clarity and agreement on how to ensure patients move quickly through the best pathway for them. This includes the Emergency Department and the planned Integrated Assessment Unit.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

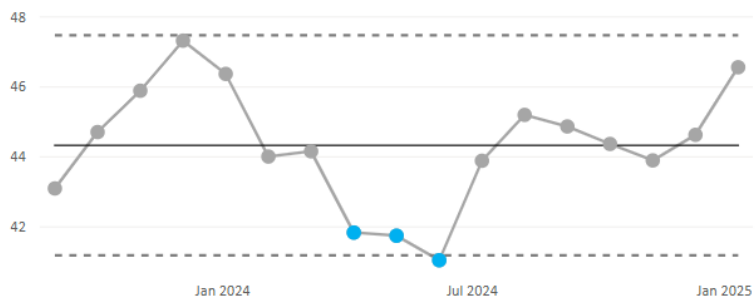
Rationale: SPC1: To understand the inpatient demand generated by Emergency Department patients. **SPC2 :** To monitor acute inpatient demand.
Target: SPC1: No Target. **SPC2:** Monthly activity plan as per chart.

Actions:

- The January 2025 conversion from attendance to admission outturn was 46.5%. This includes all admissions via ED into Same Day Emergency Care (SDEC), Assessment areas and Inpatient wards.
- At Scarborough there continues to be an Acute Physician In Charge (APIC) working in ED, supporting decisions around Criteria for Admission. At York this is not always possible due to the low number of Acute Physicians across the UEC pathway. A staffing deep-dive is scheduled for April 2025 to look at longer-term workforce requirements.

ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only

Variation Assurance

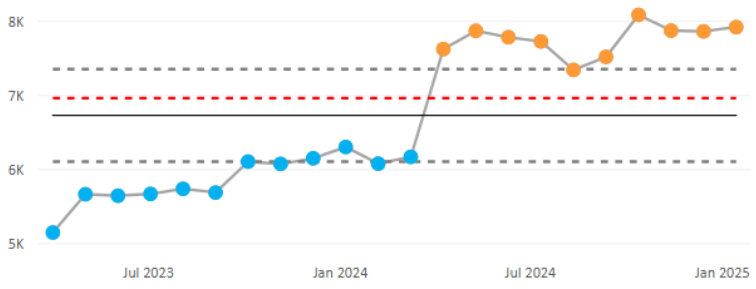


Latest Month
2025-01
Value
46.5%
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **1.9**.

Number of non-elective admissions

Variation Assurance



Latest Month
2025-01
Value
7913
Target
6953

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

The latest months value has **deteriorated** from the previous month, with a difference of **57.0**.

Acute Flow (2)
Scorecard

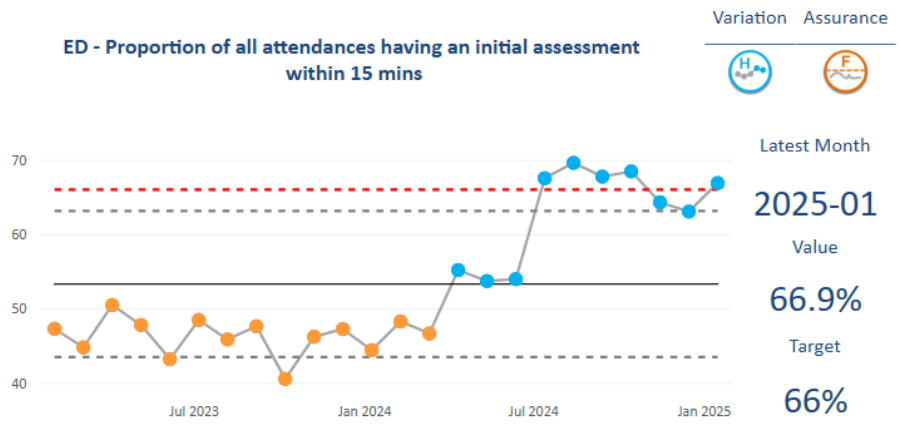
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-01			46.5%		
Number of SDEC attendances	2025-01			2362		
Proportion of SDEC attendances transferred from ED	2025-01			60%		
Proportion of SDEC attendances transferred from GP	2025-01			26.5%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-01			54.5%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-01		P	16%		20%
Number of RAFA attendances (York Only)	2025-01	H		125		
Number of attendances at SAU (York & Scarborough)	2025-01			823		
ED - Proportion of Ambulance handovers within 15 mins	2025-01	L	F	27.3%		65%
ED - Proportion of Ambulance handovers waiting > 30 mins	2025-01	H	F	43.9%		5%
ED - Proportion of Ambulance handovers waiting > 60 mins	2025-01		?	21.3%		10%
ED - Proportion of Ambulance handovers waiting > 240 mins	2025-01		?	1.3%		0%
ED - Number of ambulance arrivals	2025-01	H		4629		
ED - Ambulance average handover time (number of minutes)	2025-01		?	44	37	50

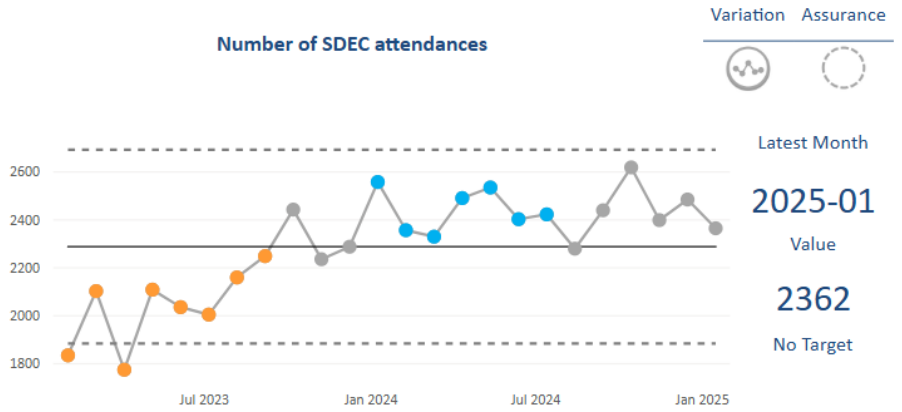
Executive Owner: Claire Hansen

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 **improved** from the previous month, with a difference of **3.9**.



The latest months value has **deteriorated** from the previous month, with a difference of **120.0**.

Rationale: SPC1: 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. **SPC2:** SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.
Target: SPC1: 66% assessed within 15 mins. **SPC2:** No target.

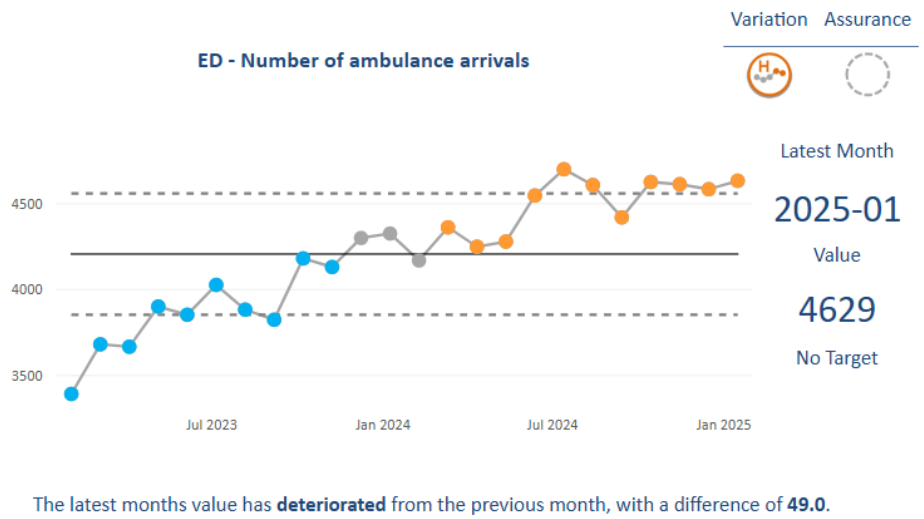
Actions:

- The proportion of patients having an initial assessment within 15 mins has increased since the launch of the Clinical Navigator role and OCS Standard Policy (July 2024) with the mean time to assessment dropping significantly at the York site at the point of OCS implementation.

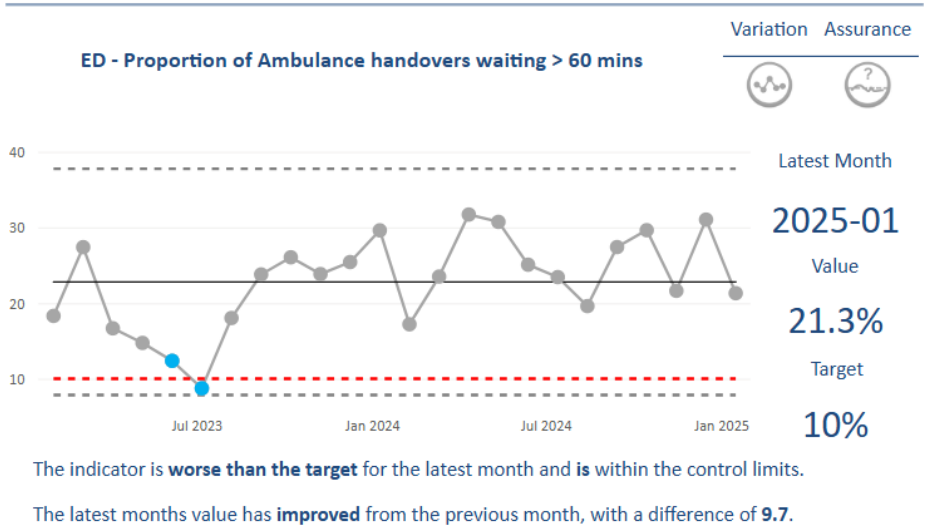
- For the patients streamed to SDEC from ED in December, 54.4% were done so within 60 minutes (up from 44% in December). This performance can be impacted by two separate issues. Firstly, some patients such as those on the chest pain pathway require further investigations e.g., an Echocardiogram (ECG) before they can go to SDEC and therefore cannot be admitted within 60 mins. Secondly when SDEC reaches full capacity patients must be held in ED until capacity is available. SDEC capacity has been impacted by vacancies with Locums utilised where possible.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **deteriorated** from the previous month, with a difference of **49.0**.



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 **9.7**.

Rationale: SPC1: To monitor Ambulance demand in A&E. **SPC2:** Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.
Target: SPC1: No target. **SPC2:** Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival. Less than 10% should wait over 60 minutes to handover.

Actions:

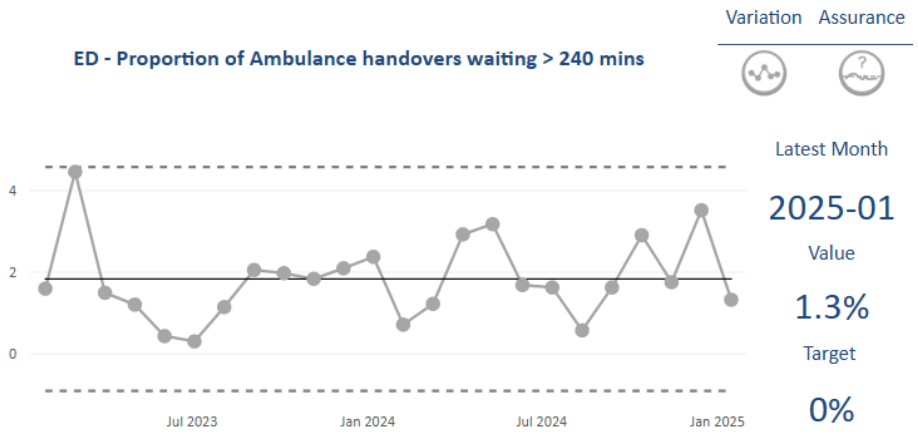
The work of the Community UEC Improvement Group (CIG), referenced above on Slide 9, aims to reduce conveyances to our Emergency Departments where there is a more appropriate alternative pathway available for the patient.

- **York**: January 2025 saw over 90% compliance with ambulance handover nurse in place from 10am – 10pm. Ambulance PIT STOP model is embedded (in one of the "cohort" rooms) to handover patients in a timely manner.

- **Scarborough**: January 2025 saw over 90% compliance with ambulance handover nurse in place from 10am – 10pm.

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 **improved** from the previous month, with a difference of **2.2**.

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Rationale: : Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.

Target: Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival, 0% should wait over 240 minutes.

Actions:

- See previous slide.

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		* Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	
COMMON CAUSE / NATURAL VARIATION		* Number of zero day length of stay non-elective admitted patients * Overnight general and acute beds open * 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 * Inpatients - Super Stranded Patients, 21+ LoS (Adult)
SPECIAL CAUSE CONCERN		* Number of non-elective admissions	

Acute Flow (3)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

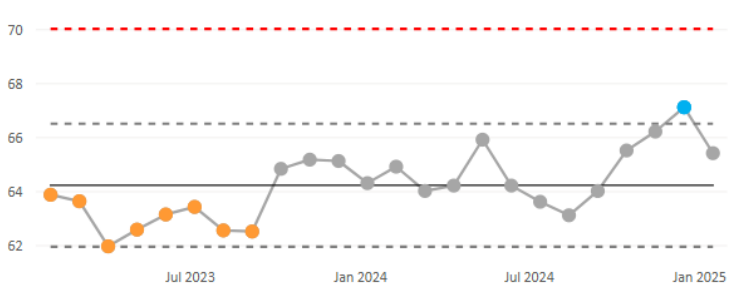
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2025-01		F	79.6%		90%
Patients with Senior Review completed at 23:59	2025-01			47.3%		
Inpatients - Proportion of patients discharged before 5pm	2025-01		F	65.4%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2025-01	H		1225		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2025-01	L	?	12.4%	20.5%	15.1%
Number of non-elective admissions	2025-01	H	?	7913	7140	6953
Number of zero day length of stay non-elective admitted patients	2025-01		?	2374	2077	2073
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2025-01		F	144	103	96
Overnight general and acute beds open	2025-01		?	899	838	838
Of those overnight general and acute beds open, proportion occupied	2025-01		?	93.9%		92%
Community bed occupancy/availability	2025-01		?	93.4%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

Inpatients - Proportion of patients discharged before 5pm



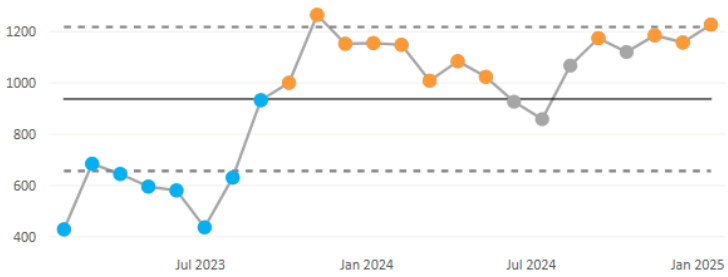
Latest Month
2025-01
Value
65.4%
Target
70%

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 **1.7**.

Variation Assurance

Inpatients - Lost bed days for patients with no criteria to reside



Latest Month
2025-01
Value
1225
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **70.0**.

Rationale: Understand flow in the acute bed base.
Target: SPC1: Internal target of 70%. **SPC2:** No target.

Actions:

- Timeliness of discharges is one of the key performance indicators for the work of the Discharge Improvement Group. A new 'Scorecard' report has recently been produced which shows timeliness of discharges at Ward level so that improvement work can be targeted where it is most needed, and to learn from areas of best practice.
- A Discharge Sprint team has been formed to improve effective, timely MDT board rounds across all medical wards in both acute hospitals by end of March 2025. This work aims to accelerate the discharge improvement project to ensure effective Board Rounds are in place across the Medicine wards footprint.
- Lost bed days for patients with no criteria to reside has been increasing despite a drop in the proportion of patients not meeting the criteria to reside. This could reflect a longer length of stay and/or longer length of delay for moving those patients to a more appropriate care setting; the detail is being considered in the Discharge Improvement Group.

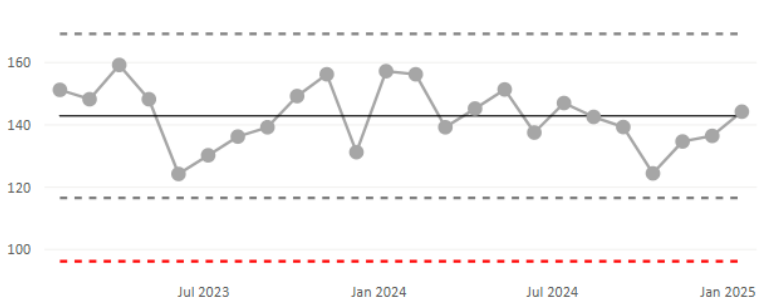
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: SPC1: Less than 96 Super Stranded patients as per activity plan (March 2025).
SPC2: Less than 15% as per activity plan (March 2025).

Inpatients - Super Stranded Patients, 21+ LoS (Adult)

Variation: F
Assurance: F



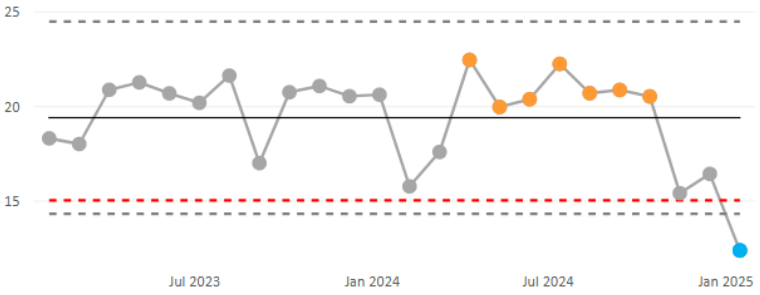
Latest Month: 2025-01
Value: 144
Target: 96

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 **7.8**.

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

Variation: L
Assurance: ?



Latest Month: 2025-01
Value: 12.4%
Target: 15.1%

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

The latest months value has **improved** from the previous month, with a difference of **4.0**.

Actions:

- The number and proportion of super-stranded patients was on a clear downward trajectory throughout 2024 but progress stalled in November and December. A six-week Sprint Project is underway to provide intensive support to all medical wards' board rounds. Ensuring clear clinical management plans are in place from the outset, and that any delays in a patient pathway are reduced or eliminated, length of stay should reduce.

- The proportion of patients who no longer meet the criteria to reside improved significantly in January 2025 and is ahead of the improvement trajectory (21%) submitted the NHSE as part of the 2024-25 planning. A new second line escalation process involving Directors of Social Services continues to support improvement in this area.

- Plans to establish a consistent Discharge to Assess (D2A) model across our footprint are adapting in response to feedback from our local authority colleagues. City of York and North Yorkshire are both progressing their own D2A pathways which although not entirely similar do have common principles at their centre. Both will rely on a multi-organisation and multi-disciplinary discharge hub team, to be hosted in Discharge Command Centres at York and Scarborough hospitals. Neither will move to a 'notification' process yet (in place of a Trusted Assessment Form) but both will put increased focus on assessing patients' needs in their usual or new place of residence. This should lead to more patients leaving acute hospitals within 24 hours of being deemed ready for discharge, and therefore an improvement against this metric.

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

The Cancer performance figures for December 2024 saw an improvement in the 28-day Faster Diagnosis standard (FDS) to 72.3% (compared to 70% in November 2024) achieving the monthly improvement trajectory of 70%.

62 Day waits for first treatment December 2024 performance was 66.4% a reduction on the 71.7% seen in November 2024 however the monthly improvement trajectory of 63.1% was achieved. The Trust has, as part of the 2024 Operational Planning, submitted trajectories to achieve the national ambition of 77% for FDS and 70% for 62 Day waits for first treatment by March 2025.

Factors impacting performance:

- December 2024 saw 2,627 total referrals across all cancer sites in the trust, the lowest volume in over 12 months. Gynaecology saw a higher volume of referrals for over 12 months, which will be reviewed in January to understand trends. There was an average of 88 referrals per calendar day, lower than the average per month seen this financial year. Seasonal variation, coupled with 3 bank holidays and patient-initiated delays in December, is expected to have some impact on performance in January.
- The following cancer sites exceeded 75% FDS in December 2024: Breast, Head and Neck, None Site Specific and Other pathways. Haematology, Skin and Urology did not achieve FDS but did achieve above internal trajectories. Colorectal, Lung and Gynaecology remain below FDS and internal trajectory, with recovery plans around additional WLI's and insourcing to recover the position.
- The following cancer sites exceeded 70% 62-day performance in December: Breast and Skin. Gynaecology, Haematology, Colorectal, Upper GI and Urology achieved above their internal trajectories.
- 31-day treatment standard was 98.1% overall, an improvement on November's position. 270 treatments were delivered in December, in comparison to 277 treatments delivered in November. Urology had the highest volume of treatments delivered (66) and achieved 100%. Colorectal delivered 45 treatments and also achieved 100%.
- At the end of December, the proportion of patients waiting over 104+ days equates to 2% of the PTL size, at 213 patients. Colorectal and Skin are 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. The Colorectal position has improved in comparison to November. The Urology position also continued to improve, November was down from 12% to 8% of the PTL past 62 days and December the volume of patients over 62 days was the lowest for 6 months.

Actions:

Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Cancer - 62 Day First Definitive Treatment Standard	* Cancer - Faster Diagnosis Standard
COMMON CAUSE / NATURAL VARIATION		* Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL * Proportion of patients waiting 63 or more days after referral from cancer PTL * Cancer 31 day wait from diagnosis to first treatment * Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	
SPECIAL CAUSE CONCERN			

CANCER
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

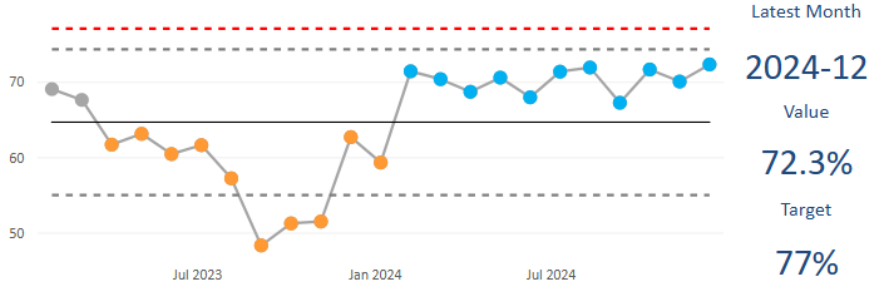
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard	2024-12	H	F	72.3%	70%	77%
Cancer - 62 Day First Definitive Treatment Standard	2024-12	H	?	66.4%	63.1%	70%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2025-01		?	175	143	143
Proportion of patients waiting 63 or more days after referral from cancer PTL	2025-01		?	8.4%		12%
Cancer 31 day wait from diagnosis to first treatment	2024-12		?	98.1%		96%
Total Cancer PTL size	2025-01	L		2033		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2025-01		?	74.4%		80%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Cancer - Faster Diagnosis Standard



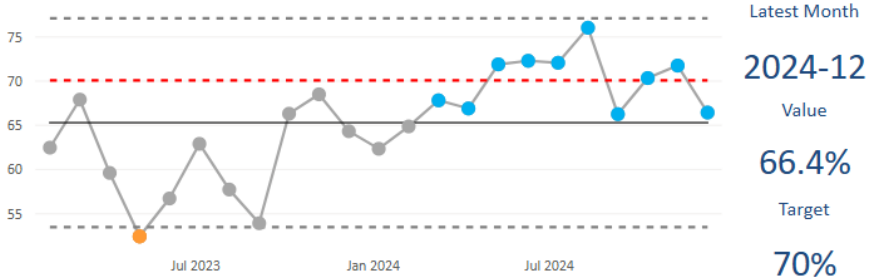
Latest Month
2024-12
Value
72.3%
Target
77%

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 **2.3**.

Variation Assurance

Cancer - 62 Day First Definitive Treatment Standard



Latest Month
2024-12
Value
66.4%
Target
70%

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 **5.3**.

Rationale: SPC1: Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. **SPC2:** National focus for 2024/25 is to improve performance against the headline 62-day standard.
Target: SPC1: 77% by March 2024. **SPC2:** 70% by March 2025.

Actions:

- NHSE performance recovery funded schemes implemented at beginning of January, including additional capacity in Prostate pathway short term change in practice for radiology to increase reporting capacity and reduce turnaround times for most challenged pathways. Prostate pathway provisional FDS position in January 2025 suggests a 25% improvement compared to January 2024. Imaging reporting for all fast-track modalities and tumour sites has improved, and prostate MRI reporting turnaround time has shortened in January to 2 days average, despite the volume of scans reported being larger in comparison to previous months.
- Colorectal improvement workshop took place in December 2024 with a short term (Q4 2024-25 delivery) and medium term (Q1 2025-26 delivery) improvement plan agreed. A follow up meeting is scheduled for February 2025 to review progress. Gynaecology session with cancer alliance attendance planned for March 2025. Urology reviewing actions from improvement plan and progressing options around a STT model for a cohort of haematuria patients.
- Planning for 2025-26 underway with national cancer planning pack released early February. Prostate, Gynecology, Skin and Breast identified as national priority pathways for improvement, with cancer alliances and providers to expected to set local priorities and operational improvement plan.

Headlines:

There were zero RTT 78-week waiters at the end of January 2025.

At the end of January 2025, the Trust had thirty-four Referral To Treatment (RTT) patients waiting over sixty-five weeks.

Factors impacting performance:

- The Trust's RTT Waiting list position is ahead of the trajectory submitted to NHSE as part of the 2024/25 planning submission, 42,554 against the trajectory of 45,072, a reduction of 798 (-2%) on the end of December 2024 position (43,352).

- The NHS Constitution established that patients "have the right to access certain services commissioned by NHS bodies within maximum waiting times". The RTT standard is a key performance standard indicating how trusts are delivering on a patient's right to receive treatment within 18 weeks of being referred to a consultant-led service. The proportion of the waiting list **waiting under 18 weeks** reduced last month with 53.9% at the end of January 2025 compared to 54.3% at the end of December 2024. The target for this metric is 92% which was last achieved nationally in February 2016. The national ambition as briefed in the Reforming Elective Care Plan published on the 7th of January 2025 states the NHS will meet the 18-week standard by March 2029. By March 2026, the intention is that the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally.

- The Trust narrowly failed to deliver the trajectory for RTT52 weeks; 1,128 against the January 2025 trajectory of 1,103. Nationally by March 2026, the intention is that the percentage of patients waiting more than 52 weeks for elective treatment will be 1% of a Trust's total RTT Waiting List.

- Delivery of the 2024/25 elective recovery plan. Initial analysis shows that at the end of January 2025 the Trust is ahead of the 2024/25 activity plan with a provisional performance of 108% of the Weighted Value Trust Activity Plan submitted to NHSE. From a financial point of view this equates to a provisional performance of 112% against the submitted plan, this is linked to the monetary value of the case mix that has been seen year to date.

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 - Total Waiting List * RTT - Waits over 78 weeks for incomplete pathways * RTT - Waits over 65 weeks for Incomplete Pathways * RTT - Waits over 52 weeks for Incomplete Pathways * RTT - Proportion of incomplete pathways waiting less than 18 weeks
COMMON CAUSE / NATURAL VARIATION			
SPECIAL CAUSE CONCERN			

Referral to Treatment (RTT)
Scorecard

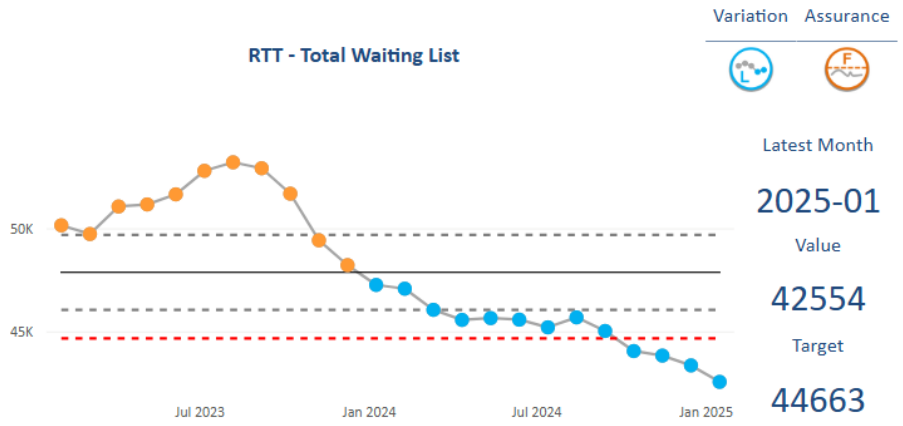
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List	2025-01	L	F	42554	45072	44663
RTT - Waits over 78 weeks for incomplete pathways	2025-01	L	F	0	0	0
RTT - Waits over 65 weeks for Incomplete Pathways	2025-01	L	F	34	0	0
RTT - Waits over 52 weeks for Incomplete Pathways	2025-01	L	F	1128	1103	923
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-01	H	F	53.9%		92%
RTT - Mean Week Waiting Time - Incomplete Pathways	2025-01	L		19		
Proportion of BAME pathways on RTT PTL (S056a)	2025-01			1.8%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2025-01			12.1%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2025-01	L		66.4%		

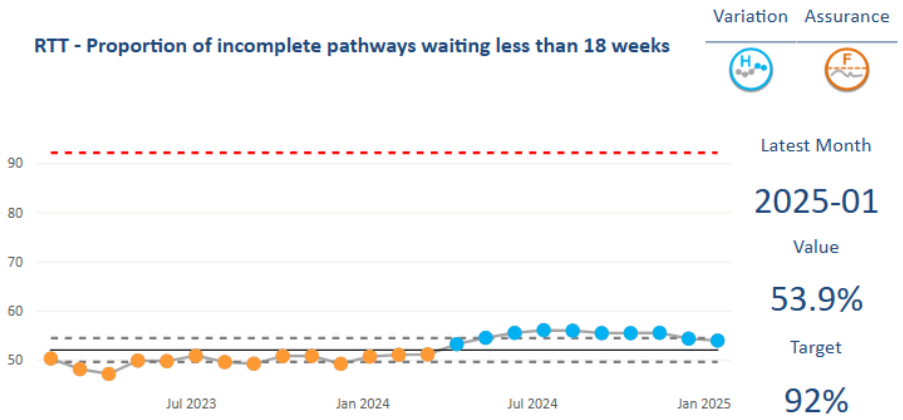
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **improved** from the previous month, with a difference of **798.0**.



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 **0.4**.

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 44,663 patients waiting by March 2025 as per activity plan.
SPC2: National constitutional target of 92% of patients should be waiting less than 18 weeks.

Actions:

- The Trust's RTT Waiting List continues to have a high data quality RTT Patient Tracking List Confidence Rating of 99.6% as awarded by the LUNA National data quality (DQ) RTT Benchmarking tool. The Trust is in the top 25 Trusts in the country for this metric which signals that our RTT waiting list is 'clean', accurate and the patients are legitimate waiters.

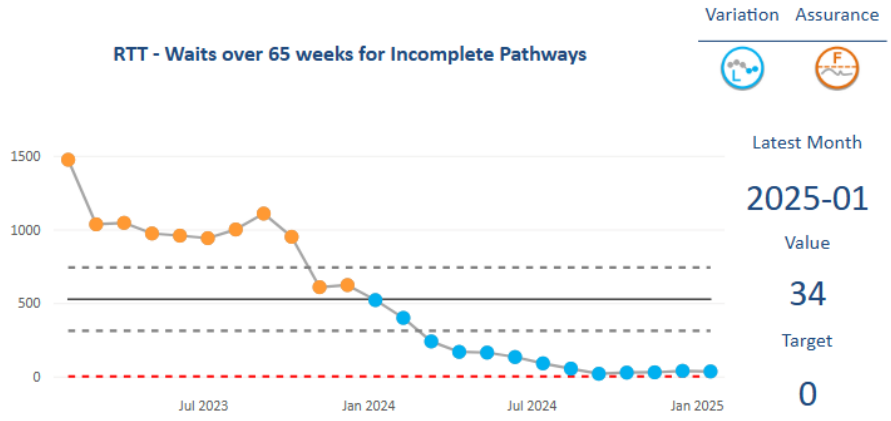
- The Trust is part of cohort 2 of the national Further Faster (FF) Programme, several specialties perform well against the key metrics including the did not attend (DNA) rate, pre-referral triage and advice and guidance. The Trust has been seen a 70.6% improvement since July 23 (baseline month) against 52-week backlog and is the second most improved Trust in cohort 2. It is the most improved Trust for CYP 52-week backlog with an 86.9% improvement, the average improvement for cohort 2 was 56.9%.

- 2024/25 Elective Recovery plan continues with the following workstreams:

  - Outpatient improvement.
  - Theatre improvement.
  - Diagnostic improvement.
  - Cancer.
  - Children and Young People.
  - Productivity and Efficiency.
  - Health inequalities.

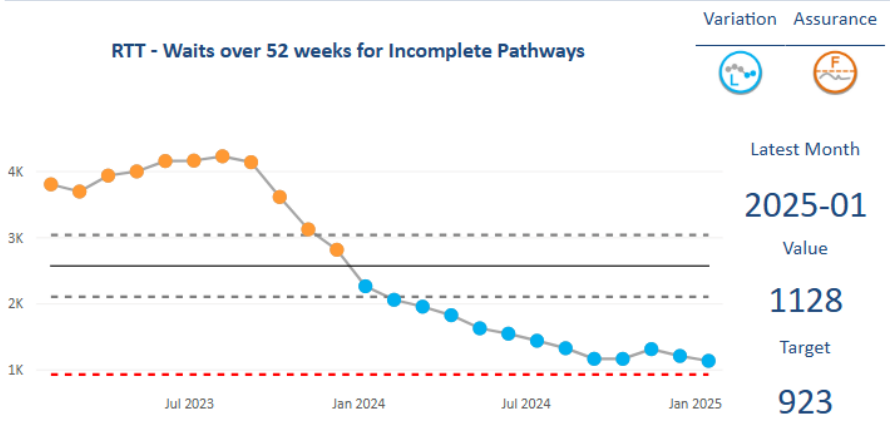
Executive Owner: Claire Hansen

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 **4.0**.



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 **74.0**.

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC2: National ambition to have 0 patients waiting more than 65 weeks by September 2024. **SPC2:** Aim to have less than 923 patients waiting more than 52 weeks by March 2025 as per activity plan.

Actions:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 and RTT65 weeks.
- Performance Team led review meetings were in place for specialties with RTT65 'risks' during January 2025 and will continue for the rest of the financial year.
- The Trust's activity plan is aligned to our improvement trajectory to deliver an improvement to have no more than 923 RTT52 week waits by the end of March 2025, that was submitted to the national team on the 2nd of May 2024. At the end of January 2025, the Trust was 25 behind the trajectory (1,128 against 1,103).
- Exploring mutual aid and independent sector capacity for Neurology. The service expected commencement of arrangement to insource capacity was delayed due to capacity issues with the independent supplier, but first clinic is now booked to start on the 22nd of February and will provide an additional 16 clinic slots per week.
- The Trust has seen continued capped theatre utilisation improvement and in further faster 2 cohort is the second highest performing Trust with utilisation above 82%.

Executive Owner: Dawn Parkes **Operational Lead:** Vicky Mulvana-Tuohy

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile

At end of: **January 2025**

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	19	5025	12.13%	8.88%
2	19	5953	14.37%	13.59%
3	19	8680	20.96%	20.94%
4	19	9178	22.16%	20.68%
5	19	12584	30.38%	35.90%
Unknown	17	1290		
Total	**19**	**42710**		

Highlights For Board To Note

As per national planning mandate, RTT Waiting List data has, in order to identify any potential health inequalities, been split to view Ethnic Groups and IMD Quintile.

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation. IMD is a combined measure of deprivation based on a total of thirty seven separate indicators that are grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area.

IMD quintiles range from one to five, where one is the most deprived. Please note that IMD quintiles are not available where we have no record of a patient postcode, the postcode is not an English postcode or is an unmatched postcode.

Ethnic codes have been grouped as per the 2021 census. Any patient where Ethnic Group is either 'Unknown' or 'Not Stated' is excluded from the PTL proportions. Areas to take into consideration when interpreting the data include the lack of available site split for Trust Catchment, and the variation that Clinical Prioritisation can bring to weeks waiting.

The Trust has established a Health Inequalities and Population Health Steering Group; the primary aim is to develop a plan that encompasses the overall Trust Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. This will align to the refreshed Trust Strategy 2024. A number of Task and Finish Groups will be established to facilitate focused and efficient implementation of specific aspects of the strategy. The overarching goal is to foster a healthcare environment that prioritises equity, inclusivity, and improved health outcomes for all individuals, considering socio-economic, demographic, or other determinants.

RTT PTL by Ethnic Group

At end of: **January 2025**

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	19	28118	98.19%	94.34%
Black, Black British, Caribbean or African	18	76	0.27%	0.94%
Mixed or multiple ethnic groups	17	145	0.51%	1.26%
Asian or Asian British	20	217	0.76%	2.97%
Other ethnic group	20	79	0.28%	0.49%
Unknown	19	11263		
Not Stated	19	2812		
Total	**19**	**42710**		

Data source for trust catchment area: Public Health England NHS Acute Catchment Areas.
*Proportion on waiting list excluding not stated and unknown.

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: 1st Attendances (Activity vs Plan)
COMMON CAUSE / NATURAL VARIATION	* Outpatient procedures * Proportion of elective admissions which are day case	* Outpatients - DNA rates * Outpatients: Follow Up 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)	* Outpatients - Proportion of appointments delivered virtually (S017a) * Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)
SPECIAL CAUSE CONCERN			* Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)

Outpatients & Elective Care
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

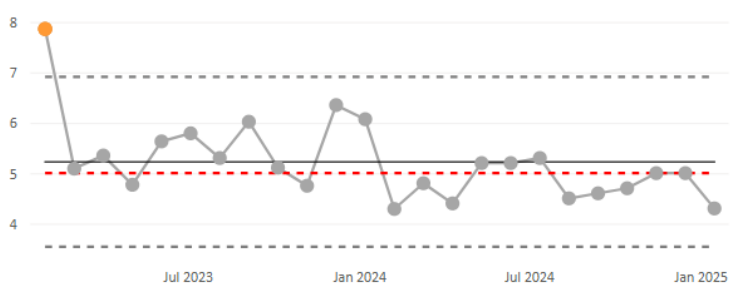
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2025-01		F	20.9%		25%
Outpatients - DNA rates	2025-01		?	4.3%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2025-01	H	F	20442	19642	19723
Outpatients: Follow Up Attendances (Activity vs Plan)	2025-01		?	47483	49636	45738
Outpatient procedures	2025-01		P	15736	8560	7884
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2025-01	H	F	27106		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2025-01		F	3.6%	4.9%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2025-01	L	F	10.2%		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*	2025-01		?	22		0
Day Cases (based on Activity v Plan)	2025-01		?	7897	7140	7037
Electives (based on Activity v Plan)	2025-01		?	652	582	576
Proportion of elective admissions which are day case	2025-01		P	92.4%		85%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Outpatients - DNA rates



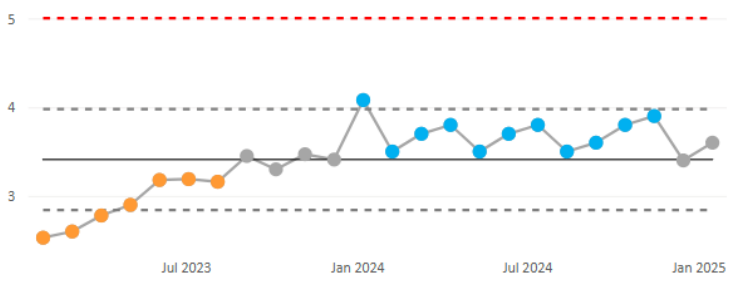
Latest Month
2025-01
Value
4.3%
Target
5%

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 **0.7**.

Variation Assurance

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



Latest Month
2025-01
Value
3.6%
Target
5%

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

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

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 5% by March 2025.

Factors impacting performance:

- Outpatient bi-directional text messaging continues to positively impact DNA rates.

Actions:

- Outpatient Procedure Code (OPCS) project is ongoing to improve outpatient procedure coding with Care Groups using reports to target specific areas where correct recording has not occurred. The Trust delivered the NHSE planning priority of 46% of first and outpatient procedures as a proportion of outpatient in January 2025 with performance of 50.2%. Year to date the Trust has achieved performance of 47.2%.

- The automatic referral upload from the e-Referral service into CPD commenced on the 27th of November. The automated process for uploading referrals has ensured that we are uploading referrals within 24 hours of the referral being available in e-RS. There has been a high volume of work which has been processed because of this change which has put additional pressure on clinical and admin teams. There has been feedback from clinicians that the way that the documents are presented in CPD is less user friendly and this is being worked on by the DIS team to understand what we can do locally. We have also requested some changes from NHSE so support the user interface.

- The medicine care group has a rapid access chest pain improvement action plan with a focus on the following actions:
    - Introducing RACP ED referral form
    - Consultant recruitment at SGH
    - Outsourcing of routine activity / waiting list initiatives
    - Demand and capacity planning

Headlines:
The January 2025 Diagnostic target position for patients waiting less than six weeks at month end was 69.1%, against the trajectory of 84.2%. The Trust saw the following modalities achieve their trajectories at month end:

- Colonoscopy.
- Flexi-Sigmoidoscopy.
- Gastroscopy.

Factors impacting performance:
- Decline in performance is consistent with seasonal trend seen in December and January in previous years. This is a combination of patient choice and reduced capacity over the Christmas period.
- Development of non-consultant workforce. Workforce plan in progress for the next 3 years.
- Age extension of Bowel Screening programme to be rolled out which requires and additional 5 sessions per week to manage demand over York and Scarborough.
- One Gastro consultant at Scarborough on reduced duties has impacted on the ability to deliver planned lists. Locum has been recruited to cover acute and elective endoscopy. Where they are not in work the York team provide cross site cover.
- Increase in outsourced work for imaging and histopathology leading to longer reporting times due to lack of in-house reporting capacity.
- Computed Topography (CT) most challenged imaging diagnostic due to demand, workforce and equipment issues. Workforce challenges within Cardiology for healthcare scientists, mitigated with insourcing.
- Capital programme in place for replacement of aging equipment over the next 2/3 years, including MRI and CT. new MRI scanner in 2025 from NHSE funding. Capital plans being worked up. CT scanner competitive process under way. MRI scanner order place and will be part of the hybrid theatre project.
- Workforce challenges across most imaging modalities, this is a national problem, and consequence of higher banding for CDC mobile so seeing increased attrition of staff. Increase in outsourced work leading to longer reporting times due to lack of in-house reporting capacity.
- Urodynamics performance was impacted by cancellations of clinics due to annual leave, sickness and reductions in capacity due to training. The service has attempted to provide additional capacity, but these have not been taken up by staff. In the short-term additional lists will be offered to substantive staff with the long-term solution to recruit additional nurse support included in the approved Urology Business Case.
- Barium Enema performance in December 2024 was impacted by capacity issues at Scarborough, service provided cover from York staff as well as additional capacity on the York site with improved performance seen in January 2025.

Actions:
Please see page below.

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

DIAGNOSTICS – National Target: 95%

Scorecard

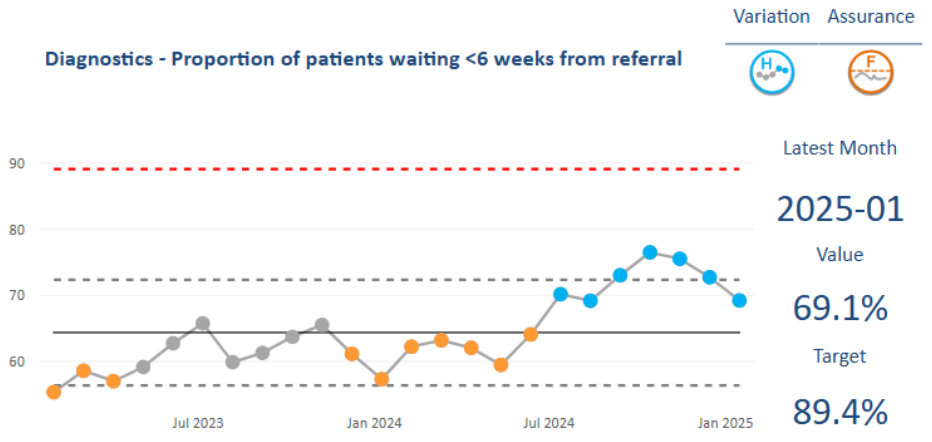
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Diagnostics - Proportion of patients waiting <6 weeks from referral	2025-01	H	F	69.1%	84.2%	89.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2025-01	H	F	74.1%	80.4%	85%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2025-01		F	67.1%	81.7%	85%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2025-01		F	67.3%	92%	95%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2025-01		?	80%	90.7%	95.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2025-01		F	53.6%	86.7%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2025-01	L	F	40.1%	93%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2025-01	H	F	71.4%	81.2%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2025-01		?	93.3%	95.7%	95.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2025-01	H	F	84.4%	95.2%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2025-01		F	24.2%	62.8%	70.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2025-01	H	F	80.7%	78.4%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2025-01	H	?	80.3%	51.3%	52.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2025-01		?	81.3%	91.7%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2025-01		?	82.1%	82.1%	84.8%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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 **3.5**.

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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 in line with the March 2025 ambition of 95%.

Actions:

Endoscopy:

- Capacity and demand analysis undertaken which shows significant gap. Review of points per lists carried out to understand impact of surgical consult and scope model; this shows the potential for an additional circa 40 colonoscopies per week across all sites, if consultation removed. Discussion regarding potential way forward is ongoing with General Surgery colleagues.
- Workforce plan in progress for the next 3 years.
- Endoscopy insourcing ceased in January 2025 across both sites, and we are now using only our own workforce (including bank/WLI)
- Core capacity increased in January 2025 as trainee clinical endoscopist has now been signed off to work independently. Additional trainee clinical endoscopist started in post at the end of January and has begun their training programme, with an 18-to-24-month timeline for completion. There were multiple applicants for the trainee programme which is encouraging for future positions as they come available.

Imaging:

- CT recovery plan in progress including insourcing of Cardiac CT. This is currently going through procurement processes anticipated to be in place by end March.
- CT3 YH replacement, supplier now agreed. No confirmed timescale yet but anticipated to be circa Autumn 2025. New MRI scanner in 2025 from NHSE funding, order placed, location finalised for South entrance at the back of VIU. MRI scanner should be operational by Autumn 2025.
- Increase in DEXA activity is planned from April because of accepting GP referrals in York. The additional activity will be a mix of DM01 and surveillance.
- CT – independent sector, mobiles and WLIs have reduced the backlog of non cardiac CT waiters.
- MSK USS – Locum advertisements submitted to medical staffing to try to get increased medical cover for MSK USS to clear the backlog. Longer term will have more MSK capacity from job plan changes. MSK sonographer training being fed into workforce strategy. Further plans to expand use of CDC site for more MSK work. Training plan for sonographers being worked up with MSK consultants.
- Funding approved to support a trial of outsourcing day time acute imaging to free up our specialist radiologists to report more in-house cancer imaging to improve turnaround of cancer diagnostic reporting. Trial has been underway in urology and has shown improvement in turnaround times with no impact on acute.

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 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 (Type 1 only)
SPECIAL CAUSE CONCERN			* Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks

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)

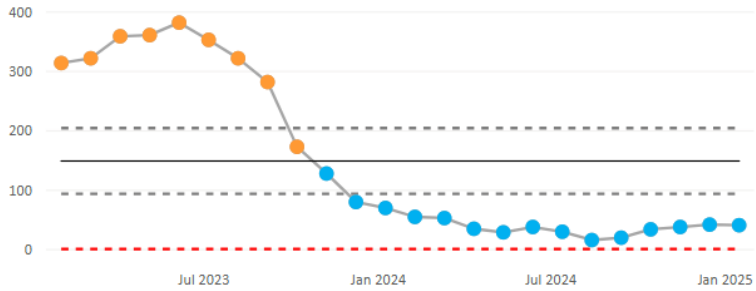
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2025-01			3		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2025-01		F	86.7%	95%	95%
Children & Young Persons: RTT - Total Waiting List	2025-01	L		3557		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-01	L	F	59.9%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2025-01	L	F	40	0	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi

Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways

Variation Assurance



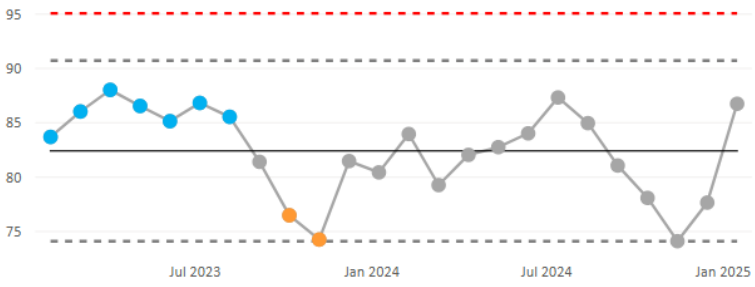
Latest Month
2025-01
Value
40
Target
0

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 **1.0**.

Children & Young Persons: ED - Emergency Care Standard (Type 1 only)

Variation Assurance



Latest Month
2025-01
Value
86.7%
Target
95%

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 **9.1**.

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: Aim to have zero patients waiting more than 52 weeks (internal target).
SPC2: NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025

Factors impacting performance:

- **SPC1:** The Trust did not deliver the trajectory for RTT52 weeks wait for patients aged under eighteen with 40 against an internal trajectory of zero. The Trust is seeking to deliver zero CYP patients waiting over 52 weeks as soon as possible with plans in place to achieve by the end of March 2025.
- **SPC2:** ECS performance for CYP has improved to 86.7% from 77.6% (December 2024).

Actions:

- **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.
- **SPC1:** Going further for children waiting times for surgery, Surgical Care Group is aiming to run additional CYP capacity in the school half-term holiday during February 2025.
- **SPC2:** Actions planned:
  - Service is conducting review of the pathway for children aged 0-17 years requiring admission to ensure patient is ready for transfer in appropriate timescales and promptly transferred to the appropriate Children/Adult Ward as per the Continuous Flow Model.
  - The team is working to finalise the Standard Operating Procedures for operational management and escalation.
  - The Team is working to ensure there is a monitoring process and audit of nursing quality metrics of children within the ED Department to include the extended stay proforma.

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	* Number of people on waiting lists for CYP services per system who are waiting over 52 weeks		* Number of open Virtual Ward beds
COMMON CAUSE / NATURAL VARIATION	* 2-hour Urgent Community Response (UCR) Compliancy %	* Proportion of Virtual Ward beds occupied	
SPECIAL CAUSE CONCERN			

COMMUNITY
Scorecard

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
Number of open Virtual Ward beds	2025-01	H	F	33		33
Proportion of Virtual Ward beds occupied	2025-01		?	54.6%		80%
Community Response Team (CRT) Referrals	2025-01	H		572		
Total Urgent Community Response (UCR) referrals	2025-01	H		553		
2-hour Urgent Community Response (UCR) care Referrals	2025-01	H		151		
2-hour Urgent Community Response (UCR) Compliancy %	2025-01		P	89.4%		70%
Number of Adults (18+ years) on community waiting lists per system	2025-01			795		
Number of CYP (0-17 years) on community waiting lists per system	2025-01	L		1913		
Number of District Nursing Contacts	2025-01			21641		
Number of Selby CRT Contacts	2025-01			2802		
Number of York CRT Contacts	2025-01	L		4471		
Referrals to District Nursing Team	2025-01			2493		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2025-01	L	P	747	1056	1056

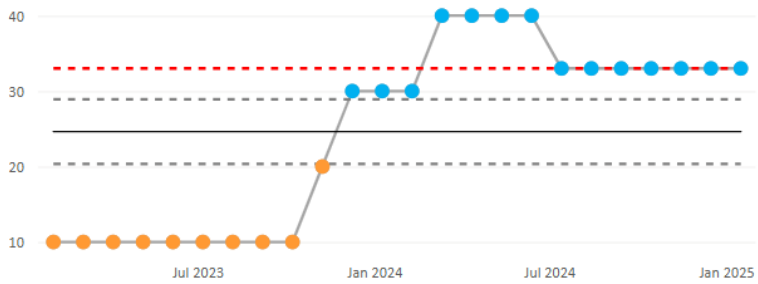
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor demand on Community virtual wards.
Target: SPC1: Trust is commissioned to deliver 33 virtual ward beds. **SPC2:** Aim to achieve 80% virtual ward bed occupancy as per activity plan.

Variation Assurance

Number of open Virtual Ward beds



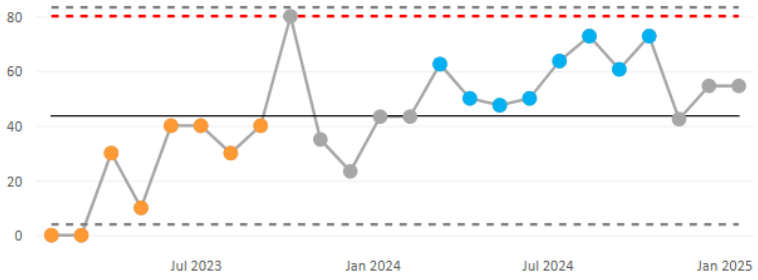
Latest Month
2025-01
Value
33
Target
33

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**.

Variation Assurance

Proportion of Virtual Ward beds occupied



Latest Month
2025-01
Value
54.6%
Target
80%

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**.

The ambition for the virtual ward utilisation rate is 80%; the 23rd January 2025 snapshot occupancy was 54.6%. Note, the data collection for virtual wards is an 8am snapshot once per fortnight, rather than an average or a cumulative count of total patients.

	Occupancy	Capacity	%
Frailty Virtual Ward	8	12	66.7%
Vascular Virtual Ward	4	8	50.0%
Heart Failure Virtual Ward	3	10	30.0%
Cystic Fibrosis Virtual Ward	3	3	100.0%
Total	**18**	**33**	**54.6%**

Actions:

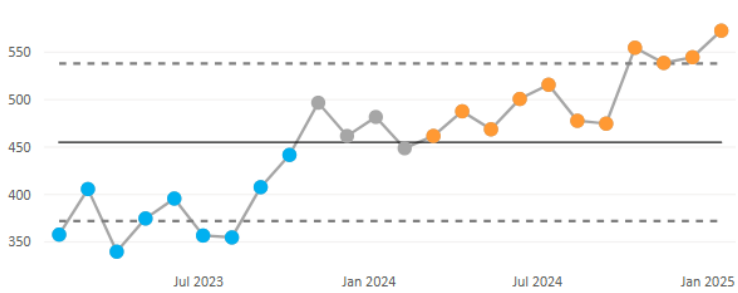
- **Frailty (FVW)** has recruited a second trust grade medic, to start in Spring 2025. This will support more consistent utilisation (including at weekends) and enable cross-cover of absences.
- A review is underway to assess whether the collaboration with the Community Response Team can be used to admit patients over a weekend (currently we support existing patients but cannot admit new ones). This would require the FVW core team to start working over a weekend.
- Two pathways in development are a step-up IV antibiotic pathway (drafted using City Health Care Partnership example) and an IV diuretics pathway which requires skills development with our nursing staff.
- **Heart Failure (HFVW):** A test of an in-reach model at York ED was successful in proving that patients with known heart failure who are in crisis can be diverted to the HFVW to receive their care, thus preventing an acute admission. A charitable funds request has been successful for 0.8WTE Band 7 nurse to expand the service as the next phase of this test of change. This model will start in Spring 2025.
- **Vascular (VVW):** Capacity is available for patients who can benefit from waiting at home for onward diagnostics or treatment, but it is not expected to be routinely 'full' as it depends on the number of suitable patients. There is not 'spare' capacity, the model uses pre-existing resource.
- **Cystic Fibrosis (CFVW):** Some patients can benefit from staying at home during a period of being acutely unwell, and the system is set up to allow this model of care and oversight for up to three patients at a time. There is not 'additional' capacity, the pre-existing team can work in a different way to support appropriate patients, and numbers will remain low due to the niche criteria.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Community Response Team (CRT) Referrals

Variation: H | Assurance: –

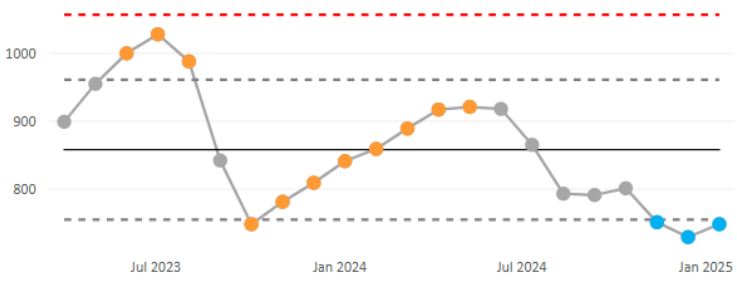


Latest Month: 2025-01
Value: 572
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **28.0**.

Number of people on waiting lists for CYP services per system who are waiting over 52 weeks

Variation: L | Assurance: P



Latest Month: 2025-01
Value: 747
Target: 1056

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 **19.0**.

Rationale: To monitor demand on Community services.
Target: SPC1: No target. **SPC2:** no more than 1,056 by end of March 2025 as per activity planning submission.

Factors impacting performance:

- **SPC1:** Referrals to Community Response Teams remain above the average control. The continued development of the Frailty Crisis Hub will likely have further impact on referrals with the YAS pathway developments.
- **SPC2:** The number of Children and Young People waiting over 52 weeks increased from 728 at the end of December 2024 to 728 at the end of January 2025.

Actions:

- **SPC1:** There is ongoing conversations with the South Hambleton and Ryedale and Selby Primary Care Networks re the UCR model and creating better integration with primary care to ensure better equity of service.
- **SPC1:** Additional therapy resource has been funded by NYCC place to support step down beds and IPU flow in the Selby area only.
- **SPC2:** SLT are discussing an insourcing option with an Independent Sector supplier to provide support for the telephone triage system, a follow up meeting to progress is now scheduled in February 2025.
- **SPC2:** Plan for OT service in place to deliver improvement from January 2025.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

February 2025

Summary MATRIX 1

Quality and Safety: *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		* Patient Falls per thousand Bed Days	
COMMON CAUSE / NATURAL VARIATION		* Total Number of Trust Onset MSSA Bacteraemias * Total Number of Trust Onset MRSA Bacteraemias * Total Number of Trust Onset C. difficile Infections * Total Number of Trust Onset E. coli Bacteraemias * Total Number of Trust Onset Klebsiella Bacteraemias * Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias * Total Number of Never Events Reported * Monthly SHMI * Monthly HSMR	
SPECIAL CAUSE CONCERN			

Quality & Safety
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

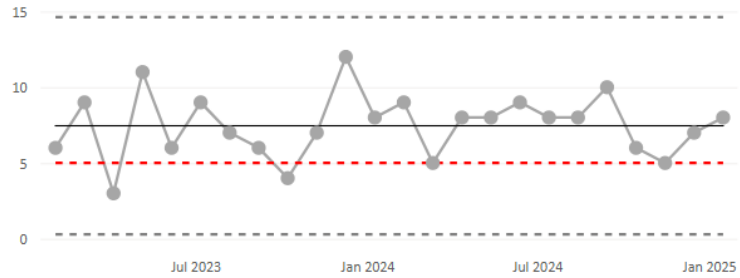
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2025-01			8	5	5
Total Number of Trust Onset MRSA Bacteraemias	2025-01			0		0
Total Number of Trust Onset C. difficile Infections	2025-01			13	10	10
Total Number of Trust Onset E. coli Bacteraemias	2025-01			10	13	13
Total Number of Trust Onset Klebsiella Bacteraemias	2025-01			4	5	4
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2025-01			1		2
Pressure Ulcers per thousand Bed Days	2025-01			3.9		
Patient Falls per thousand Bed Days	2025-01			7.8		8.7
Medication incidents per thousand bed days	2025-01			5.2		

Executive Owner: Dawn Parkes

Operational Lead: Sue Peckitt

Total Number of Trust Onset MSSA Bacteraemias

Variation Assurance



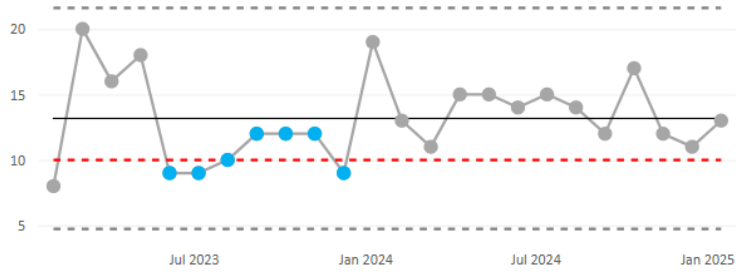
Latest Month
2025-01
Value
8
Target
5

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 **1.0**.

Total Number of Trust Onset C. difficile Infections

Variation Assurance



Latest Month
2025-01
Value
13
Target
10

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 **2.0**.

Rationale: To drive reduction in avoidable health care associated infection, facilitate patient safety and improve patient outcomes

Target: National thresholds for 2024/25 are a 5% reduction on the 2023/24 year end position.

Factors impacting performance:

- MSSA bacteraemia - 8 cases recorded in January, 6 cases attributed to Medicine Care Group, 1 attributed to Surgery Care Group and 1 case attributed to Family Health Care Group 12.5% of the cases are attributed to Scarborough Hospital, 12.5% of the cases are attributed to Family Services Care Group and 75% of the cases are attributed to York Hospital. The Trust is 8 cases over the year- to date trajectory.
- The Trust has recorded 0 MRSA Bacteraemia cases in January but have recorded a total of 4 cases for 2024/25 against a zero target..
- 13 Trust attributed Clostridioides difficile cases recorded in January against a trajectory of 12. Of the 13 cases 54% were attributed to York Hospital, 31% attributed to Scarborough Hospital, 15% attributed to community hospital sites. The Trust is 18 cases over the year to date target.
- Following a period of intensive support Ward 36 has not had a Clostridioides difficile attributed case in January and has reported 1 MSSA bacteraemia, which is a much improved position.

Actions:

- The care group IPC/AMS meetings have all now commenced and are reviewing and actioning improvement requirements.
- All MSSA bacteraemia undergo a review using a PSIRF approach, learning identified improvement needed with hand hygiene compliance, IV cannula documentation, ANTT compliance. The move towards care groups leading in these reviews has commenced.
- Clostridioides difficile cases are reviewed using PSIRF approach, learning identified is being addressed via the Care Group IPC/AMS meetings. 75% of all cases have undergone review, a much-improved position on previous years.
- The Trust MRSA/MSSA guidelines have been refreshed and are now published on the Trust intranet

Quality & Safety
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

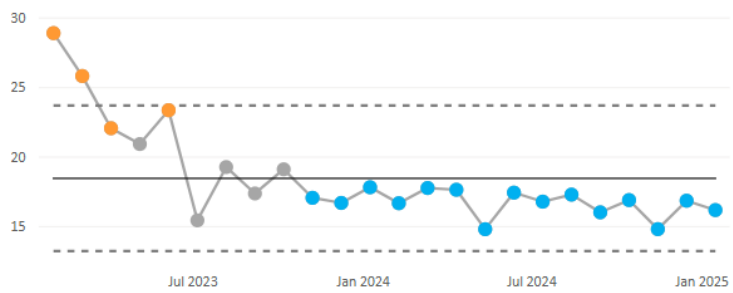
Executive Owner: Adele Coulthard/ Dawn Parkes **Operational Lead:** Dan Palmer/ Tara Filby/ Sacha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patient Safety Incidents per thousand Bed Days	2025-01			54.6		
Harmful Incidents per thousand bed days	2025-01			16.1		
Total Number of Never Events Reported	2025-01			0		0
In-Hospital Deaths	2025-01			244		
Quarterly SHMI	2024-06			96.7		100
Monthly SHMI	2024-10			92.4		100
Quarterly HSMR	2024-09			113		100
Monthly HSMR	2024-11			124.2		100
Trust Complaints	2025-01			79		
Antepartum Stillbirths	2024-11			1		
Intrapartum Stillbirths	2024-11			0		
Early neonatal deaths (0-7 days)	2024-11			0		
PPH > 1.5L as % of all women - York	2024-11			4.2%		
PPH > 1.5L as % of all women - Scarborough	2024-11			2%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2024-12			69.1%		

Executive Owner: Adele Coulthard/ Dawn Parkes/Karen Stone **Operational Lead:** Dan Palmer/ Tara Filby

Variation Assurance

Harmful Incidents per thousand bed days

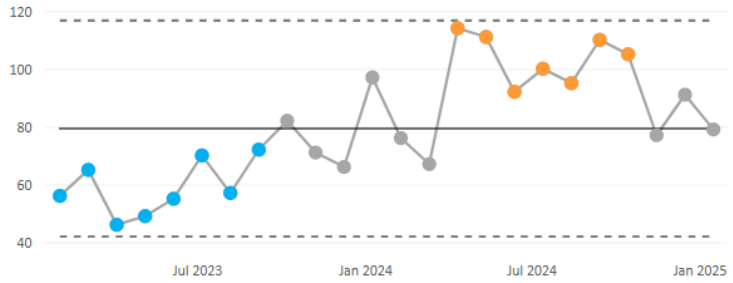


Latest Month
2025-01
Value
16.1
No Target

The latest months value has **improved** from the previous month, with a difference of **0.7**.

Variation Assurance

Trust Complaints



Latest Month
2025-01
Value
79
No Target

The latest months value has **improved** from the previous month, with a difference of **12.0**.

Rationale: The Trust is committed to learning from incidents and complaints and improving the patient experience
Target: No target identified as the reporting of incidents/complaints is an indicator of an open reporting culture

Factors impacting performance:

Duty Of Candor:

Duty of Candor is monitored via datix dashboards. However, the process is overseen by each individual care group. It is the care groups responsibility to report on this information via other reporting avenues.
The patient safety team are unable to influence if the care groups send letters when reasonably practical.

It should be noted that this data only shows two stages of duty of Candor. Which reflects the new policy however we still have the old stages of duty of Candor running concurrently until there is closure of all SI's in the old framework.

Moderate Harm:

The Bench marking target is based on last years out turn. The harms should be benched marked against providers of a similar size and service.

Having a base line target for the level of harm the organisation we tolerate can be detrimental. The level of harm is subjective decided by clinical staff. This decision making can differ between members of staff and is not an exact science.

The number of moderate harm incident can also be affected by the number of incidents that are yet to be investigated. Until the investigation is complete the level of harm may not be determined.

The patient safety team were commissioned to carry out closure of over due no and low harm incidents. 1400 Individual incidents have been themed and closed. Of the 350 remaining incidents overdue by 58 days all are awaiting investigation and were related to Information Governance, Medicines Safety or a PSIRF response which were exclude from the closure proposal.

Unfortunately, since the closure of incidents the overdue incidents have jumped back to 1400.

Factors impacting performance:
The number of new complaints remains high. The number has however reduced in the last month.

The area receiving the highest number of complaints continues to be the Emergency Department in York, with themes of staff attitude, ineffective communication and delays in being seen. This appears to correlate with ongoing operational pressures, with protracted waits for ambulance handover, wait to be seen by a doctor and wait to be transferred to an assessment space. These themes also continue to feature in the top 5 themes across all areas of the Trust.

Actions:
Work is underway to relieve the pressures in ED, to improve patient flow and therefore improve patient experience. A 'continuous flow' model has been commenced as a pilot on 4 wards in York (from 23rd October) and 2 wards at Scarborough (from 30th October). This has been further rolled out in November in York hospital and plans in place to roll out in Scarborough 11th December.

In Q2 the complaints feedback has been triangulated with other data sources. A 'patient, carer and families experience and engagement framework' has been codesigned with high level aims and objectives agreed. This has been circulated for consultation in Q3.

An improvement plan is under development, focusing on key themes of communication, accessible information and staff attitude. The plan will be developed in Q4 and presented to the Patient Experience Subcommittee. Customer care training to be scheduled for Jan-March.

To support improvements in patient experience, it has been agreed to re-set the Matron role, including being released from any meetings before 11.00am – this will increase the visibility of nursing leadership in clinical areas, aimed at promoting high quality care and effective communication with patients and families.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

February 2025

Summary MATRIX 1 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* Community midwife called in to unit - Scarborough		
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough	* Bookings ≥13 weeks (exc transfers etc.) - Scarborough * Births - Scarborough * No. of women delivered - Scarborough * Women affected by suspension - Scarborough * Maternity Unit Closure - Scarborough * SCBU at capacity - Scarborough * SCBU at capacity of intensive care cots - Scarborough * 1 to 1 care in Labour - Scarborough * L/W Co-ordinator supernumerary % - Scarborough	* Bookings <10 weeks - Scarborough
SPECIAL CAUSE CONCERN		* SCBU no of babies affected - Scarborough	* Planned homebirths - Scarborough * Homebirth service suspended - Scarborough * Anaesthetic cover on L/W - Scarborough

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2024-12		P	85		169	Target
Bookings <10 weeks - Scarborough	2024-12		F	62.4%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2024-12		?	4.7%		10%	Target
Births - Scarborough	2024-12		?	94		113	Target
No. of women delivered - Scarborough	2024-12		?	94		112	Target
Planned homebirths - Scarborough	2024-12	L	F	0%		2.1%	Target
Homebirth service suspended - Scarborough	2024-12	H	F	30		3	Target
Women affected by suspension - Scarborough	2024-12		?	0		0	Target
Community midwife called in to unit - Scarborough	2024-12	L	P	0		3	Target
Maternity Unit Closure - Scarborough	2024-12		?	2		0	Target
SCBU at capacity - Scarborough	2024-12		?	4		0.3	Baseline
SCBU at capacity of intensive care cots - Scarborough	2024-12		?	11		3.8	Baseline
SCBU no of babies affected - Scarborough	2024-12	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2024-12		?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2024-12		?	95.1%		100%	Target
Anaesthetic cover on L/W - Scarborough	2024-12	L	F	1		10	Target

Summary MATRIX 2 of 3

Maternity Scarborough

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	* Intrapartum Stillbirths - Scarborough	* Normal Births - Scarborough * Assisted Vaginal Births - Scarborough * C/S Births - Scarborough * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * Induction of labour - Scarborough * HDU on L/W - Scarborough * BBA - Scarborough * HSIB cases - Scarborough * Neonatal Death - Scarborough * Antepartum Stillbirth - Scarborough * Preterm birth rate <37 weeks - Scarborough * Preterm birth rate <34 weeks - Scarborough * Preterm birth rate <28 weeks - Scarborough	
SPECIAL CAUSE CONCERN		* Cold babies - Scarborough	

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Normal Births - Scarborough	2024-12			43.6%		57%	Target
Assisted Vaginal Births - Scarborough	2024-12			2.1%		12.4%	Target
C/S Births - Scarborough	2024-12			54.3%		40.1%	Baseline
Elective caesarean - Scarborough	2024-12			26.6%		16.9%	Baseline
Emergency caesarean - Scarborough	2024-12			27.7%		23.2%	Baseline
Induction of labour - Scarborough	2024-12			39.4%		45%	Baseline
HDU on L/W - Scarborough	2024-12			1		5	Target
BBA - Scarborough	2024-12			0		2	Target
HSIB cases - Scarborough	2024-12			0		0	Target
Neonatal Death - Scarborough	2024-12			0		0	Target
Antepartum Stillbirth - Scarborough	2024-12			0		0	Target
Intrapartum Stillbirths - Scarborough	2024-12		P	0		0	Target
Cold babies - Scarborough	2024-11	H		4		1	Target
Preterm birth rate <37 weeks - Scarborough	2024-12			3.2%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2024-12			1.1%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2024-12			0%		0.5%	Target

Summary MATRIX 3 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Breastfeeding Initiation rate - Scarborough * Breastfeeding rate at discharge - Scarborough	* Carbon monoxide monitoring at 36 weeks - Scarborough
COMMON CAUSE / NATURAL VARIATION	* 3rd/4th Degree Tear - normal births - Scarborough	* Low birthweight rate at term (2.2kg) - Scarborough * Smoking at booking - Scarborough * Smoking at 36 weeks - Scarborough * Smoking at time of delivery - Scarborough * Carbon monoxide monitoring at booking - Scarborough * PPH > 1.5L as % of all women - Scarborough * Shoulder Dystocia - Scarborough * Informal Complaints - Scarborough * Formal Complaints - Scarborough	
SPECIAL CAUSE CONCERN	* 3rd/4th Degree Tear - assisted birth - Scarborough		

Maternity Scarborough
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - Scarborough	2024-12			1.1%		0%	Target
Breastfeeding Initiation rate - Scarborough	2024-12	H		78.7%		75%	Target
Breastfeeding rate at discharge - Scarborough	2024-12	H		59.1%		65%	Target
Smoking at booking - Scarborough	2024-12			5.9%		6%	Target
Smoking at 36 weeks - Scarborough	2024-12			7.6%		6%	Target
Smoking at time of delivery - Scarborough	2024-12			8.4%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2024-12			85.9%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2024-12	H	F	74.7%		95%	Target
SI's - Scarborough	2023-10			1		0	Target
PPH > 1.5L as % of all women - Scarborough	2024-12			1.1%		2.3%	Baseline
Shoulder Dystocia - Scarborough	2024-12			0		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2024-12		P	0%		2.8%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2024-12	H	P	1.1%		6.1%	Target
Informal Complaints - Scarborough	2024-12			0		0	Target
Formal Complaints - Scarborough	2024-12			2		0	Target

Summary MATRIX 1 of 3

Maternity York

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* SCBU at capacity - York * SCBU no of babies affected - York	
COMMON CAUSE / NATURAL VARIATION	* Bookings ≥13 weeks (exc transfers etc.) - York * Anaesthetic cover on L/W - York	* Bookings - York * Bookings <10 weeks - York * Births - York * No. of women delivered - York * Planned homebirths - York * Homebirth service suspended - York * Women affected by suspension - York * Community midwife called in to unit - York * Maternity Unit Closure - York * SCBU at capacity of intensive care cots - York * 1 to 1 care in Labour - York * L/W Co-ordinator supernumerary % - York	
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - York	2024-12			303		295	Target
Bookings <10 weeks - York	2024-12			73.6%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2024-12		P	3%		10%	Target
Births - York	2024-12			235		245	Target
No. of women delivered - York	2024-12			230		242	Target
Planned homebirths - York	2024-12			1.7%		2.1%	Target
Homebirth service suspended - York	2024-12			3		3	Target
Women affected by suspension - York	2024-12			1		0	Target
Community midwife called in to unit - York	2024-12			1		3	Target
Maternity Unit Closure - York	2024-12			0		0	Target
SCBU at capacity - York	2024-12	L		0		0.3	Baseline
SCBU at capacity of intensive care cots - York	2024-12			28		20.8	Baseline
SCBU no of babies affected - York	2024-12	L		0		0	Target
1 to 1 care in Labour - York	2024-12			100%		100%	Target
L/W Co-ordinator supernumerary % - York	2024-12			100%		100%	Target
Anaesthetic cover on L/W - York	2024-12		P	10		10	Target

Summary MATRIX 2 of 3

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	* Intrapartum Stillbirths - York	* Normal Births - York * Assisted Vaginal Births - York * Elective caesarean - York * Emergency caesarean - York * Induction of labour - York * BBA - York * HSIB cases - York * Neonatal Death - York * Antepartum Stillbirth - York * Cold babies - York * Preterm birth rate <37 weeks - York * Preterm birth rate <34 weeks - York * Preterm birth rate <28 weeks - York	
SPECIAL CAUSE CONCERN		* C/S Births - York	

Maternity York
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Normal Births - York	2024-12			48.5%		57%	Target
Assisted Vaginal Births - York	2024-12			10.6%		12.4%	Target
C/S Births - York	2024-12	H		40.9%		35.4%	Baseline
Elective caesarean - York	2024-12			14.9%		14.5%	Baseline
Emergency caesarean - York	2024-12			26%		20.9%	Baseline
Induction of labour - York	2024-12			46.1%		45.5%	Baseline
HDU on L/W - York	2023-10			8		5	Target
BBA - York	2024-12			2		2	Target
HSIB cases - York	2024-12			0		0	Target
Neonatal Death - York	2024-12			0		0	Target
Antepartum Stillbirth - York	2024-12			1		0	Target
Intrapartum Stillbirths - York	2024-12		P	0		0	Target
Cold babies - York	2024-12			0		1	Target
Preterm birth rate <37 weeks - York	2024-12			6%		6%	Target
Preterm birth rate <34 weeks - York	2024-12			3%		2%	Target
Preterm birth rate <28 weeks - York	2024-12			0%		0.5%	Target

Summary MATRIX 3 of 3

Maternity York

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* Breastfeeding Initiation rate - York		* Carbon monoxide monitoring at 36 weeks - York
COMMON CAUSE / NATURAL VARIATION	* 3rd/4th Degree Tear - assisted birth - York	* Low birthweight rate at term (2.2kg) - York * Breastfeeding rate at discharge - York * Smoking at booking - York * Smoking at 36 weeks - York * Smoking at time of delivery - York * Carbon monoxide monitoring at booking - York * PPH > 1.5L as % of all women - York * Shoulder Dystocia - York * 3rd/4th Degree Tear - normal births - York * Informal Complaints - York * Formal Complaints - York	
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - York	2024-12			0.4%		0%	Target
Breastfeeding Initiation rate - York	2024-12	H	P	91.5%		75%	Target
Breastfeeding rate at discharge - York	2024-12			72.9%		65%	Target
Smoking at booking - York	2024-12			6.9%		6%	Target
Smoking at 36 weeks - York	2024-12			2.5%		6%	Target
Smoking at time of delivery - York	2024-12			4.3%		6%	Target
Carbon monoxide monitoring at booking - York	2024-12			91.1%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2024-12	H	F	75.2%		95%	Target
SI's - York	2023-10			2		0	Target
PPH > 1.5L as % of all women - York	2024-12			4.7%		4.4%	Baseline
Shoulder Dystocia - York	2024-12			1		2	Target
3rd/4th Degree Tear - normal births - York	2024-12			0.4%		2.8%	Target
3rd/4th Degree Tear - assisted birth - York	2024-12		P	0.8%		6.1%	Target
Informal Complaints - York	2024-12			3		0	Target
Formal Complaints - York	2024-12			2		0	Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

February 2025

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)	* Total Agency Whole Time Equivalent Filled * Overall stat/mand training compliance * Overall corporate induction compliance * A4C staff stat/mand training compliance * A4C staff corporate induction compliance	* Annual absence rate * HCSW vacancy rate * Medical & dental staff corporate induction compliance * Appraisal Activity
COMMON CAUSE / NATURAL VARIATION		* Midwifery vacancy rate * Medical and dental vacancy rate * Registered Nursing vacancy rate * AHP vacancy rate * Total Bank Whole Time Equivalent Filled	* Medical & dental staff stat/mand training compliance
SPECIAL CAUSE CONCERN		* Monthly sickness absence * Overall vacancy rate	

Workforce
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

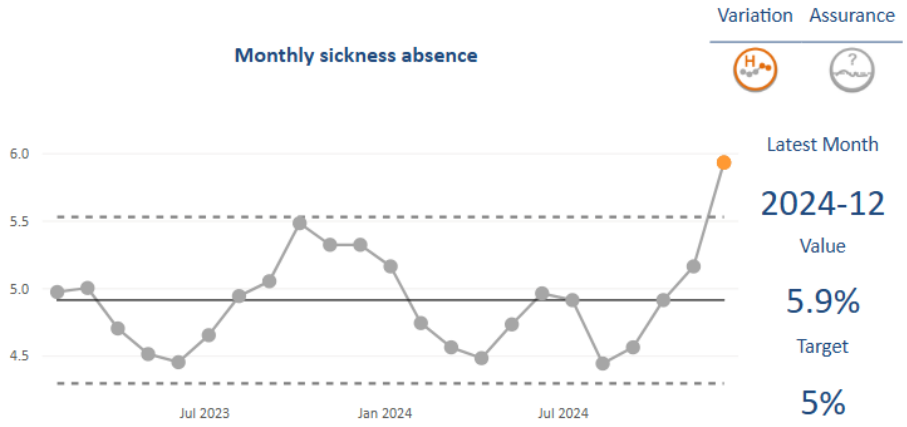
Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2024-12	H	?	5.9%		5%
Annual absence rate	2024-12	L	F	4.9%	4.7%	4.7%
12 month rolling turnover rate Trust (FTE)	2025-01	L	P	8.6%		10%
Overall vacancy rate	2025-01	H	?	9.5%		6%
HCSW vacancy rate	2025-01	L	F	9.4%		5%
Midwifery vacancy rate	2025-01		?	-0.1%		0%
Medical and dental vacancy rate	2025-01		?	7%		6%
Registered Nursing vacancy rate	2025-01		?	6.5%		5%
AHP vacancy rate	2025-01		?	6.8%	8.5%	8.5%
Total Agency Whole Time Equivalent Filled	2024-12	L	?	126.5		151
Total Bank Whole Time Equivalent Filled	2024-12		?	591.2		557
OVERALL: Percentage of rosters approved six weeks before start date	2024-12		F	21.3%		100%
NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent	2024-12		?	5244.2	0	0
NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)	2024-12		F	28%	22%	22%

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

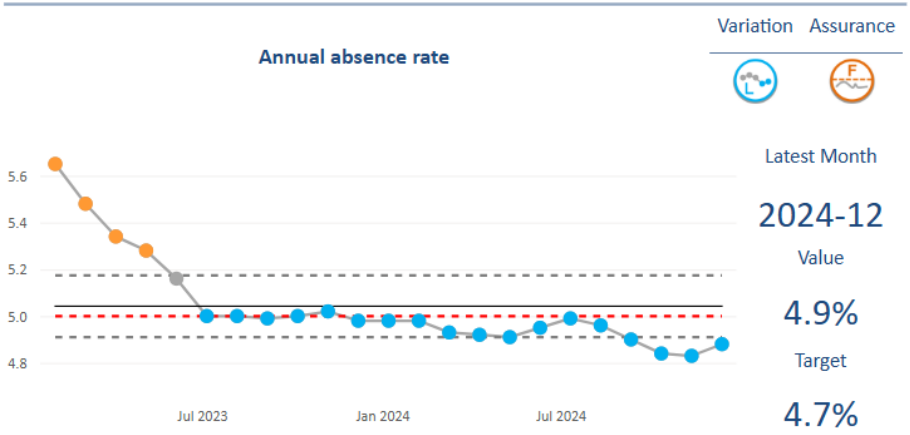
Monthly sickness absence



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

The latest months value has **deteriorated** from the previous month, with a difference of **0.7**.

Annual absence rate



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

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

Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.7%

Factors impacting performance and actions:

Staff absence rates have been increasing month-on-month since August 2024. The latest absence data shows a significant increase from November to December (from 477 WTE to 543 WTE lost). Stress and anxiety remains the leading cause of absence and for the second month in a row accounted for a 122 WTE loss. Episodes of cold and 'flu related absence increased by 6% in December, equating to a loss of 93 WTE.

Increased monthly absence rates have impacted the rolling annual rate, resulting in a 0.1% increase from last month. In 2025-26 the Trust has agreed to aim for a 4.3% annual target as part of its Operational Plan.

The Trust is continuing to make 'flu vaccination available to staff with a further drop-in session scheduled for 4 March. 31% of staff have taken up the offer of vaccination this winter.

The Trust's Occupational Health service recently received SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation. SEQOHS is a set of standards and a voluntary accreditation scheme for occupational health services in the UK. This accreditation is awarded for five years, subject to services demonstrating continuing high standards through annual renewal assessments.

The Trust has ratified a new Sexual Misconduct Policy. This will be launched with a new anonymous reporting tool in line with the Trust's No Excuse for Abuse campaign.

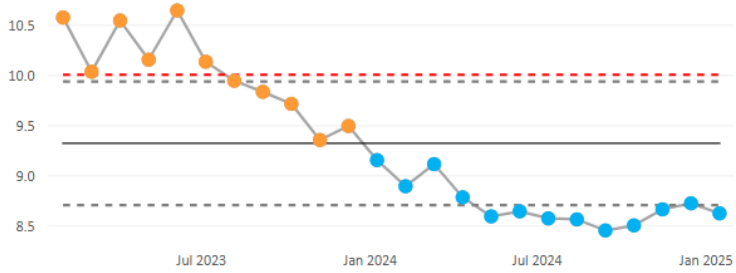
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 10% Vacancy Rate 6%

12 month rolling turnover rate Trust (FTE)

Variation: L | Assurance: P



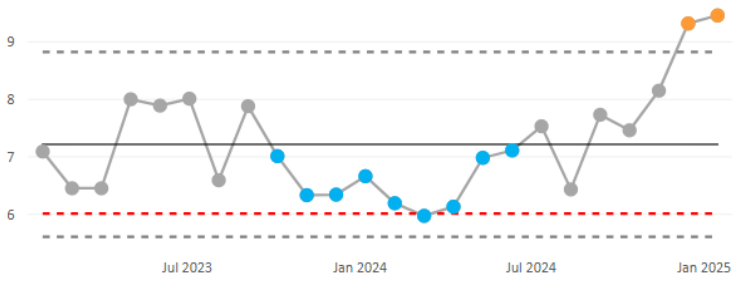
Latest Month: 2025-01
Value: 8.6%
Target: 10%

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

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

Overall vacancy rate

Variation: H | Assurance: ?



Latest Month: 2025-01
Value: 9.5%
Target: 6%

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

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

Factors impacting performance and actions:

The Quarterly Pulse Survey was open throughout January. The Trust had a 6% response rate - higher than the 3.4% response rate from a year ago but lower than in July 2024. All engagement metrics are lower than previous surveys and the Trust is below the national average. All Care Groups and Corporate Services are working on improvement plans following the Staff Survey and these will be shared widely after the reporting embargo.

The Trust continues to report the lowest rate of staff turnover in Humber and North Yorkshire ICS. As part of the Operational Plan, the Trust will seek to maintain this rate in 2025-26.

Since December, the vacancy rate has increased nominally due to a 14 WTE uplift in budgeted establishments, attributable in part to budget being drawn into the Tobacco Dependency Service.

Recruitment restrictions remain in place through the enhanced vacancy control process. At the end of December 2024, the Trust was 0.06% (62 WTE) above its 2024-25 workforce plan. A little over half this amount (32 WTE) can be linked to business cases or receipt of external funding that was transacted after the start of the financial year.

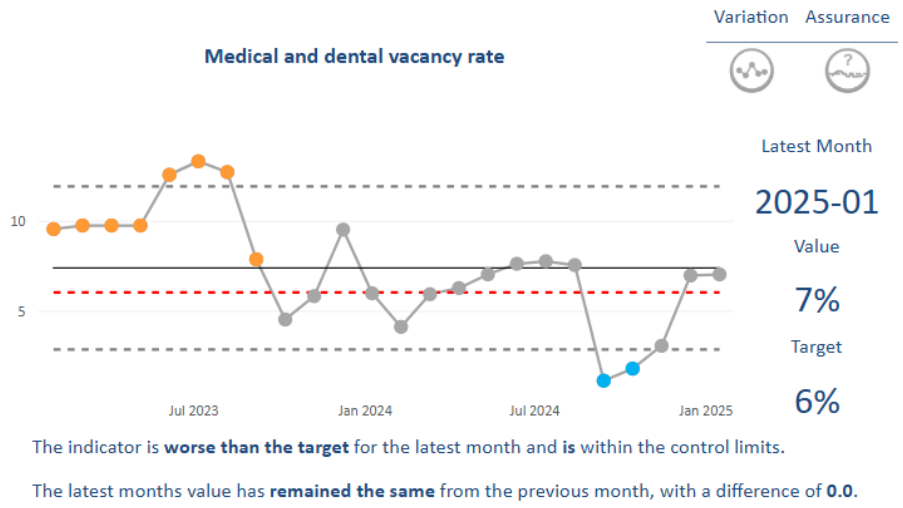
NHS England have begun monitoring recruitment performance through a Time to Hire data collection. The exercise aims to reduce loss of applicants in the hiring process by troubleshooting any issues or common themes across the service nationally.

The first published report showed the Trust averaged a turn-around of 38.9 working days from advert to conditional offer. In the North East and Yorkshire region, the provider average was 38.8 working days. The national average was 40.8 working days.

Measurement from advert to start date in the Trust produced a hire time of 72 working days. The regional and national averages were 79 and 78.8 working days respectively.

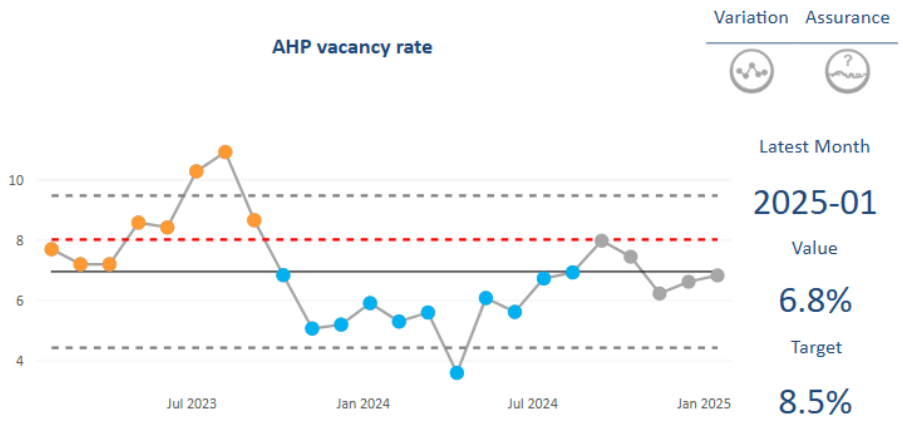
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

The latest months value has **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 **0.2**.

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 8.5%

Factors impacting performance and actions:

In January, the Trust welcomed six new medical staff into posts, including two substantive consultants, one with Histopathology and one within Paediatrics.

In addition, eight offers were made for medical posts across the Trust, including two permanent Consultant posts in Palliative Care and Gastroenterology. As a result of the offers made, the Trust is due to end two agency locum bookings, including one long-term booking which has been in place since 2019.

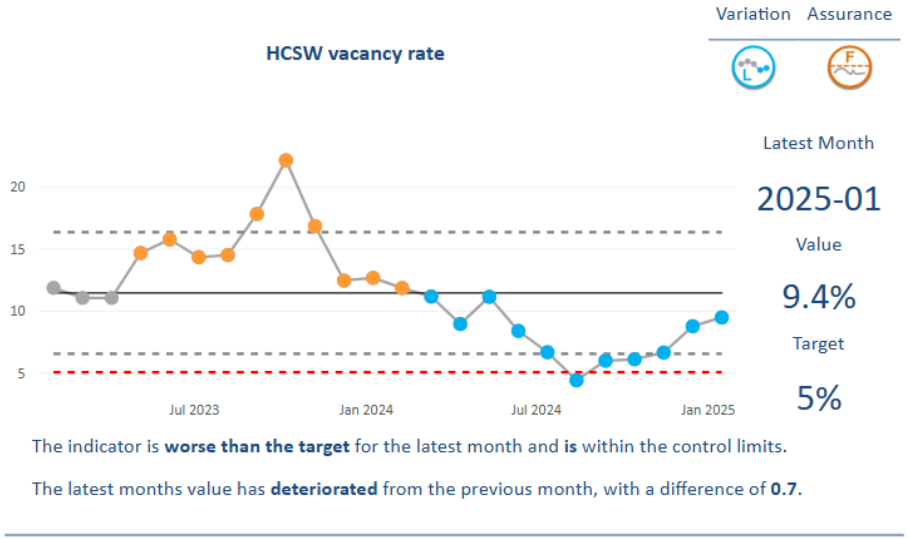
December's report included details of budgetary changes that had impacted the medical and dental vacancy rate between November and December. This included the establishment of a 13 WTE Hull Cellular Pathology Consultant budget for the Scarborough Hull York Pathology Services. As the medical staff in this service are employed by Hull University Teaching Hospitals NHS Trust, the change added 13 WTE to the vacancy count which is not representative of an actual gap. When this is set aside the vacancy rate reduces to 5.92%, in line with the Trust's target vacancy rate.

On 17 February, the Trust will welcome nine internationally educated nurses (the final cohort for 2024-25). This group are the first to be recruited by the Trust after completing the bridging course from the colleges in Kerela, India.

Last year, the Trust introduced a starting salary process to recognise the previous experience of internationally educated nurses. 200 existing members of staff have been contacted about the process and advised of their eligibility to apply for a salary adjustment. To date, 118 requests have been processed, and the Trust is working to support the remaining staff.

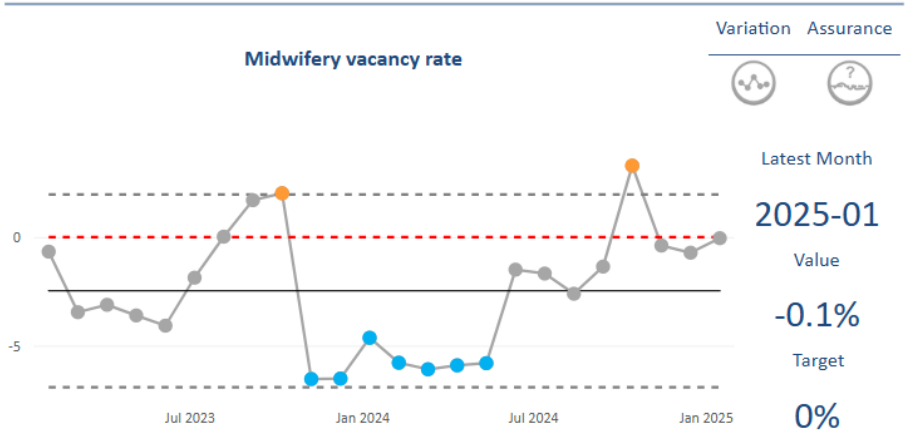
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

The latest months value has **deteriorated** from the previous month, with a difference of **0.7**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **0.6**.

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 5%, Midwifery vacancy rate 0%

Factors impacting performance and actions:

There are currently 43 WTE HCSWs within the recruitment pipeline, with 28 WTE currently undertaking pre-employment checks with the Trust. An additional 15 WTE HCSWs are booked onto upcoming Academy programmes.

Over the last 12-months, the Trust has worked in partnership with Trade Unions to review HCSW roles. This has resulted in the development of new job descriptions reflective of national job profiles at Bands 2 and 3. The Trust is now seeking to align staff with these job descriptions and provide recompense to those who have been under-paid. A detailed proposal has been made to Trade Unions who are consulting with members about whether to accept the Trust's offer. The consultation will close on 3 March.

As part of the ongoing monitoring of Nursing Associates it was agreed to include the number of Nursing Associates employed by the Trust in the TPR. The numbers for nursing associates has shown a nominal decrease with the headcount reducing from 61 to 60 and the WTE reducing from 56 to 55.

There are 45 Apprentice Nursing Associates in the Trust who are due to qualify between January 2025 and September 2026. The Trust is planning to add to this group; however, from April, NHS England will no longer pay £4,400 per apprentice per year to back-fill new enrolments. Although there is a national review of apprenticeship provision which may alter the funding position again, the Trust has committed to using Health Care Support Worker vacancies to mitigate the position and sustain the pipeline of Nursing Associates into the organisation. The next cohort will commence in September 2025.

Workforce Table

Workforce (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

	WTE Funded Establishment	WTE Vacancy	WTE Sickness	WTE Temporary Staffing Requested	WTE Variance between Requested and Vacancy & Sickness	WTE Filled by Bank	WTE Filled by Agency	WTE Variance between Total Filled and Vacancy & Sickness
Nursing								
Oct-24	2570.38	85.45	116.49	307.10	105.16	165.90	76.60	40.56
Nov-24	2571.33	95.11	124.86	311.60	91.63	170.40	79.90	30.33
Dec-24	2596.26	137.15	142.53	299.70	20.02	156.80	65.80	-57.08
HCA								
Oct-24	1266.83	86.77	58.20	266.90	121.93	203.30	0.00	58.33
Nov-24	1265.84	83.39	61.25	261.40	116.76	208.00	0.00	63.36
Dec-24	1277.11	111.41	69.13	276.00	95.46	208.60	0.00	28.06
M&D								
Oct-24	1065.02	18.90	47.84	129.72	62.98	70.10	37.72	41.08
Nov-24	1066.55	32.46	50.88	170.56	87.22	74.10	76.31	67.07
Dec-24	1105.74	76.81	57.92	159.68	24.95	71.20	59.65	-3.88

Factors impacting performance and actions:

The Nursing eRostering Assurance Group continues to monitor KPIs and ensure temporary staffing use is being managed effectively. The group is driving efficiencies within temporary staffing usage, with key areas of focus including reducing day shifts for bank and agency, removing bank incentives and ensuring nights and weekends are rostered effectively, to reduce requirements for bank and agency at these peak times.

All ad hoc nursing agency shifts within the Trust are now within the NHSE agency price cap. This leaves several agency block bookings within Maternity and Theatres outside the agency price caps but the Trust has proactively worked with these suppliers to reduce the rates below the 50% price cap breach from December onwards. The Nursing eRostering Assurance Group will monitor block bookings and explore opportunities to reduce costs moving forward.

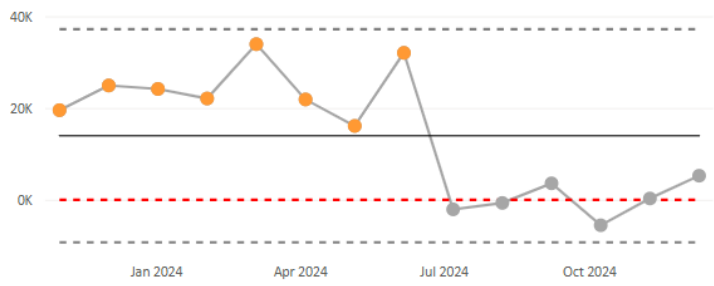
The Trust has relaunched the Medical Temporary Staffing Review Group with representation from the Medical Director's Team, Clinical Directors, Care Group Management, Finance Management and HR teams specialising in medical recruitment and medical bank and agency use. The initial focus of the group is the reduction of agency spend by reducing rates, need for agency workers (concentrating on targeted recruitment in the areas using high-cost agency) and replacing long term or high-cost agency workers. As work progresses, the scope of the meeting will develop to include a reduction in bank usage and improving the governance and processes that support medical temporary staffing use.

The Trust has been monitoring the number of administrative bank shifts undertaken each month. 746 shifts were worked in January which is a reduction from the previous month, when 787 shifts were worked. With further restrictions introduced around vacancy control, the organisation will continue to monitor this activity closely.

Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent

Variation Assurance



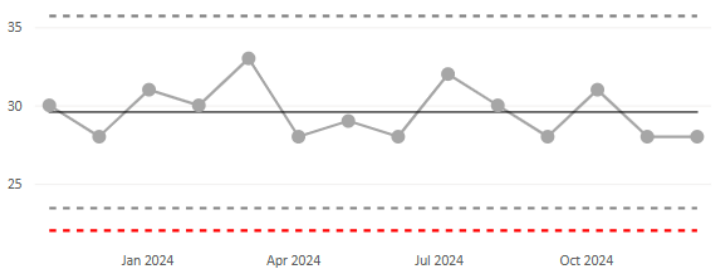
Latest Month
2024-12
Value
5244.2
Target
0

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

The latest months value has **deteriorated** from the previous month, with a difference of **4964.7**.

NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)

Variation Assurance



Latest Month
2024-12
Value
28%
Target
22%

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: Ensure maximum availability of workforce through effective rostering, supporting reduction in temporary staffing reliance.
Target: Net hours fewer than 12.5 hours per person.
Clinical Unavailability within budgeted headroom.

Factors impacting performance and actions:

The Trust has self-assessed at Level 4 (the highest level) of the NHS England Level of Attainment Standards for eRostering within nursing in-patient ward areas. Work is now underway to replicate this both within non-inpatient nursing units (non-IPU) which are currently at Level 2, and in the Allied Health Professional (AHP) group currently at Level 1.

Within nursing in-patient ward areas, the latest data shows 95% of rosters were published on time, compared to 44% for non-IPUs, a reduction from the previous reporting period. The aim is to publish 100% of rosters with at least 6 weeks' notice.

The utilisation of self-rostering or the auto-roster function is low at present. The Trust is exploring ways to increase take-up, to release efficiencies and support a better work life balance for staff.

	% of rosters self-rostered	Number of areas self-rostered	% of areas using auto-roster function	Number of areas using auto-roster function	% of rosters auto-rostered where function used
In-patient Wards	5%	3	23%	13	16.81%
Non-IPU's	0%	0	47.2%	52	17.52%

The Trust is aiming to have 90% of the clinical workforce on eRostering by Summer 2025, and to complete the full implementation of eRostering by Spring 2026.

Staffing Group	% on Healthroster	Staffing Group	% on Healthroster
Nursing and Midwifery	99%	AHP	97%
Additional Clinical Services	84%	Healthcare Scientists	23%
Sci and Technical	48%	Medical and Dental	38%
Admin and Clerical	43%	Estates and Ancillary	4%

Workforce
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

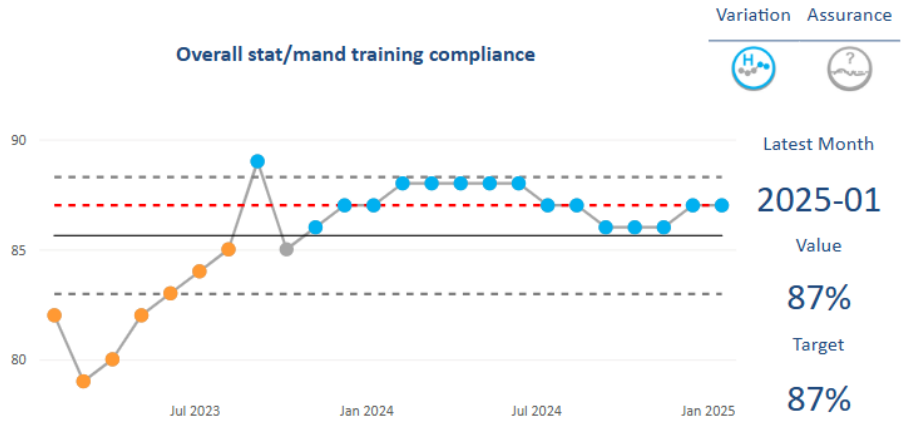
Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

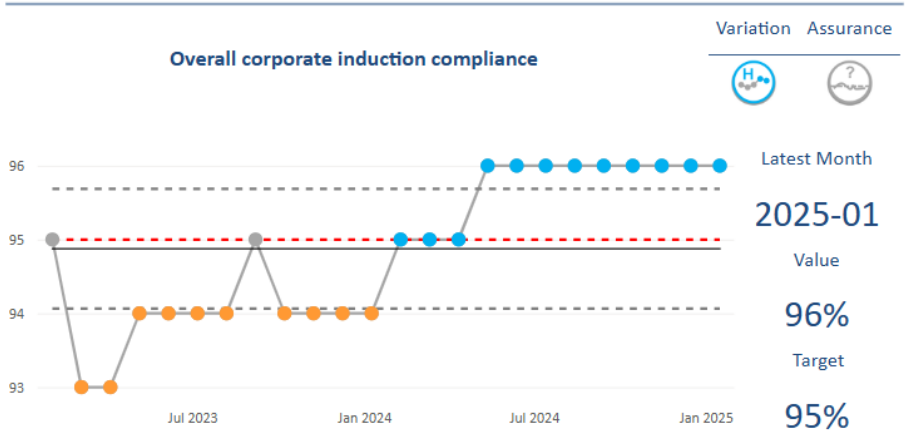
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2025-01	H	?	87%		87%
Overall corporate induction compliance	2025-01	H	?	96%		95%
A4C staff stat/mand training compliance	2025-01	H	?	88%		87%
A4C staff corporate induction compliance	2025-01	H	?	97%		95%
Medical & dental staff stat/mand training compliance	2025-01		F	73%		87%
Medical & dental staff corporate induction compliance	2025-01	H	F	95%		95%
Appraisal Activity	2024-12	H	F	88.2%	92.3%	95%
Percentage recommending the Trust as a place to work (quarterly - data source is PULSE, Staff Survey data omitted for Q3)	2024-07			37.8%		
Percentage recommending the Trust as a place to receive treatment (quarterly - data taken from PULSE, Staff Survey data omitted for Q3)	2024-07			39.9%		

Executive Owner: Polly McMeekin

Operational Lead: Will Thornton & Gail Dunning

Rationale: Trained workforce delivering consistently safe care
Target: Mandatory Training 87% and Corporate Induction 95%





Factors impacting performance and actions:

Compliance with mandatory training has maintained at 87%, in line with the Trust's target. Corporate induction attendance has also maintained at 96%, 1% above the Trust target.

Training completion rates are generally strong across the organisation; however, there remains a focus on seeking to improve compliance across all Resuscitation training and some sub-levels of Safeguarding training. The latter subject falls into a wider awareness drive in the Trust, which has included investment in two new Domestic Abuse Educator roles.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

DIGITAL AND INFORMATION SERVICES

February 2025

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		* Percentage of FOIs and EIRs responded to within 20 working days (monthly)	
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents*	
SPECIAL CAUSE CONCERN	* Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)		

Digital & Information Services (DIS)
Scorecard

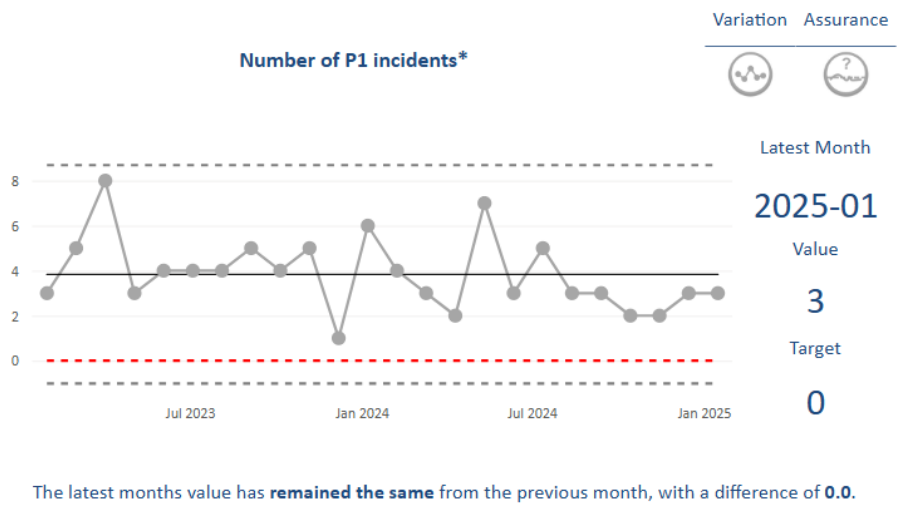
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: James Hawkins **Operational Lead:** Steve Lawrie/Rebecca Bradley

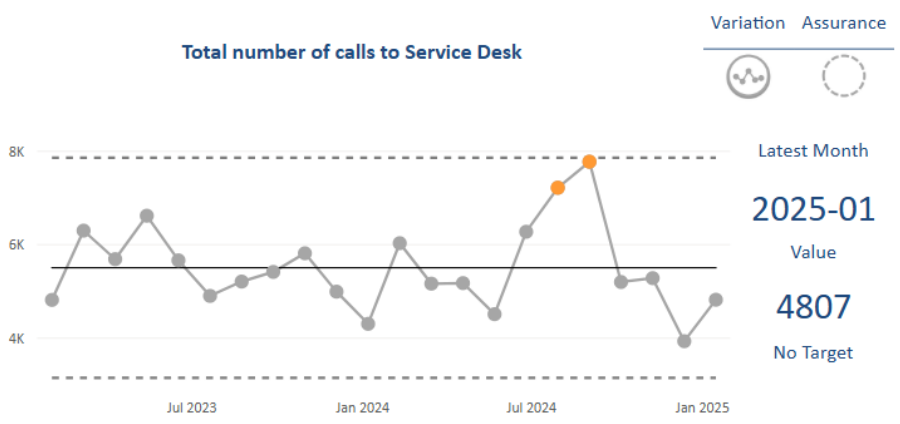
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2025-01		?	3		0
Total number of calls to Service Desk	2025-01			4807		
Total number of calls abandoned	2025-01			1618		
Number of information security incidents reported and investigated	2025-01			43		
Number of patient Subject Access Requests (SAR) received (monthly)	2025-01			351		
Number of patient Subject Access Requests (SAR) completed (monthly)	2025-01			103		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2025-01	L	P	99%		80%
Number of FOIs and EIRs received (monthly)	2025-01			105		
Number of FOIs and EIRs completed (monthly)	2025-01			71		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2025-01	H	?	97%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



The latest months value has **remained the same** from the previous month, with a difference of **0.0**.



The latest months value has **deteriorated** from the previous month, with a difference of **888.0**.

Rationale: Reduction in P1 Incidents and Service Desk Calls are a proxy for better digital service

Target: 0 P1 Incidents

Factors impacting performance:

3x P1 incidents occurred.

1. 17/1 CPD unavailable overnight between midnight and 0045hrs. Underlying cause escalated to Oracle software support for investigation.

2. 17/1 Network connection to Bridlington Hospital offline for approx. 10mins.

3. 27/1 Internet Service Provider fault affecting external connections to systems such as SystmOne and Badgernet - CPD and Nucleus were not affected.

Actions:

DIS are seeking to enhance IT services to improve the end user experience and better support the organisation across all functional areas. Some key priorities include faster ticket resolution, increased call queue capacity, clearer communication and a more efficient change management process.

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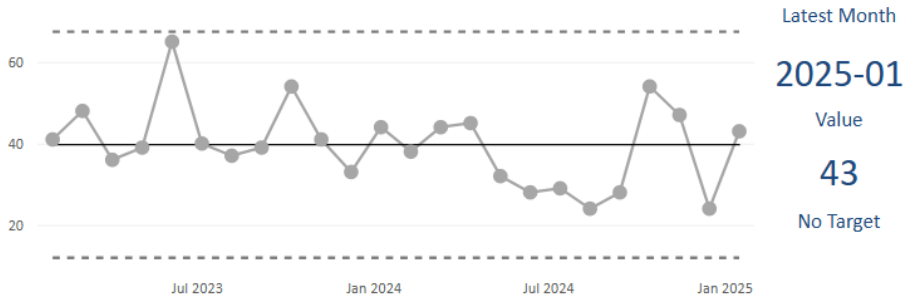
Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2025-01
Value
43
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **19.0**.

Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

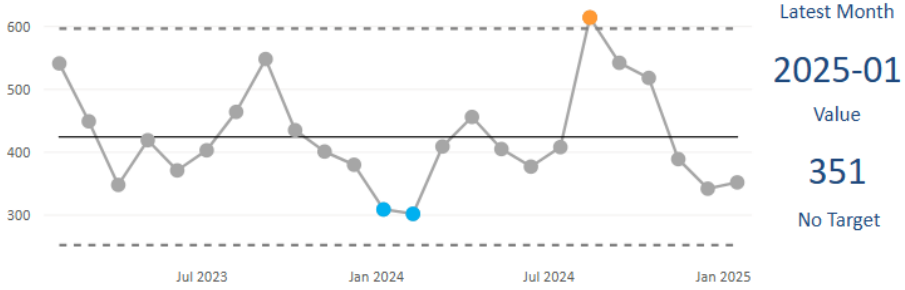
Factors impacting performance:

There has been an increase in security incidents reported, this is expected after a decrease in December due to staff annual leave.

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
2025-01
Value
351
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **10.0**.

Rationale: Monitoring of Subject Access Requests received to ensure the Trust is managing its statutory obligations under the UK GDPR.

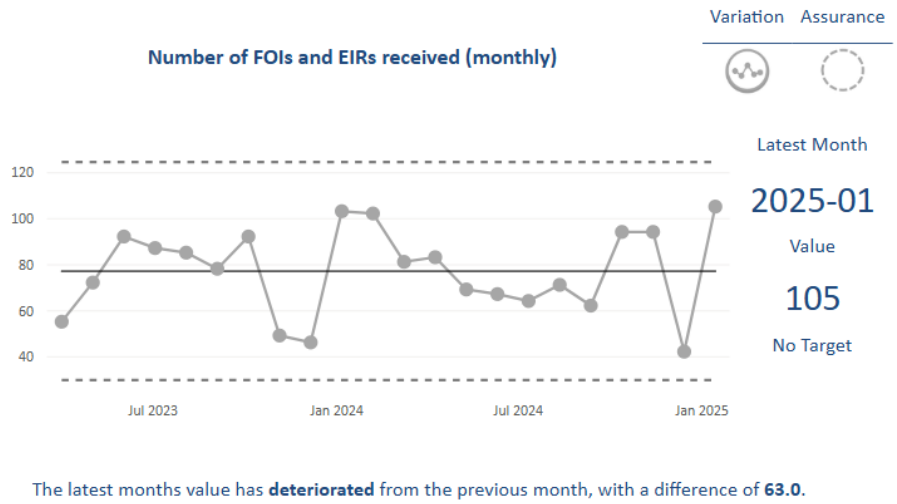
Number of Subject Access Requests submitted by patients

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. It has been highlighted that processes are being reviewed by the IG manager.

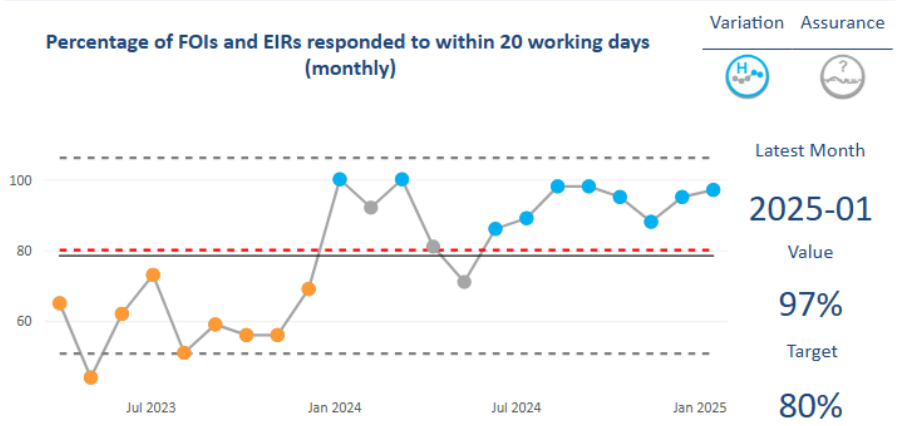
Actions: The team's processes are being reviewed by the IG manager; this may impact on timeliness of responses later in the calendar year.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley



The latest months value has **deteriorated** from the previous month, with a difference of **63.0**.



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

The latest months value has **improved** from the previous month, with a difference of **2.0**.

Rationale: Ensuring the Trust responds to FOI in line with legislation
Target: 80% FOIs responded to within 20 days

Factors impacting performance:.

Number of FOIs Received

There has been a significant increase in the number of requests received in January. Several were about the Trust finances, but generally there are no apparent trends regarding the type of requesters or the subject matter of requests.

Actions: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has increased.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

Summary Dashboard and Income & Expenditure

Finance (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£9.3m	-£11.2m	↓	Deteriorating
Core CIP Delivery Variance to Plan (£20.0m Target)	£3.5m	£2.8m	↓	Deteriorating
Corporate CIP Delivery Variance to Plan (£33.3m Target)	-£9.6m	-£14.2m	↓	Deteriorating
Variance to Agency Cap	£1.0m Below	£1.9m Below	↑	Improving
Month End Cash Position	£4.7m adverse to plan	£11.2m adverse to plan	↓	Deteriorating
Capital Programme Variance to Plan	£0.08m behind plan	£7.8m behind plan	↓	Deteriorating

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	745,780	621,154	640,190	19,036
Other Income	70,595	58,926	64,207	5,282
Total Income	816,375	680,079	704,397	24,318
Pay Expenditure	-523,179	-439,833	-460,480	-20,648
Drugs	-68,812	-57,421	-64,737	-7,316
Supplies & Services	-87,292	-72,551	-77,283	-4,732
Other Expenditure	-165,774	-116,455	-110,189	6,266
Outstanding CIP	23,737	11,414	0	-11,414
Total Expenditure	-821,320	-674,845	-712,690	-37,845
Operating Surplus/(Deficit)	-4,945	5,234	-8,292	-13,527
Other Finance Costs	-12,225	-10,198	-7,770	2,427
Surplus/(Deficit)	-17,169	-4,964	-16,063	-11,099
NHSE Normalisation Adj	17169	363	245	-118
Adjusted Surplus/(Deficit)	0	-4,600	-15,818	-11,218

The I&E table takes into account the £16.6m deficit support funding and presents a balanced plan. From a YTD perspective, the table confirms an actual adjusted deficit of £16m against a planned deficit of £4.6m for January (Month 10).

There is recognition across the ICB that the system is going to struggle to meet plan. Discussions have continued regarding the NHSE Forecast Change Protocol and a system recovery plan to significantly reduce this pressure to a new system deficit total of £34m. At M10 the Trust is now formally forecasting an £18m deficit, 53% of the predicted system deficit. This position has been agreed with NHSE and from this month is now being reported to the ICB and NHSE.

There continues to be risk in the position linked to additional ERF. Of significant note is that some of this risk has reduced from high to low risk as we get closer to the M9 freeze submission deadline and we become clearer on the value of the additional work done. Also of note is that the ICB has now identified most of the resource necessary to support the system M7 release of uncommitted ICB provisions to support High-Cost Drug Pressures.

Analysis of significant year to date income & expenditure assumptions

	Adjustment M10 YTD (£'000)	Assumptions	Risk Rating
ICB Income	583	OPCS Coding – Potential opportunities to increase income re improved OPCS coding	Low
	1,417	Advice & Guidance – Income in position assumed to planned £6.7m, current allocation provided at £5m.	High
	3,565	Ophthalmology – Improved coding, back dated to April – risk re backdating & clinic set up.	Low
	550	BCU – 24/25 East Riding Allocation £200k YTD (£300k FYE) + £300k re prior year allocation not received (Prior Year High Risk, Current year expected)	Medium
	5,650	Provisional agreement reached with ICB and system to release uncommitted ICB provisions to support High-Cost Drug Pressure.	Medium
	250	CDC Recovery	Medium
	942	Additional ERF Activity	Low
Total	**12,957**		

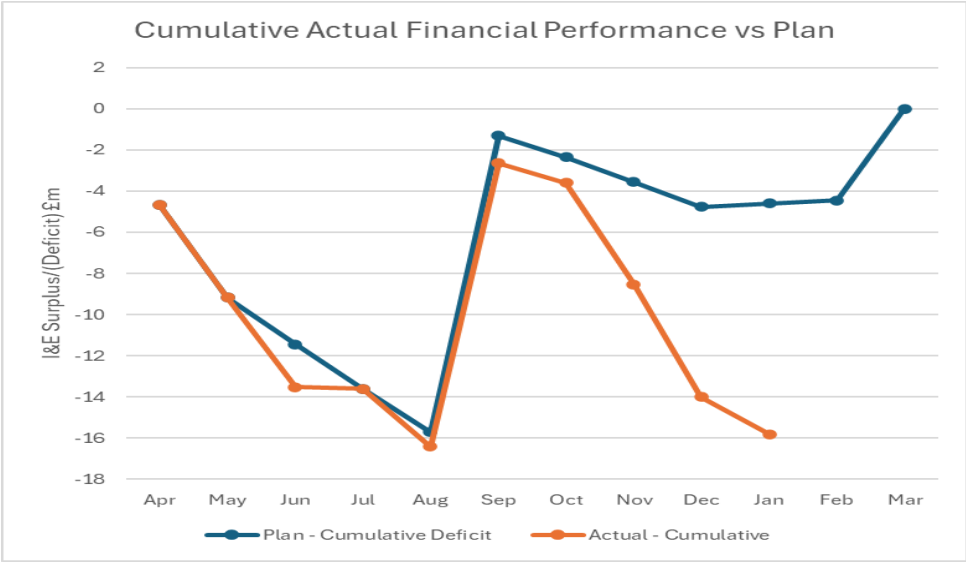
Key Subjective Variances: Trust
Finance (3)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	2,075	ERF overperformance & pay award funding	No mitigation or action required.
ICB Income	17,073	ERF overperformance & pay award funding	No mitigation or action required.
Employee Expenses	(20,648)	Agency, bank and WLI spending is ahead of plan to cover medical vacancies and deliver increased elective activity. Pay award actioned in M9, offset by income although shortfall in funding of £1.3m YTD (£1.6m FYE)	To continue to control agency spending within the cap into 2024/25. Work being led by HR Team to apply NHSE agency best practice controls, continued recruitment programmes (including overseas recruitment). Vacancy control measures now in place.
Drug expenses	(7,316)	Relates primarily to an increase of in-tariff drug and device costs which were previously contracted on a pass-through basis but now included in the block contract, plus out of tariff drugs & devices costs covered by NHSE contracts for which additional income is earned.	Provisional agreement has been reached with ICB and system to release uncommitted ICB provisions to support.
Clinical Supplies & Services	(4,732)	Increased spending linked to increased elective activity for which additional ERF income is expected to compensate. Also includes overspending on pathology direct access and devices, which was previously covered by a variable tariff, but is now included in the block contract with the ICB.	No mitigation or action required – Provisional agreement has been reached with ICB and system to release uncommitted ICB provisions to support.
CIP	(11,414)	The Core Programme is £2.8m ahead of plan and the Corporate Programme £14.2m behind plan at M10	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.

Cumulative Actual Financial Performance vs Plan

Finance (4)



On the 12th June the Trust resubmitted it's plans which aligned M1 & M2 to actual expenditure and assumed, in M12, the £4.2m the Trust expects to receive as a proportion of the £24m identified to reduce the overall ICB deficit from £74m to £50m, thereby improving the planned cumulative deficit from £21m in February to £16.5m in March.

In September the Trust received £16.6m deficit support funding to improve our plan to a balanced position.

The YTD plan is an adjusted deficit of £4.6m at M10 with an actual deficit of £15.8m.

Forecast			
	Adjusted Surplus/(deficit)		
Scenario	Plan £'000	Forecast £'000	Variance £'000
Likely Case	0	-18,790	-18,790
Best Case	0	-18,790	-18,790
Worst Case	0	-38,685	-38,685

Likely Case
The likely case forecast has improved from the M9 position and is a deficit of £18m against a balanced plan. Details with regards to the assumptions and risks are included on slide 5. This position has now been formally reported.

Best Case
At M10 the Trust were required to present a forecast that most accurately reflects the expected outturn. A £18m deficit forecast aligned to the most likely case has therefore been submitted for Month 10.

Worst Case
The worst case forecast is a deficit of £38.7m against the balanced plan. This forecast, in addition to the assumptions in the most likely case, assumes there will be a further deterioration of delivery of CIP (£6.7m), a reduction in clinical income of (£9.3m), and further run rate deterioration of £4.7m

YSTHFT 2024/25 Financial Recovery

Finance (5)

Actual V's Forecast				
	Adjusted Surplus/(deficit)			
Scenario	FOT £'000	Forecast YTD M10 £'000	Actual YTD M10 £'000	Variance
Likely Case	-23,376	-16,372	-15,818	554

The actual YTD M10 deficit (£15.8m) tracks just under the most likely forecast outturn of £23.7m prepared in M7-M9. Taking into account this positive movement in the run rate, and a review of our assumptions, the forecast outturn at M10 has been revised to a deficit of £18m. Assumptions and risks are detailed below:

Likely Case
The table opposite demonstrates the component parts of the £18m deficit and assesses the potential risks within this position.

Key Assumptions
The pay award pressure of £1.6m is no longer assumed to be funded; B2-B3 re banding has been adjusted from the previous £3.2m to £2.2m due to the timing of the negotiations and the protocol required for staff to take up the B3 roles; A technical review of aged and low value accruals has given a favourable adjustment of £1.9m; Income continues to be assumed to offset the pressure against high cost drugs; Unidentified and high risk CIP are consistent at £12.2m, this is offset by ERF over recovery of £3m and 'other' £5.5m

Risks
There continues to be a small risk related to the agreement reached with the ICB for high-cost drug funding that is £1.3m lower than the Trusts assumption. This is reflected in the position. There is further risk in the £18m FOT in respect of Advice and Guidance, the Trust have a planned income of £6.7m for Advice & Guidance as agreed with the ICB in the 12th June plan, the M8 fixed ERF forecast position only includes £5m based on an assessment made by the ICB of the Trusts allocation. This is also reflected in the position.

Opportunities
A technical review is ongoing on a line by line transaction basis, £1.9m has already been identified, but there is potential further opportunities that are being validated.

Mitigations
Further work on Discretionary Expenditure and Enhanced vacancy controls are expected to reduce run rate by £0.5m and £0.3m respectively, with further reductions in medical agency and other smaller opportunities bringing the residual risk to £18.1m

2024/25 Forecast	£m
Unidentified CIP / High Risk Plans	-12.2
Pay Award pressure	-1.6
Pass through drugs (net of ICB provisions)	-8.1
B2-3 re banding	-2.2
ICS Income Target	-4.3
ERF Over recovery (net of expenditure)	3.0
Technical Review	1.9
Other	5.5
2024/25 FOT	**-18.0**
Risks to FOT	
ICB High Cost Drug Income	-1.3
Advice & Guidance	-0.9
Total FOT incl. Risks	**-20.2**
Opportunities	
Accruals review	1.0
Residual Risk	**-19.2**
Mitigations	
Cease Medical Agency	0.1
Other	0.2
Discretionary Expenditure Control	0.5
Enhanced Vacancy Control	0.3
Further Technical Adjustments	TBC
Optimal Residual Risk	**-18.1**

Cumulative Actual Financial Performance vs Plan

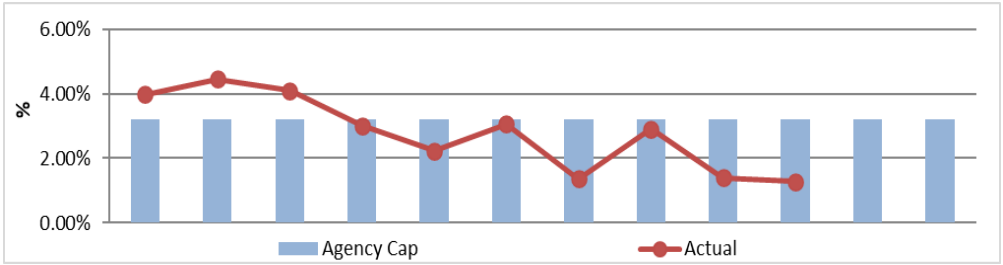
Finance (6)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Year to Date 2024/25 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	216,834	176,696	180,012	-3,316	181,197	1,185	Underspend driven by CIP delivery ahead of plan and high vacancies, particularly CDC's, these are offsetting significant overspends on Outsourcing and Drugs now within the block contract.
Family Health Care Group	83,817	69,636	72,301	-2,666	70,082	-2,219	£1.5m relates to the premium cost of covering medical vacancies, £0.7m Community Nursing overspend, £0.5m Midwifery overspend, £0.2m non-pay underspend, £0.4m overachieved CIP.
Medicine	189,897	158,367	168,976	-10,609	158,973	-10,003	£6.8m relates to the premium cost of covering medical vacancies, £3.4m drug overspend.
Surgery	157,941	131,809	135,163	-3,353	132,081	-3,081	Overspend mainly relates to Resident Doctors pay costs over budget - £1.9m (driven by premium cost to cover vacancies as well as having rotas over substantive budgets). Other cost pressure relates to theatre capacity gap (premium pay) reduced by non-recurrent vacancy savings.
TOTAL	648,490	536,507	556,451	-19,944	542,333	-14,118	

Full Year 2024/25 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	216,834	216,803	-146	216,656	178	Forecast deterioration due to pressures from Winter Flu Testing, Outsourcing and Drug Expenditure. These are largely offset by CIP delivery and Vacancies.
Family Health Care Group	83,817	86,855	0	86,855	-3,037	£1.9m relates to the premium cost of covering medical vacancies, £0.8m Community Nursing overspend, £0.6m Midwifery overspend, £0.2m non-pay underspend.
Medicine	189,897	202,579	-79	202,500	-12,603	£8.1m relates to the premium cost of covering medical vacancies, £4.1m drug overspend and £1.1m CIP planning gap.
Surgery	157,941	162,584	-147	162,437	-4,496	£2.2m over-spend on Resident Doctors mainly relates to premium cost of covering medical vacancies; £1.6m Theatre capacity gap; & £0.3m CSS over-spend due to non-elective activity over plan (7%)
TOTAL	648,490	668,820	-372	668,447	-19,957	

Agency, Workforce, Elective Recovery Fund
Finance (7)



Agency Controls

The Trust's has an agency cap of 3.2% of its overall pay spend in its plan. YTD M10 agency spend is 2.73% of overall pay spend, £12.6m against a plan of £14.5m.

	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,594.02	2,451.50	142.52	119,136	117,667	1,469
Scientific, Therapeutic and Technical	1,301.18	1,233.85	67.33	59,238	58,050	1,187
Support To Clinical Staff	1,925.14	1,714.25	210.89	53,765	54,560	-795
Medical and Dental	1,106.04	1029.64	76.4	122,241	134,474	-12,233
Non-Medical - Non-Clinical	3,260.51	2,821.09	439.42	98,185	93,837	4,348
Reserves				-14,517	0	-14,517
Other				1,785	1,894	-108
TOTAL	10,186.89	9,250.33	936.56	439,833	460,480	-20,648

Workforce

This table presents a breakdown by staff group of the planned and actual workforce establishment in whole time equivalents (WTE) and spend for the year. The reserves relate to agreed but at this point undrawn activity and cost pressures, and nursing investments.

The table illustrates that a key driver for the pay position (other than reserves) is spend against Medical and Dental staff.

Trust Performance Summary vs ERF Target Performance

Commissioner	24-25 Target % vs 19/20	ERF Confirmed Targets Weighted Value at 24/25 PA prices	ERF Month 10 Phase (Av %)	Activity to Month 10 Actual	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	104.00%	£132,127,127	£110,501,254	£130,968,805	£20,467,551	123.3%
West Yorkshire	103.00%	£1,389,900	£1,162,408	£1,182,363	£19,955	104.8%
Cumbria and North East	115.00%	£175,391	£146,684	£202,007	£55,324	158.4%
South Yorkshire	121.00%	£154,746	£129,418	£149,239	£19,821	139.5%
Other ICBs - LVA / NCA	-				*£0*	-
All ICBs	***104.02%***	***£133,847,164***	***£111,939,765***	***£132,502,415***	***£20,562,651***	**123.1%**
NHSE Specialist Commissioning	113.38%	£4,652,252	£3,890,796	£3,074,756	-£816,040	89.6%
Other NHSE	104.13%	£296,661	£248,105	£216,980	-£31,125	91.1%
All Commissioners Total	**104.31%**	**£138,796,077**	**£116,078,665**	**£135,794,151**	**£19,715,486**	**122.0%**

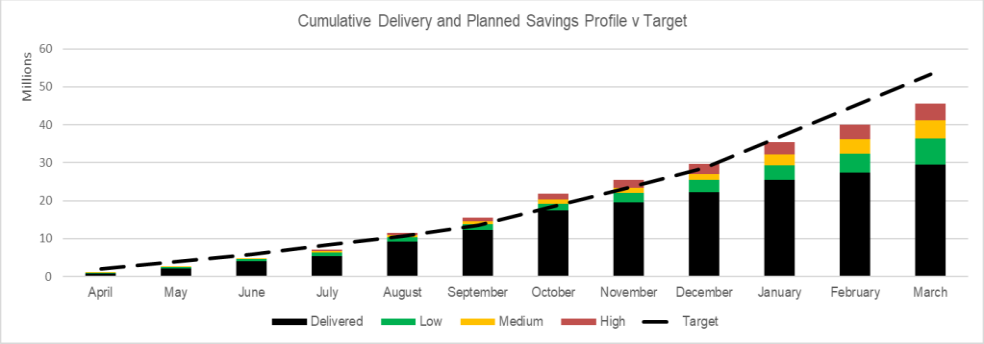
Elective Recovery Fund

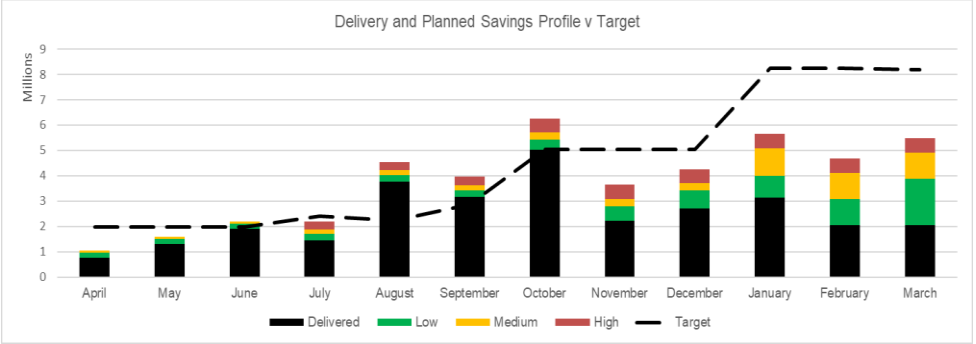
To give an early indication of ERF performance, we have developed an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity. Whilst acknowledging the limitations of using partially coded activity and estimates, activity remains significantly up against the ERF Baseline target and potentially presents a £19.7m surplus for the period up to Month 10.

ICB commissioned activity remains above plan with NHSE Specialist Commissioned services behind on plan. This is mainly due to the removal of OP "contact" activity from the actual figures, whilst remaining in the ERF baseline. In the M10 ERF assessment this now appears to have been addressed and is just being validated.

Cost Improvement Programme
Finance (8)

York and Scarborough Teaching Hospitals NHS Foundation Trust





2024/25 Cost Improvement Programme - January Position

	Full Year CIP Target	January Position			Full Year Position		Planning Position		Planning Risk		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Corporate Programme	33,326	23,042	8,866	14,176	10,541	22,784	20,905	12,421	12,391	4,171	4,342
	33,326	**23,042**	**8,866**	**14,176**	**10,541**	**22,784**	**20,905**	**12,421**	**12,391**	**4,171**	**4,342**
Core Programme											
Medicine	4,152	2,871	2,229	642	2,563	1,588	3,120	1,032	3,120	0	0
Surgery	4,120	2,849	3,284	-435	3,824	296	4,143	-23	3,968	175	0
CSCS	6,290	4,348	6,753	-2,404	7,562	-1,272	8,568	-2,279	8,266	215	87
Family Health	1,797	1,242	1,620	-377	1,833	-36	1,833	-36	1,833	0	0
CEO	104	72	34	38	41	63	41	63	41	0	0
Chief Nurses Team	207	143	139	4	161	47	161	47	161	0	0
Finance	382	264	225	39	235	147	235	147	235	0	0
Medical Governance	23	16	18	-2	22	1	67	-45	67	0	0
Ops Management	233	161	198	-37	227	6	232	1	232	0	0
DIS	427	295	355	-61	427	0	478	-52	478	0	0
Workforce & OD	361	250	214	36	251	110	445	-83	251	194	0
YTHFM LLP	1,840	1,272	1,476	-204	1,843	-3	1,849	-9	1,849	0	0
Central	0	0	0	0	0	0	3,454	-3,454	3,436	18	0
	19,936	**13,785**	**16,546**	**-2,762**	**18,988**	**949**	**24,626**	**-4,690**	**23,938**	**601**	**87**
Total Programme	**53,262**	**36,827**	**25,413**	**11,414**	**29,529**	**23,733**	**45,531**	**7,731**	**36,330**	**4,772**	**4,429**

Corporate Efficiency Programme

The Corporate efficiency programme currently consists of 29 schemes which, following an initial risk assessment, give planned savings of £20.9m towards the £33.3m target.

In January £10.5m of the target was delivered in full year terms, £7.4m of which are recurrent savings, The YTD position shows delivery of £8.9m against target of £23m, £14.2m behind plan.

Core Efficiency Programme

The core efficiency programme currently has plans totaling £24.6m towards the required £20m target.

In January £19m of the target was delivered in full year terms. £6.8m of which was recurrent. The YTD position shows delivery of £16.5m against target of £13.8m, £2.8m ahead plan.

Current Cash Position and Better Payment Practice Code (BPPC)

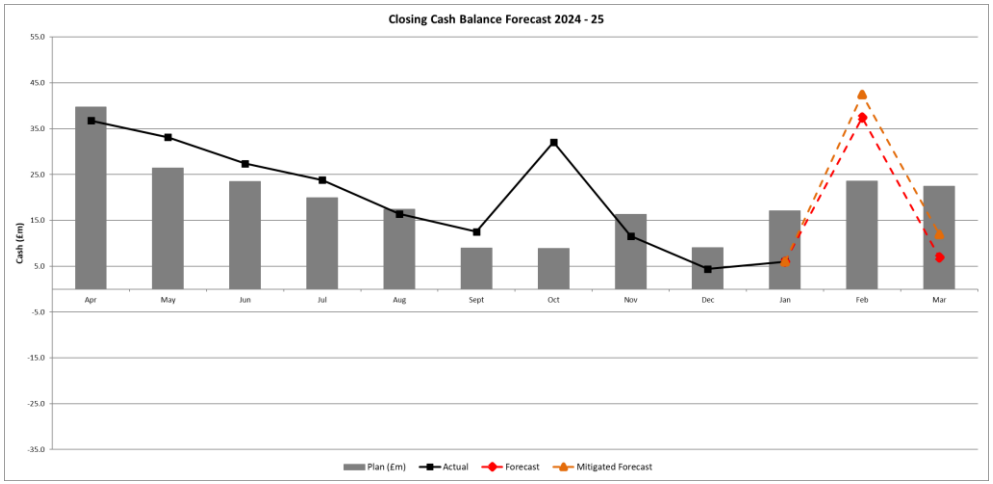
Finance (9)

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Group's cash plan for 2024/25 is for the cash balance to reduce from £47.5m at the end of March 2024 to £22.4m at the end of March 2025, with the planned I&E deficit being a key driver in the reduced balance. The cash balance for January was £11.2m adverse to plan.

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	39,790	26,407	23,541	19,964	17,437	9,006	8,886	16,306	9,059	17,101	23,624	22,454
Actual	36,793	33,128	27,407	23,821	16,460	12,559	32,078	11.572	4,422	5,856		



The cash forecast graph illustrates the cash position based on the actual cash balance at the end of January, at £5.9m against a plan balance of 17.1m.

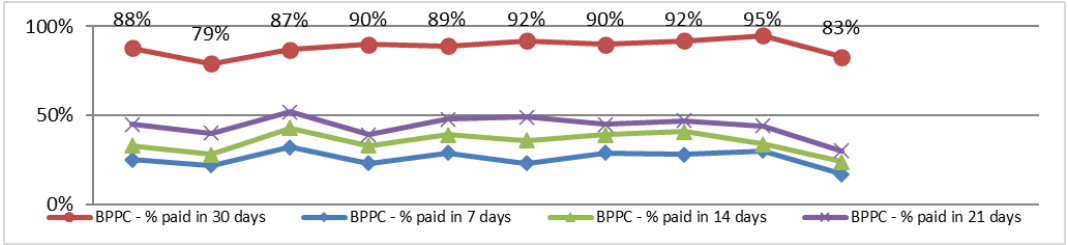
The red dotted line on the graph opposite illustrates the Trusts current forecast cash trajectory based on current cash run rates. The orange dotted line on the forecast represents the current cash forecast with mitigations in place to improve cash. Mitigations include ERF income due before year end forecasted in March estimated at £13m and the timing of capital receipts drawn in February and March for capital creditors not due until April 2025.

Based on the forecast cashflow with mitigations being achieved as planned, the Trust is forecasting that we will not need a cash support request this year.

<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 January the Trust managed to pay 83% of its suppliers within 30 days.



Current and Forecast Capital Position

Finance (10)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

For 2024/25 the main schemes are the completion of SGH UECC and SGH CDC, the commencement of the construction phase of VIU / PACU and the start of the implementation of the EPR scheme.

M10 Plan £000s	M10 Actual £000s	Variance to Plan £000s
35,409	27,675	(7,775)

The capital programme at month 10 is behind plan by £7.8m. This is due to the York VIU/PACU project and IFRS 16 leasing running behind the plan phasing. We are working closely with the York VIU/PACU project team to accelerate the project where possible. There are approx. £4.5m of leases on the cusp of completion and therefore we expect the leasing allocation to return to plan by year end.

Forecast Outturn

The forecast has increased by £3.6m from the M9 reported position. This is due to the announcement of national PDC funding for the Scarborough Critical Infrastructure (£2.5m) and LED Lighting/Building Management System scheme (£1.18m).

The £2.5m Scarborough Critical Infrastructure provides a funded source for the pressure highlighted in previous months. This has reduced the unfunded pressure of £5.2m reported previously to £2.7m. We continue to mitigate this pressure mainly through reprofiling expenditure on the EPR scheme to 25/26.

The current total capital forecast is £69.2m.

£0.95m is funded via the charity, therefore the net CDEL impact to the DH group is £68.2m, outlined in the capital forecast table.

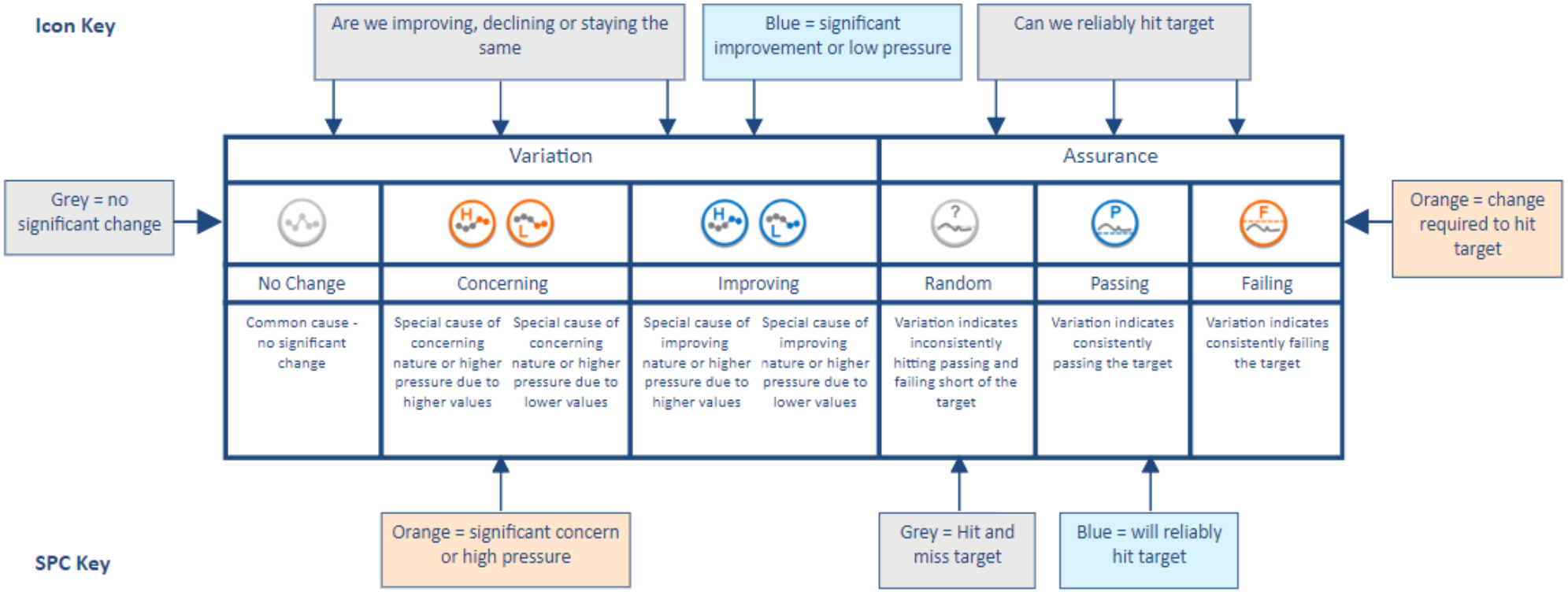
As we approach year end, the timing of expenditure on schemes such as VIU/PACU, ACTIF & RAAC are key to obtaining a balanced capital position. We are working with capital colleagues to understand any implications and including these in a refresh of the existing pressure mitigations. This work will be ongoing up to 31st March as we work to mitigate any risk to obtaining balance in 24/25 whilst also limiting any impact on the 25/26 programme.

2024/25 Capital Forecast	£000s
PDC Funded Schemes	39,036
IFRS 16 Lease Funded Schemes	8,323
Depreciation / Loan Funded Schemes	20,996
Charitable Funded Schemes	800
Unfunded Pressures	2,700
Mitigations	(2,700)
Total Capital Forecast	**69,155**
Less Charitable Funded Schemes	(950)
Total Capital Forecast (Net CDEL)	**68,205**

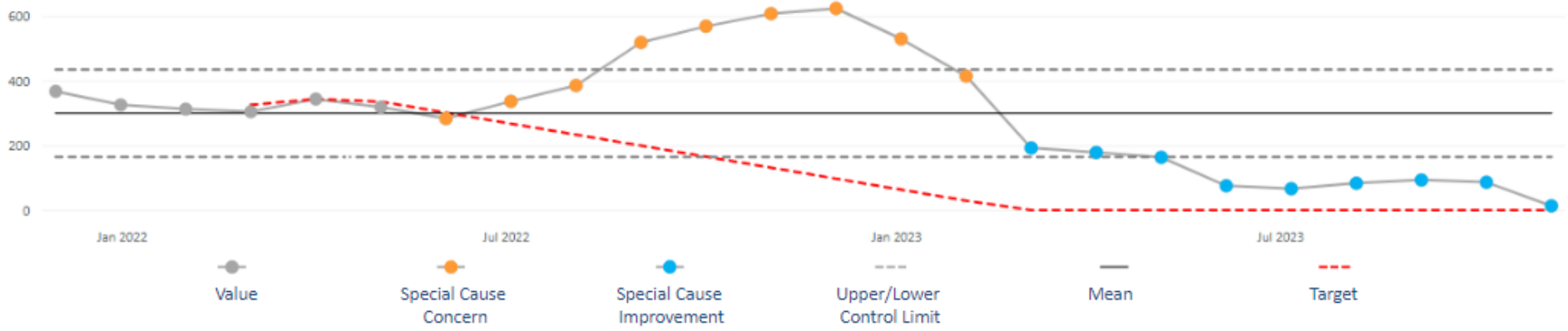
Keys

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.

Report to:	Board of Directors
Date of Meeting:	26th February 2025
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Dawn Parkes, Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☐ Assurance ☒ Information ☒ A Regulatory Requirement ☐

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☒ Quality Standards
☒ Great place to work, learn and thrive	☒ Workforce
☒ Work together with partners	☒ Safety Standards
☐ Research, innovation and transformation	☒ Financial
☒ Deliver healthcare today without compromising the health of future generations	☒ Performance Targets
☒ Effective governance and sound finance	☐ DIS Service Standards
	☐ Integrated Care System
	☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Summary of Report and Key Points to highlight:

This report provides an update on the progress of improvements in the maternity and neonatal service as well as provide monthly key quality and safety metrics for the services for the month of December 2024.

Recommendation:
The Board is asked to receive the updates from the maternity and neonatal service for August and approve the CQC section 31 report before submission to the CQC.

Report Exempt from Public Disclosure
No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History

Meeting	Date	Outcome/Recommendation
Quality Committee	18/02/2025	1/ To note the progress with the safety actions and improvement work in maternity and neonatal services. 2/ To formally receive and approve the CQC Section 31 monthly report.

Introduction

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the Trust Board and the LMNS Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team.

The maternity and neonatal services continue to review and monitor improvements in key quality and safety metrics and in this paper provide the Trust Board the performance metrics for the month of December 2024.
Annex 1 provides the current delivery position for the service against the core national safety metrics.

Perinatal Quality Surveillance Model

In line with the perinatal quality surveillance model, we are required to report the information outlined in the data measures proforma monthly to the Trust Board. Data is for the month of December 2024.

Perinatal Deaths

In December 2024 there was sadly one antenatal stillbirth. Following an immediate review there were no concerns highlighted with the care therefore this case will be reviewed using the National Perinatal Mortality Review Tool (PMRT). There were no neonatal deaths in the month of December. There were no reviews using the PMRT requiring completion during December 2024.

Maternity and Newborn Safety Investigations (MNSI)

In the month of December there were no new cases that met the criteria for referral to MNSI.

Moderate Harm Incidents and above

The postpartum haemorrhage (PPH) rate was 3.6% (12 cases). The local SPC charts demonstrate common cause variation. The national digital dashboard demonstrates a decline in the Trust PPH rate. All cases of PPH over 1500mls have been reviewed at the multidisciplinary Maternity Case Review meeting and no concerns were highlighted that could have resulted in a different outcome. A postpartum hemorrhage sprint audit has started during in January 2025 auditing 13 cases from November and December, the audit identified that 12 of the 13 women had been risk assessed as being at high risk of PPH, areas of non-compliance are around the completion of the PPH proforma and risk assessments, actions are in place to improve compliance in this area.

CQC Maternity Survey 2024

The CQC Maternity Services 2024 Survey was published in December 2024. The Transformation Lead Midwife has met with the Maternity and Neonatal Voice Partnership Lead and have finalised a co-produced action plan which has been imbedded in the Maternity and Neonatal single improvement plan and will be reviewed and updated through the LMNS choice and personalisation working group.

CQC Section 31 Progress Update

Annex 2 provides the December 2024 monthly update to CQC on the service progress against the Section 31 concerns and key improvement workstreams in place in the maternity and neonatal improvement programme. The Trust Board are asked to approve this submission to CQC.

There were no CQC information requests made in December 2024.

Perinatal Mental Health

There continues to be capacity issues with the Amethyst Midwifery perinatal mental health team within the trust which is further impacted by the lack of capacity in the perinatal mental health team in TEWV. The Local Maternity and neonatal system along with the Integrated care board are in the process of undertaking full review of the TEWV service looking at four key areas: referrals and acceptance rates/thresholds, workforce including. staff capacity and skills, serious clinical incidents, and support to midwives. The review team include consists of the Senior responsible officer of the Local Maternity and Neonatal system, leads and Director of Quality, perinatal mental health service and mental health collaboratively leads.

LMNS Assurance Visit

There was an Local Maternity and neonatal system/ Integrated care Board and Regional Midwifery Team assurance visit on the 12th February 2025. High level feedback recognised the improvements being made despite the ongoing capacity and resource challenge. A formal report is expected in the next 4-6 weeks.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

- 82 out of the 229 milestone actions have been completed to date (6 completed in January 2024)
- 1 milestone actions is at risk of becoming off track with the end date prior to 28/02/2025.
- 95 milestone actions are off track as the delivery date has passed and the action has not been completed (5 in January 2025). –

- 14 milestone actions have mitigations in place for these to completed during February 25 – April 25 –
- 38 milestone actions require a timeline extension as the staffing gap continues to impact upon delivery. These milestone actions are informing the maternity strategy for 2025/26 - 1 milestone actions are completed but evidence is required prior to sign off –
- 24 milestone actions cannot progress due to funding constraints.
- 18 actions need timelines resetting to National, LMNS or Trust wide projects
- 38 milestone actions are not scheduled to start yet

Key Achievements in December 2024

- The estates minor works and aircon installation for the 5th scan room on G3 at the York site has been completed in line with the implementation of the scanning business case (approved December 2024).
- The Midwifery Senior Leadership Team refresh and reset day took place. The day provided a safe space to discuss accountability and responsibility of roles, agree line management responsibility of our Specialist Midwives, general operational items, discussed the Quality and Patient Safety framework and general escalations.
- The maternity strategy for 2025/26 was submitted to support the trust wide annual planning.
- EPAU & GAU were successfully decanted to the antenatal unit and the endoscopy suite. We would like to take this opportunity to thank everyone who was involved in this rapid piece of work for all their hard work and support to ensure the move was delivered successfully and on time to enable the estates improvement works to commence on the women's unit.
- The digital skills passport for the midwifery workforce has been developed on smart sheets and is now moving into the testing phase following review by the Director of Midwifery

- The maternity service has successfully appointed 2 x WTE community midwives for equitable health to support case loading vulnerable women.
- The review of BadgerNotes from a service user perspective has been completed with the MNVP lead and a process mapping session is planned for March 2025 to continue this review with wider stakeholders.
- The community midwifery caseload and teams review has been completed.
- A review of the national service specification of care for women in prison has been completed. Engagement work and development of a guideline in partnership with Askham Grange prison is underway.
- The review of personalised care plans took place at hot topics in January and development of a York and Scarborough personalised care plan in line with best practice guidance is now underway.
- The schedule of business forward to board reporting has been produced and has commenced.
- The new neonatal training day has launched as part of the 2025 training week in line with the core competency framework and national best practice guidance.
- There was recognition at the Humber & North Yorkshire LMNS Perinatal Forum that York has had no off-pathway births since December 2022

Risks

Safety

1. 40 guidelines are overdue, this is a reduction in 22 since the 30th of December 2024. There are now twice monthly guideline meetings in place to address the backlog and 6-month horizon scanning has been implemented. The Deputy Director

of Midwifery has taken handover of the portfolio. A monthly exception report will be submitted to the Maternity Directorate.

2. The maternity service does not have a substantive audit midwife, this is recommended mandated post as referenced in the NHS England Maternity self-assessment toolkit. Maternity services have an audit plan in place, but compliance and completion is off track which is impacting on assurance of MIS, Section 31, SBL V3 and SI actions due to having no substantive resource.
3. There has been a significant reduction in the capacity of the trust Midwifery Perinatal Mental Health Team due to sickness alongside an increase of referrals into the service with significant and ongoing further reductions of capacity with TEWV (Mental Health Provider). A 6-month fixed term WTE Band 6 Midwife has been approved to support the team.

Resource
There is a clinical resource gap which is resulting in limited resource which can be released to support service improvement and progress the Maternity & Neonatal Single Improvement Plan actions in the planned timescales, this has led to a significant number of actions becoming off track and at risk.

Recommendations to Trust Board
To note the contents of this report and agree the CQC section 31 submission in annex 2

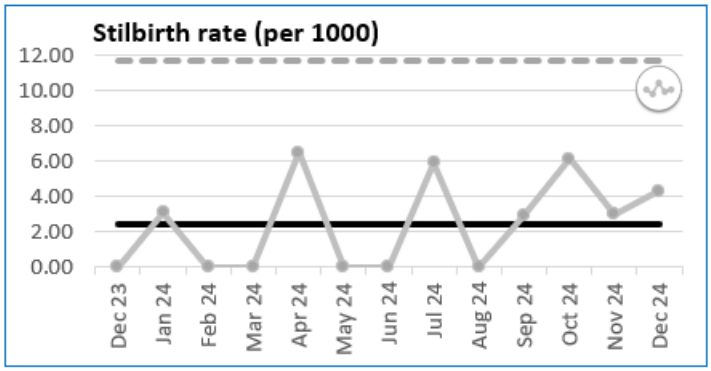
Date: 26th February 2025

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery November 2024.

Dashboard

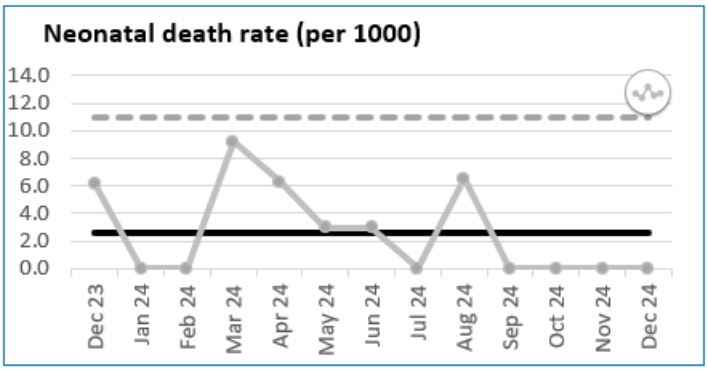
Latest month	01/12/24
Still birth rate/1000	**4.3**

No significant change



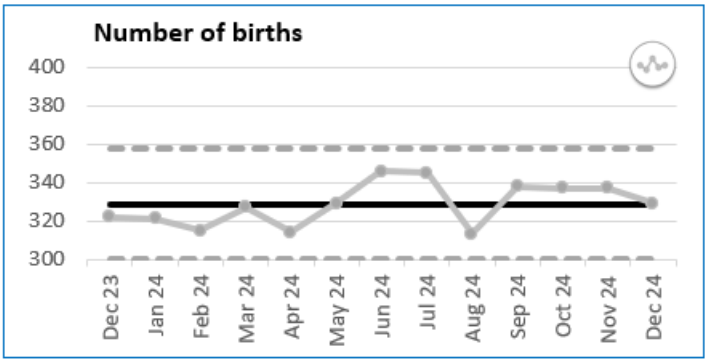
Latest month	01/12/24
Neonatal Death rate/1000	**0.0**

No significant change



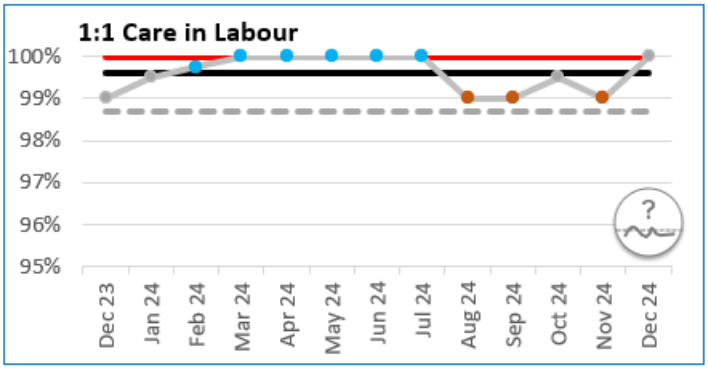
Latest month	01/12/24
Number of births	**329**

No significant change



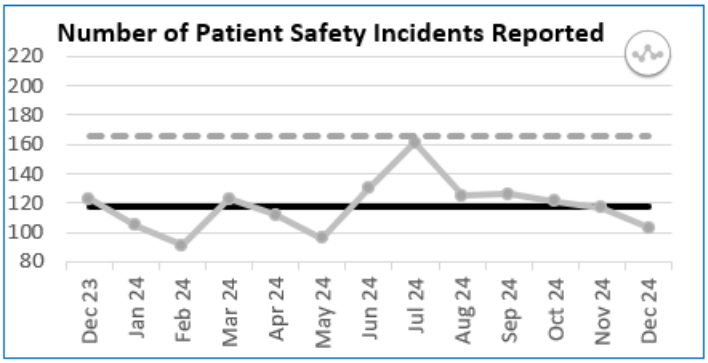
Latest month	01/12/24
1:1 Care in Labour	**100%**

No significant change



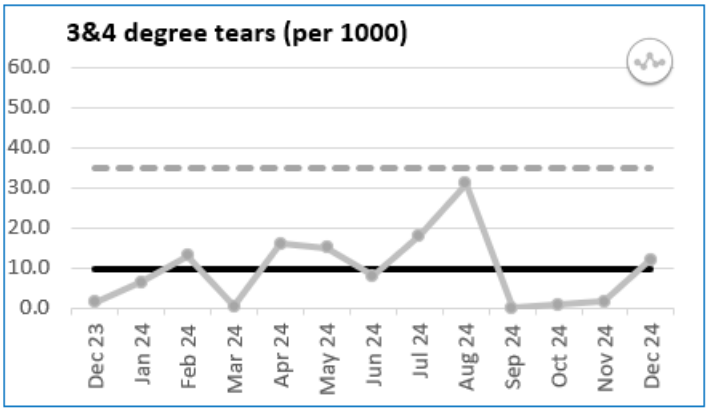
Latest month	01/12/24
Number of Patient Safety Incidents	**103**

No significant change



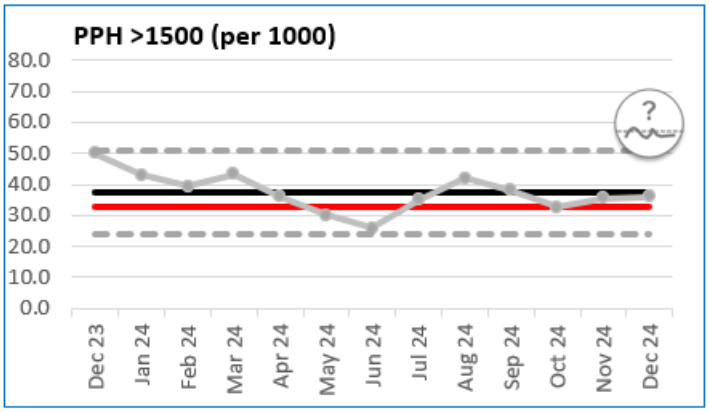
Latest month	01/12/24
3&4 degree tears (per 1000)	**12.0**

No significant change



Latest month	01/12/24
PPH >1500 (per 1000)	**36.0**

No significant change



Annex 2

Report to:	Quality Committee
Date of Meeting:	18 February 2025
Subject:	Maternity CQC Section 31 Update
Director Sponsor:	Dawn Parkes, Chief Nurse and Executive Maternity Safety Champion
Author:	Sascha Wells-Munro, Director of Midwifery and Strategic Clinical lead for Family Health Donna Dennis, Deputy Director of Midwifery

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☐ A Regulatory Requirement ☒

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care ☐ Great place to work, learn and thrive ☐ Work together with partners ☐ Research, innovation and transformation ☐ Deliver healthcare today without compromising the health of future generations ☐ Effective governance and sound finance	☒ Quality Standards ☐ Workforce ☒ Safety Standards ☐ Financial ☐ Performance Targets ☐ DIS Service Standards ☐ Integrated Care System ☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

On the 25 November 2022, the CQC, under Section 31 (S31) of the Health and Social Care Act 2008 imposed conditions on the Trust registration in respect of maternity and

midwifery services. This Trust updates the CQC monthly on the 23rd of the month with progress against the S31 notice.

Recommendation:

- To approve the February 2025 monthly submission to the CQC which provides assurance on progress and impact on outcomes in December 2024.

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
Maternity Assurance Group	11 February 2025	

CQC Section 31 Progress Update

Maternity Services at York and Scarborough NHS Teaching Hospitals Foundation Trust have embarked on a programme of service and quality improvements.

This report provides assurance on the progress to date in delivering against the improvement plan for the purpose of the monthly submission to CQC following the Section 31 Notice.

A.2 Fetal Monitoring

A.2.2 Fetal Monitoring Training

Current Fetal Monitoring compliance figures, by site, set against the target of 85% at the end of December 2024 are outlined below.

Staff Group	York	Scarborough
Midwives	95% (178/188)	95% (73/77)
Consultants	100% (18/18)	90% (9/10)
Obstetric medical staff	80% (8/10)	100% (11/11)

The two Obstetric staff who were not complaint in December, have completed their training in their training in January 2025. Compliance remains above the Trust target of 85% from January 2025 and will continue to be monitored at the Maternity Directorate, Quality Assurance Committee and Trust Board.

A.3 Risk Assessments and Care Plans

All antenatal risk assessments are recorded on BadgerNet. Table 1 highlights the antenatal risk assessment compliance.

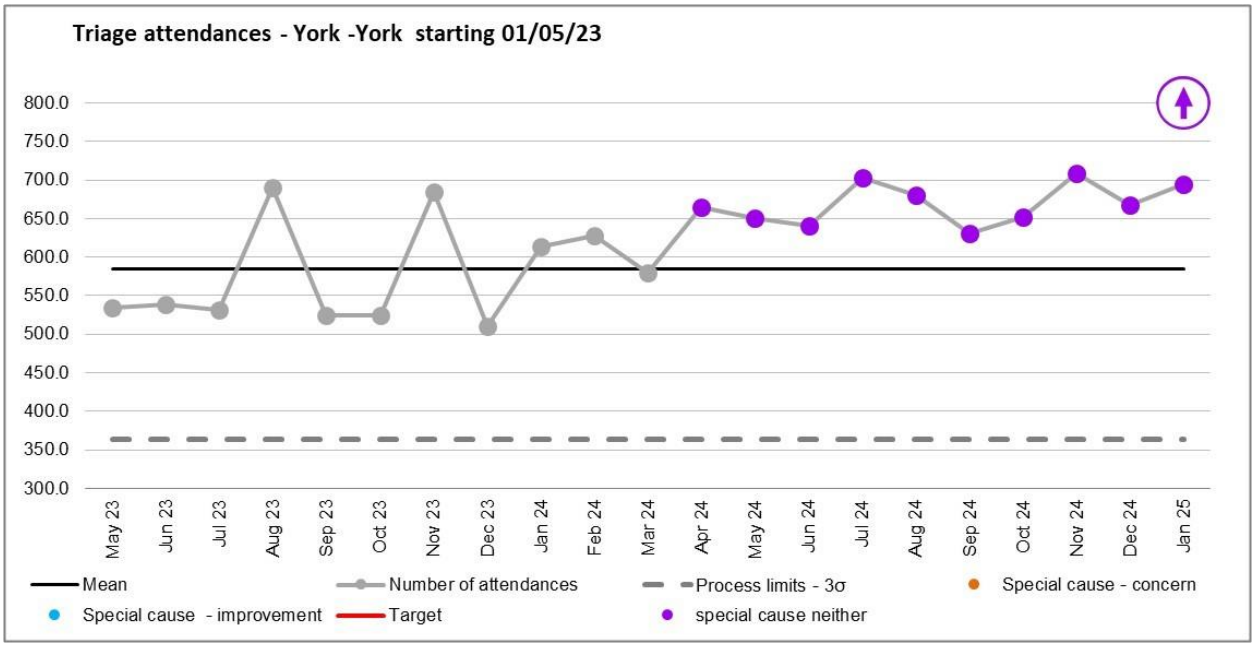
Month	Antenatal Risk Assessments
August 2024	98%
September 2024	98.5%
October 2024	98%

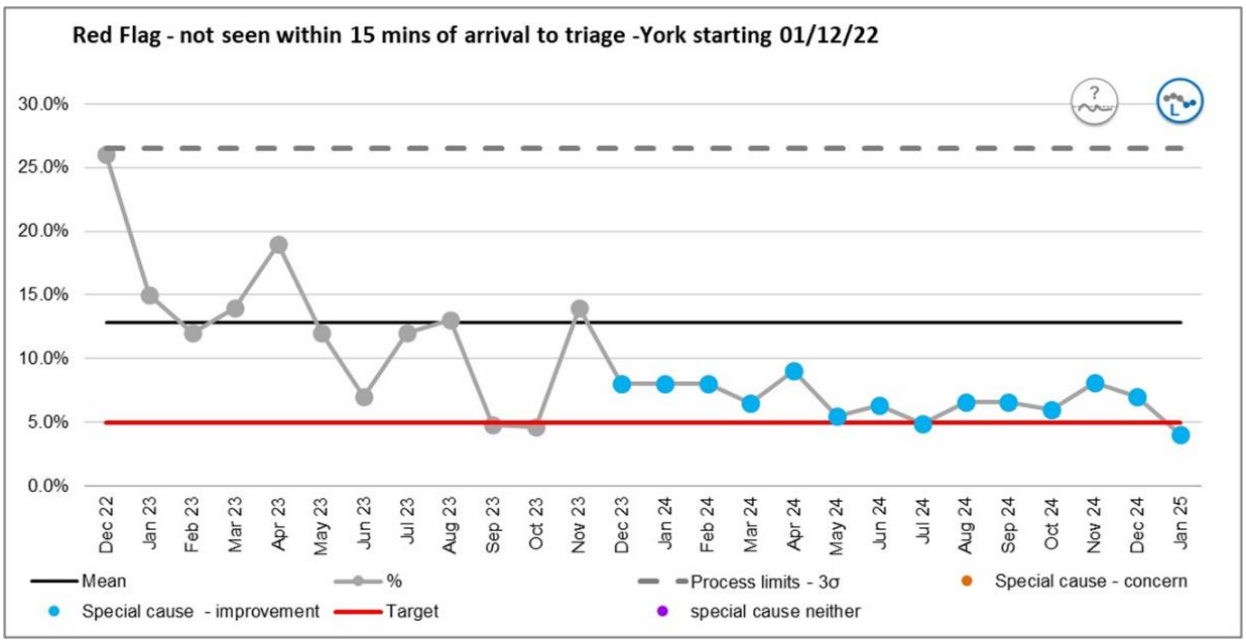
November 2024	98%
December 2024	98%

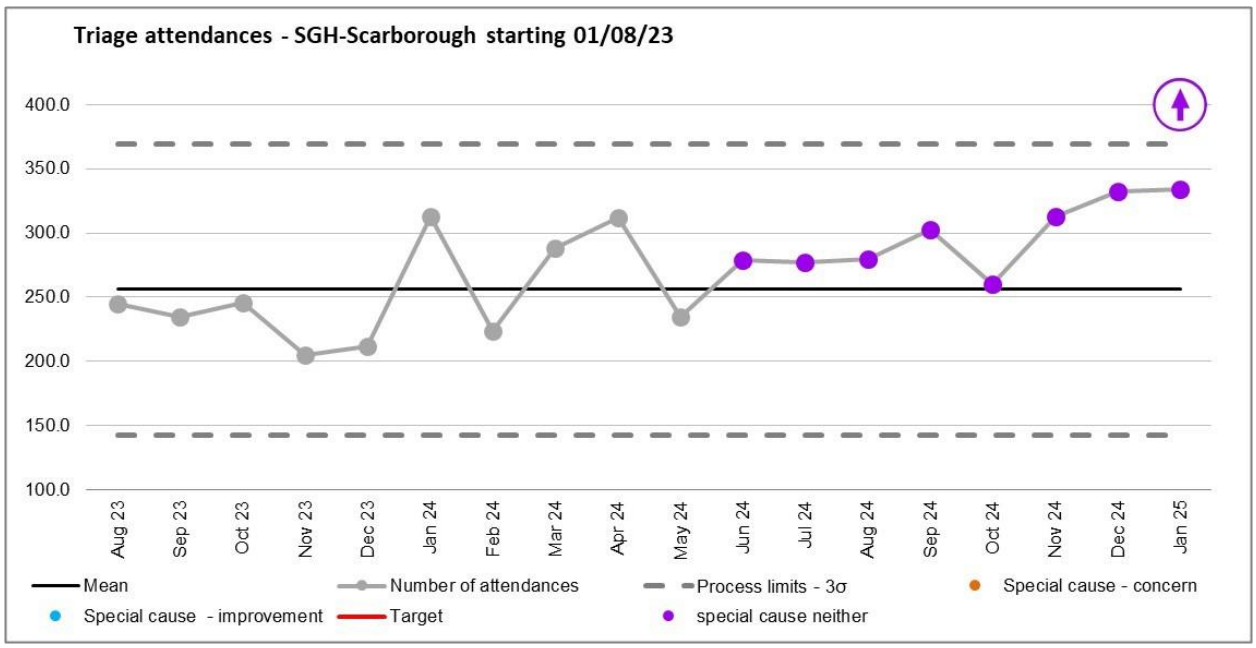
Quarter 3 audit for 2024/25 for intrapartum fetal monitoring highlighted:

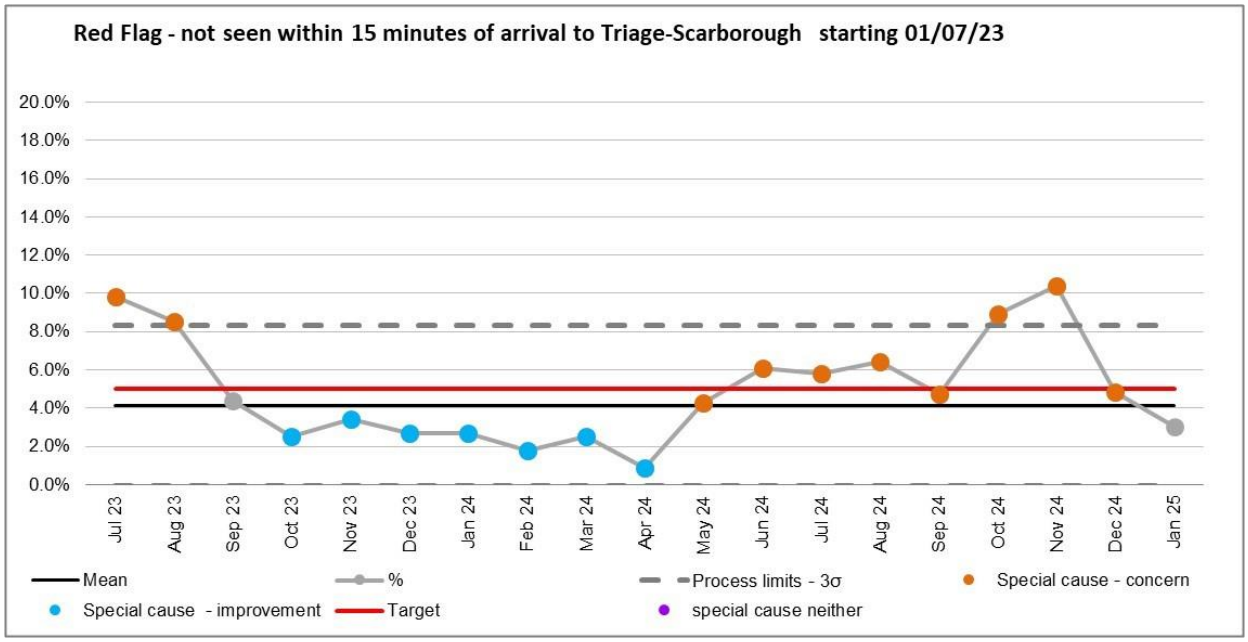
- 100% of intrapartum risk assessments were completed.

A.4 Assessment and Triage

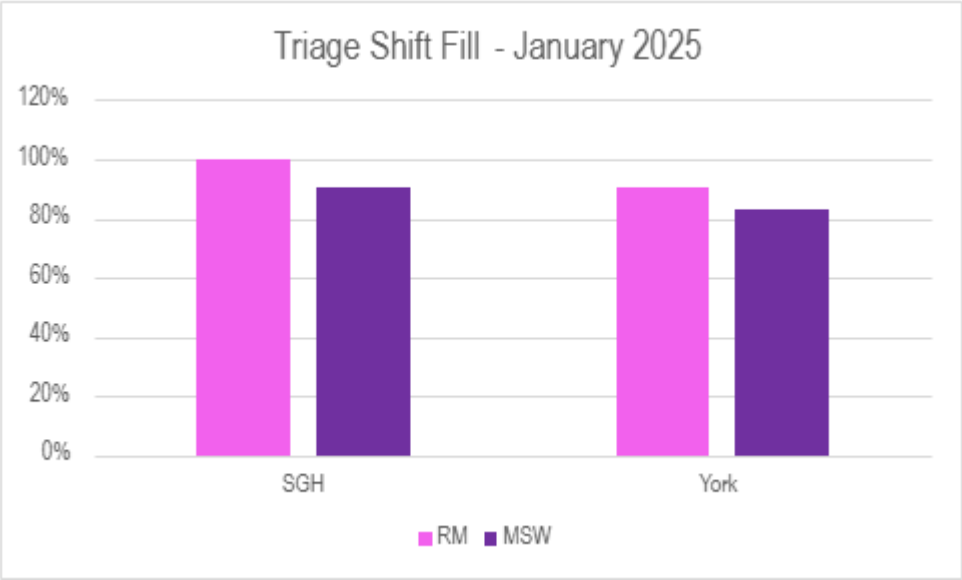




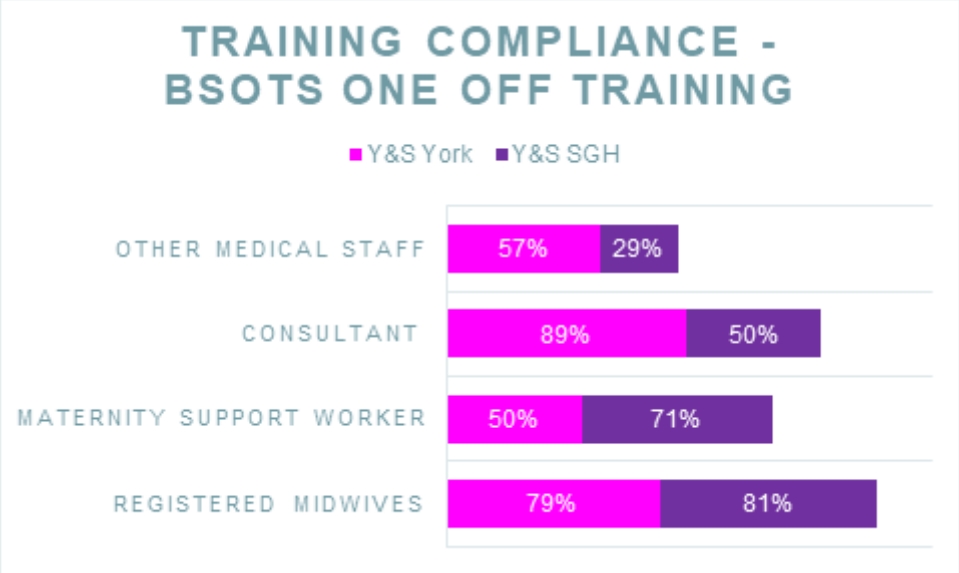




Staffing and skill mix remain a challenging across the Scarborough site which has resulted in Triage being undertaken on Labour Ward. Agreement reached with temporary staffing and Standard Nursing Agency to provide consistency and stability to maternity triage on both sites. Audit commenced on shift fill across both sites for Registered Midwife and Maternity Support Worker. There has been a special cause for improvement of women not being seen within 15 minutes of arrival to triage at York and the data for Scarborough in January has already shown a reduction.



Training compliance reported as below, with an anticipated completion date of April 2025.Birmingham symptom specific Obstetric triage System (BSOTS) training is now a mandatory requirement before shifts can be undertaken by Bank or Agency midwives and maternity support workers.



B. Governance and Oversight of Maternity Services

B.1 There is oversight at service, division and board level in the management of the maternity services

A schedule of business has been developed for Quality Committee and Trust Board reports for Maternity Services to ensure that the Trust Board is informed and aware of safety concerns in maternity and the learning identified and actions taken as well as to meet the national reporting requirements for Maternity Incentive Scheme and the Ockenden recommendations.

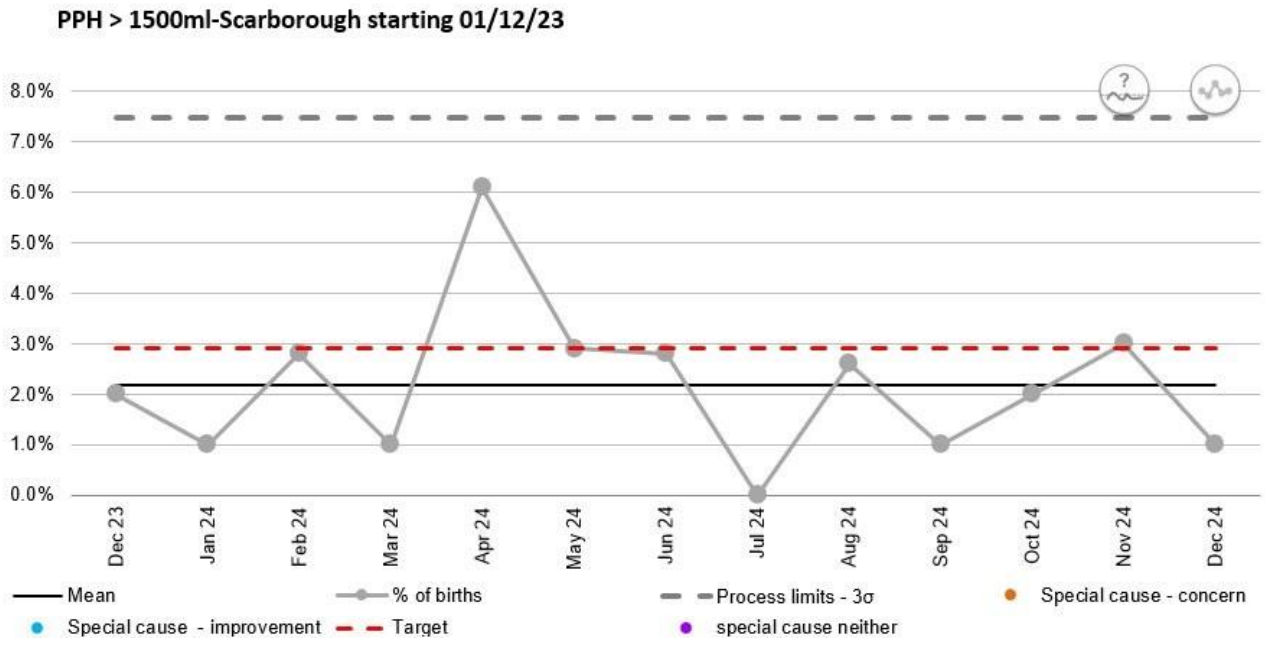
B.2 Postpartum Haemorrhage (PPH)

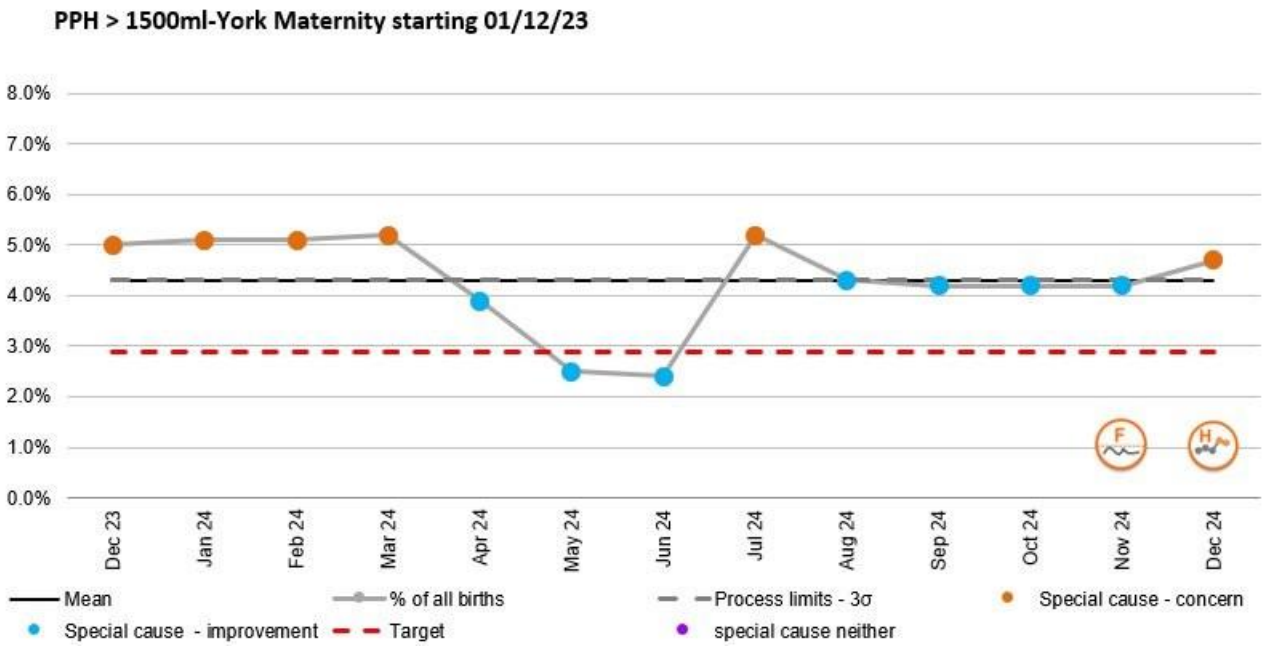
PPH over 1.5 litres

The reduction in the rate of postpartum haemorrhage (PPH) over 1500ml is a key priority for the maternity service. The PPH rate for December 2024 was 3.6% of all deliveries across both sites.

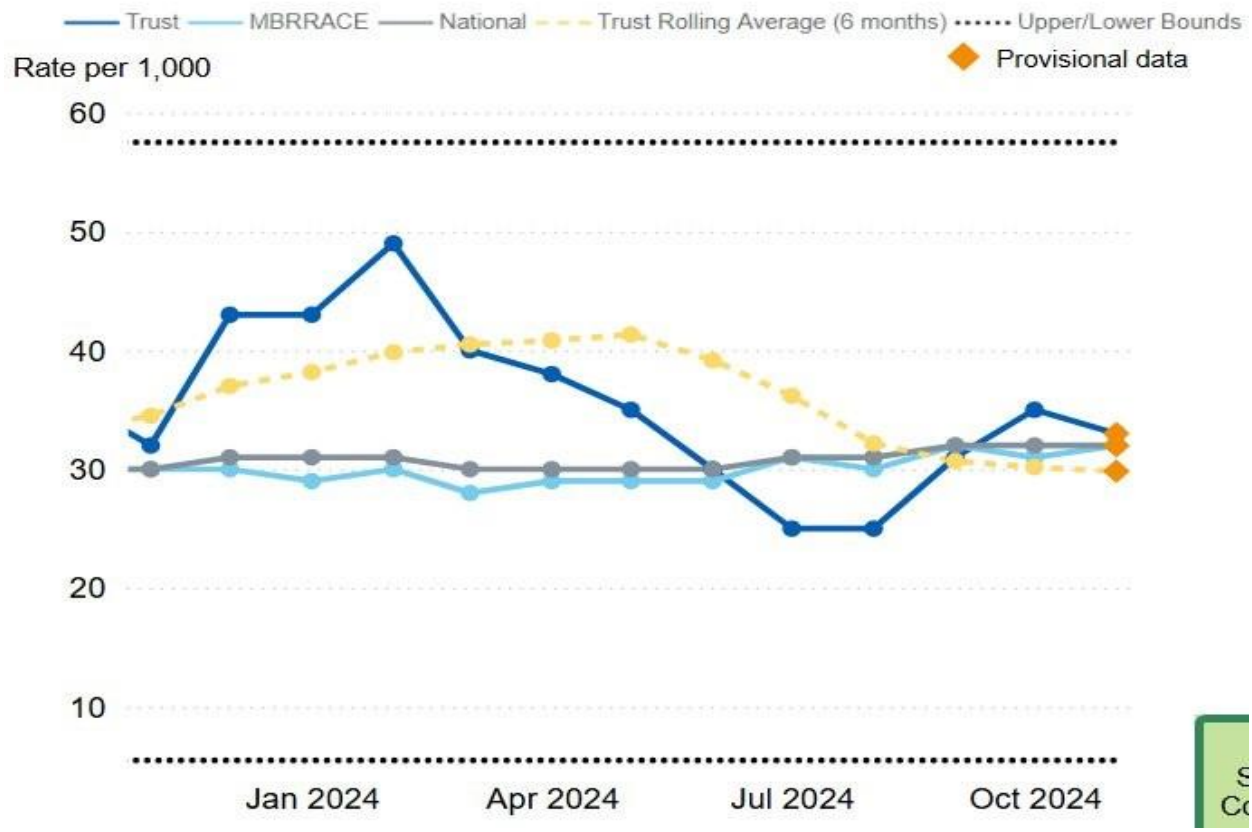
All PPHs are reviewed at the multidisciplinary Maternity Case Review meeting. The themes identified link to the ongoing improvement workstreams identified in the cluster review.

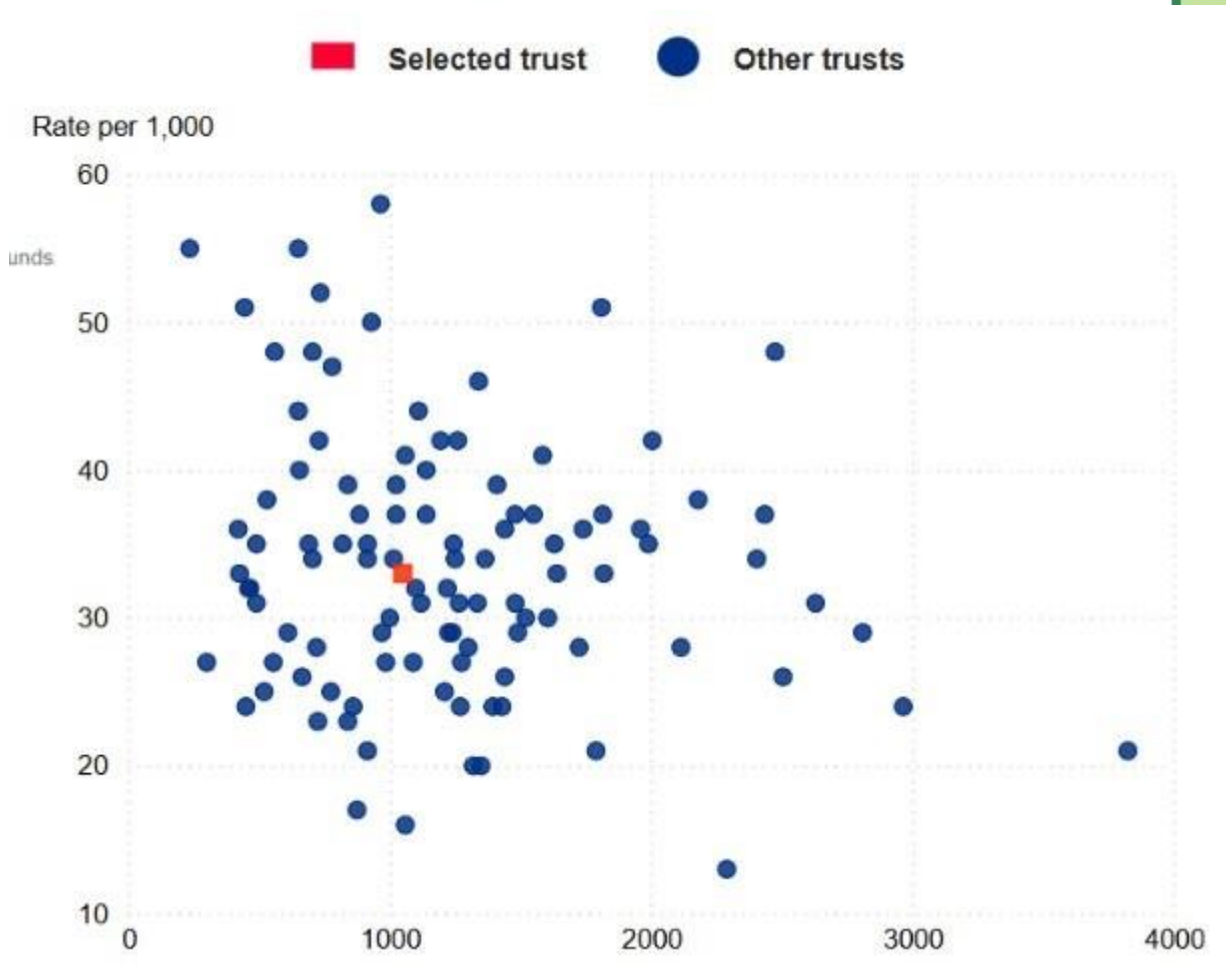
Blood Loss	Number in December 2024
1.5l – 1.9l	8
2l – 2.4l	3
> 2.5l	1




PPH > 1500ml-York Maternity starting 01/12/23
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Mean
% of all births
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither

National Maternity Digital Dashboard showing PPH Rate over 1500mls





The national digital dashboard demonstrates a reduction in the Trusts PPH rate. The local SPC charts show common cause variation for Scarborough and York a special cause for concern. All the December cases have been reviewed at the Maternity Case Review and no concerns regarding management was highlighted which would have resulted in a different outcome. The data demonstrates there has been an overall reduction in PPH ≥1500mls. A monthly PPH sprint audit which identifies the process measures monitored commenced in January 2025. The monthly PPH sprint audit will be presented at the monthly labour ward forum and Maternity Directorate Group.

Overview of the Monthly Sprint Audit

Standard	Results	Comments
FBC taken at 28 weeks	85% (11/13)	There were 2 women who had them taken at 26 weeks
Was Haemoglobin managed in accordance with guidance	100% (13/13)	
36-week PPH risk assessment completed	73% (8/11)	2 women had given birth prior to 36 weeks
PPH risk assessment completed on admission for birth	85% (11/13)	
Management of third stage of labour	100% Active management	
In Caesarean section consider prophylactic use of 1g Tranexamic acid IV after delivery of the baby if moderate to high risk of bleeding	100% (6/6)	
Postnatal oxytocin infusion should be used when there is moderate or high risk of postpartum haemorrhage	100% (13/13)	
PPH proforma fully completed	54% (7/13)	

12 out of the 13 women had multiple risk factors for PPH. Actions are in place to address areas of partial compliance.

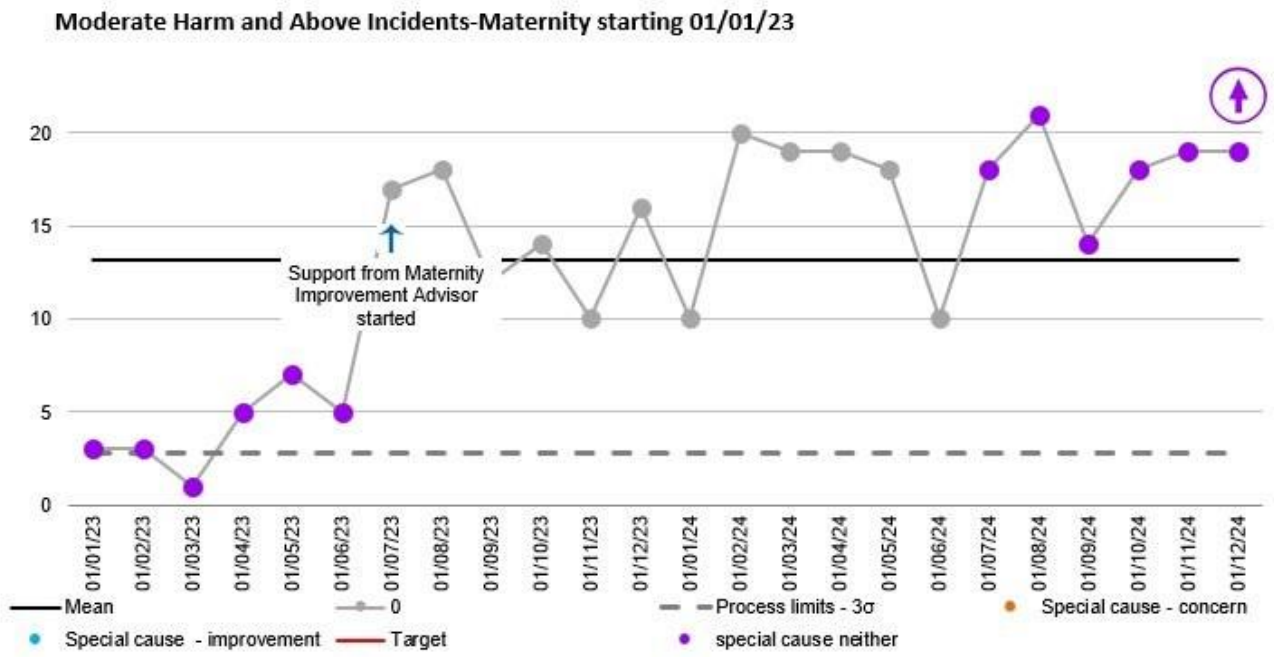
B.3 Incident Reporting

There were 19 moderate harm incidents reported in December 2024.

Datix ID	Incident Category	Outcome/Learning/Actions	Outcome
28862	Allergic reaction	Appropriate clinical care provided at the time	To feed into the ongoing work about iron infusion
28074 27938	3rd/4th degree tear	Care and follow up provided in line with the OASI bundle	Ongoing audit
27789 28924	Issues with performing an invasive procedure	Individual learning identified and fed back	DoC provided; no ongoing care needed

27708		Antenatal stillbirth	No immediate safety actions identified	To be reviewed using PMRT
31143 33142 29240 27748 27636 27634	28953 29820 28849 28183 28176	PPH ≥1500mls	PPH sprint audit started in January 2025	The PPH rate continues to be monitored through the Maternity Assurance Group. The rate has reduced over 12 months.
29156 27882		Unexpected Term Admission to SCBU	All admission to SCBU were agreed as being appropriate.	Continued focused work on the warm baby bundle which is being monitored through ATAIN

Incident grading is reviewed at the Maternity Services daily triage Monday to Friday to ensure it is accurate and in line with national guidance. The increase in moderate incidents is a positive one demonstrating a positive safety and reporting culture and recognition of harm experienced rather than harm perceived.



B.4 Management of Risks

B.4.1.1 Project Updates York

The maternity theatres at York have been refurbished and are operational.

B.4.1.2 Project Updates Scarborough

The use 24/7 security at Scarborough continues until a permanent solution to the baby tagging issue can be reached.

B.4.2 Scrub and Recovery Roles

There is collaboration across maternity and surgery to review the national requirements of having two scrub nurses for each list, the potential benefits, and risks in not meeting this standard that may release some staff funding back into maternity services to support recruitment of midwives as an alternative. The Director of Midwifery continues to work with the Surgical care group leads and the Chief nurse to review and update the Quality Impact assessment.

Recruitment update:
Position from 1st January 2025:
Fully recruited to at the Scarborough site.
The vacancy rate on the York site is 1.46WTE Scrub Nurses. Active recruitment remains ongoing.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

Report to:	Board of Directors – Public Meeting
Date of Meeting:	26 February 2025
Subject:	Care Quality Commission (CQC) Inspection Update
Director Sponsor:	Dawn Parkes, 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 ☐ A Regulatory Requirement ☐

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☒ Quality Standards
☐ Great place to work, learn and thrive	☐ Workforce
☒ Work together with partners	☒ Safety Standards
☐ Research, innovation and transformation	☐ Financial
☐ Deliver healthcare today without compromising the health of future generations	☐ Performance Targets
☒ Effective governance and sound finance	☐ DIS Service Standards
	☐ Integrated Care System
	☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

- Board Members are asked to note this update following the CQC unannounced inspection at York Hospital on the 14 and 15 January 2025.

Report History

Meeting	Date	Outcome/Recommendation
N/A		

1. CQC Inspection

Inspectors from the CQC visited the York Hospital site on 14 and 15 January 2025. Two teams were onsite who undertook:

- An unannounced inspection of the Urgent and Emergency care pathway to review the rating received following the last inspection in 2022.
- An unannounced inspection of the Medical Care Services to again review the Trust rating. This was done as part of the new CQC Systems Pathway Pressures inspection process.

Following the conclusion of the visit on Wednesday 15 January, verbal feedback on both aspects of the inspection was provided. To support this, written feedback was received from the CQC for the Urgent and Emergency Care Service aspect of the inspection on 16 January 2025. The Trust responded on 17 January 2024. Written feedback for the Medical Services review was received on 21 January 2025 and the Trust responded on 24 January 2025.

The letters have not been appended to this paper as they were included in the public Board paper for the meeting held on 29 January 2025. The exception to this was the Trust response to the Medical Services review, which has been reported as part of the action log.

2. CQC Evidence Request

The CQC sent the Trust an initial request for 132 evidence categories to support the inspection on 14 January 2025. A further evidence request was received on 23 January 2025 which included 29 evidence categories.

At the time of writing this paper (18 February 2025), 31 evidence categories remain open.

A robust process for the collation, review and approval of all documentation prior to submission to the CQC has been established:

- An MS Teams channel, accessible to all evidence leads, has been used to oversee progress with the submission.
- A 9am daily MS Teams call, chaired by the Director of Quality, Improvement and Patient Safety, with all evidence leads has been held to review progress and resolve any queries with the submitted documentation.
- A summary sheet is completed for each evidence category. This lists the documentation submitted, provides a narrative description of what the documentation shows and how the process is managed within the organisation.
- All evidence and summary sheets are reviewed by the Director of Quality, Improvement and Patient Safety or the Head of Compliance and Assurance.
- All evidence categories were assigned an Executive Lead. Some evidence categories required approval through the Medicine Care Group Quadrumvirate prior to submission to the assigned Executive Director.
- Following review by the Executive Director, and any feedback has been addressed, the evidence is submitted through the CQC portal.

The use of the summary sheets to support the evidence submission has been welcomed by our CQC colleagues and they have reportedly found these very useful.

An update on the Trust position following the CQC inspection, and submission of the evidence requests was provided at the Integrated Quality Improvement Group (IQIG) on

13 February 2025. IQIG is part of the NHS England tiering and segmentation review process attended by regional colleagues and the Integrated Commissioning Board (ICB).

3. Next Steps

- Submit all required evidence to the CQC.
- In March 2025, a post inspection After Action Review will be completed. This will include (but will not be limited to) the immediate Trust response to the inspection, communication during the inspection, the Trust response to the CQC feedback and a reflection on the Trust evidence retention and collation process.
- The report from the inspection will be published on the CQC website. Since the introduction of the Single Assessment Framework, the revised format does not include must and should do actions. Therefore, the Trust will start to formulate an action plan to include any identified areas for improvement which are not already part of ongoing programmes of work.

4. Recommendations

Board Members are asked to note this update following the CQC unannounced inspection on the 14 and 15 January 2025.

Report to:	Board of Directors
Date of Meeting:	26th Febuary 2025
Subject:	Research & Innovation Strategy 2025-2028
Director Sponsor:	Dr Karen Stone, Medical Director
Author:	Lydia Harris, Head of Research and Innovation

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ A Regulatory Requirement ☐

Trust Objectives	**Board Assurance Framework**
☐ Timely, responsive, accessible care ☐ Great place to work, learn and thrive ☐ Work together with partners ☒ Research, innovation and transformation ☐ Deliver healthcare today without compromising the health of future generations ☐ Effective governance and sound finance	☐ Quality Standards ☐ Workforce ☐ Safety Standards ☐ Financial ☐ Performance Targets ☐ DIS Service Standards ☐ Integrated Care System ☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Summary of Report and Key Points to highlight:

The Research and Innovation (R&I) Department has made significant progress in recent years, with numerous achievements of which to be proud. The department, formerly known as the Research and Development (R&D) Department, has evolved to reflect its

growing role in innovation. This transition has been driven by the Trust's increasing recognition at a regional level for pioneering activities, including workforce initiatives, Professor James Turvill's ColoCap study, and the DAISY project, an A&E robotic innovation. In response to this recognition both the Trust Board and the Integrated Care System (ICS) has requested that the Trust further highlight and showcase its innovation initiatives within the new R&I strategy.

The forthcoming Research and Innovation Strategy, covering the period 2025–2028, is aligned with the Trust's overarching strategy, Towards Excellence, ensuring a cohesive and complementary approach.

The initial version of the R&I strategy was presented to the Board of Directors in December 2024. Following feedback from the Directors, the strategy has been revised to place greater emphasis on innovation within the Trust's research and development plans. The updated version has been presented to the Executive Committee, where is was approved and is now presented alongside this paper for your approval.

As an enabling strategy to Towards Excellence, the R&I strategy directly supports the Trust's strategic objectives by fostering research, innovation, and transformation, ultimately leading to improved patient outcomes and a healthier future for our communities.

The R&I strategy facilitates the Trust's strategic goals by enhancing engagement in research, quality improvement, and innovation opportunities. The vision remains to ensure that research opportunities are accessible to all patients and staff, aligning with the Trust's commitment to excellence and continuous improvement.

By strengthening partnerships with academic and commercial institutions and encouraging staff to contribute to innovative ideas and proposals, the Trust aims to secure increased funding for research initiatives. These efforts will drive continuous improvement and reinforce the Trust's reputation as a learning organisation.

Recommendation:
The Board of Directors is requested to review the revised Research and Innovation Strategy and approve its content.

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	Date	Outcome/Recommendation
Board of Directors	23rd October 2024	Asked for additional Innovation emphasis within the strategy
Executive Committee	19th February	Approved

Research & Innovation Strategy 2025-2028

1. Introduction and Background

The Trust's Strategy, 'Towards Excellence' describes the ambitions and objectives of the organisation for the next 5 years. This paper presents the Research and Innovation (R&I) Strategy as a key enabler to support the achievement of the overarching Trust's Strategy.

R&I is a department that facilitates and delivers research and innovation across all of the Trust's Care Groups, with research teams based in York, Scarborough, Laboratories and Pharmacy. The department, in collaboration with internal and external partners, has a strong track-record of achievement and reports these to Trust Board on an annual basis.

This report presents the final draft of the Research and Innovation Strategy which has been further developed to strengthen content regarding innovation and other changes, noted in this paper (section 3) following stakeholder feedback.

2. Strategy Development & Engagement

A collaborative approach has been adopted throughout the development of the Research & Innovation (R&I) Strategy. Extensive engagement with both internal and external stakeholders was undertaken to ensure a comprehensive and inclusive process. Stakeholders were actively encouraged to review and contribute to the first draft of the strategy during its initial development in summer 2024, with all feedback considered and incorporated into the final version presented today.

Engagement was conducted through a structured series of consultations, meetings, and discussions, ensuring broad representation across key groups. This included consultants, Principal Investigators (research-active staff), the R&I team, Care Group Management and research leads, Directors, research champions, and academic partners from York St John University and the University of York. Further contributions were sought from the Integrated Care Board (ICB), the Innovation, Research and Improvement System collaboration (IRIS), and the Research Delivery Network, ensuring alignment with regional and national research priorities.

Feedback received expressed strong support for the strategy and a commitment to engaging further on implementation. In addition, R&I was a strong theme within specialty presentations at the Trust Board Planning Day held in January 2025. Future meetings have been scheduled to progress these discussions and ensure effective operationalisation of the strategy.

3. Amendments

This section details the key copy changes made between the versions that have been presented to Board. The modifications aim to refine objectives, enhance clarity, update figures, and strengthen strategic priorities. Key areas of change include research impact, workforce development, financial sustainability, and digital health integration.

Change Log: Summary of Modifications

Section	Change Description	Reason for Change	Impact
Title & Formatting	Document retitled to *Research Strategy V2 Final*	Align with final strategy versioning	Improved consistency
Foreword	Reframed to emphasise *R&I makes a big difference*	Stronger positioning of research benefits	More engaging for stakeholders
Introduction	Renamed from *Review* to *Your Local Trust*	More context on geography & demographics	Enhanced local relevance
	Expanded details on York and Scarborough's health challenges	Highlighting socio-economic factors	Stronger case for funding and support
Research Impact	Adjusted patient recruitment figures: *4,000/year → 3,000/year*	Corrected reporting & data accuracy	More precise performance metrics
Delivery Activities	Increased *BaBi participants* from 1,000 to 2,000	Updated based on program expansion	Reflects growth in study reach
Innovation Activities	Expanded DAISY AI project description	Clarity on scope and testing location	More transparency on implementation
Objectives	Added *Financial Sustainability* as a key focus area	Strengthen emphasis on long-term viability	Clearer roadmap for securing funding
Workforce Development	Introduced *Innovation Manager* and *Innovation Champions* roles	Foster a culture of innovation	Supports talent retention & innovation leadership
Infrastructure	Strengthened focus on *Digital Health, AI, and Bioinformatics*	Align with NHS priorities	Enhances research capabilities
Partnerships	Added *Strategic Alliances with CROs & Pharma Companies*	Boost commercial research opportunities	Expands funding and collaboration prospects
Finance	More emphasis on *NIHR grant applications & Research Capability Funding (RCF)*	Strengthen research funding strategy	Increased grant applications
Conclusion → What Next?	Added *Quarterly Review of Action Plan*	Ensure accountability and tracking progress	More structured follow-up
Appendices	New *Performance Operating Framework* added	Introduce KPI tracking	Improved measurement of R&I success

Amendments have been made to achieve the following:

- Incorporate innovation, and innovation activities throughout the strategy reflecting the Trust's ongoing commitment to supporting innovation projects.
- Incorporate the distinct, unique needs of York and Scarborough into the vision reflecting the differing health needs for their populations. This underpins the work the Trust does to provide appropriate care to each population and to tailor to research interest.
- Highlight the unique opportunities the Trust's geography offers for R&I initiatives within the introduction.
- Reflect on the success of R&I activities.
- Commit to providing career development opportunities for the workforce and commit to embedding this, and research, opportunities within the Trust.
- Reflect on the objectives and highlight the continuation of an open-door policy to R&I whereby any member of Trust staff can pitch their ideas to the team providing holistic support for all our workforce.
- Extend opportunities available to the workforce to be involved in R&I and identifying career development opportunities.
- Reflect the Trust's dedication to innovation and strengthen the commitment to digital infrastructure, utilising big data and working alongside the ICB to develop safe data environments which drive innovation opportunities.
- Commit to using Research Capacity Funding in a strategic manner to support posts which will capacity build to continue R&I initiatives. This includes the digital resources already used to develop the department.
- Include a suite of definitions for Research, Innovation, and Quality improvement.
- The inclusion of a R&I performance operating framework for 2025-2028, included in appendix 2.

4. Alignment with Trust Strategy

The R&I strategy has been written as an enabling strategy to the Trust's Strategy 'Towards Excellence'. The R&I Strategy complements the Trust's Strategic objectives relating to developing a better tomorrow, leading to a healthier future for our patients, through research, innovation and transformation, creating a great place for our people to work, learn and thrive, and ultimately, improving patient experience.

The R&I strategy facilities the Trust's Strategic Objectives through enhancing involvement in research, improvement and innovation opportunities. The R&I vision is to bring research opportunities to all our patients and staff, which is commensurate with the Trust's Strategic Objectives.

To further embed the strategy and R&I within the Care Groups, the R&I team is supporting the development of speciality clinical strategies.

5. Monitoring Process

This strategy will be implemented and delivered by working closely with the Care Groups, Lead Nurse for research in Nursing & Midwifery, Head of AHP research, lead collaborators and stakeholders (internal and external), and a core group will meet quarterly to provide leadership and assurance for the programmes of work.

A supporting detailed action plan has been developed which describes actions required to deliver the objectives of the Strategy. An R&I scorecard (appendix 2) will describe achievements against the R&I Strategic Objectives will be received by the Board

annually. An action plan has been drafted detailing the activities and outputs that will be reported to Board of Directors annually.

6. Refreshing the R&I Strategy

It is proposed the R&I strategy remains a living document and will therefore be reviewed on an annual basis. The annual review will consider any changes to context in which the Trust operates and identify any significant opportunities that may impact on the ambitions within the R&I Strategy.

7. Recommendations and Next Steps

The Board of Directors are requested to review the revised Research and Innovation Strategy, approve its content and enable its implementation.

On approval, the Strategy will be published, the action plan will be finalised, and trajectories and scorecard details will be updated.

Achievements and activities will be communicated via a combination of approaches including at the annual R&I event in November; through regular social media updates; via staff briefs, monthly Staff Matters articles; monthly accrual updates; within the Trust's Annual Report and within the scorecard presented to Trust Board.

Date: 14th Feb 2025

Kindness Openness Excellence

York and Scarborough Teaching Hospitals
NHS Foundation Trust

2025–2028

Research & Innovation Strategy

Table of Contents

Research and Innovation makes a big difference to all our patients and staff

We are proud to share our Research and Innovation strategy for 2025–2028.

Research and Innovation (R&I) is an integral part of our plans at York and Scarborough Teaching Hospitals NHS Foundation Trust. Being research active brings lots of positives to our organisation; research active hospitals provide higher quality care, can attract commercial and non-commercial income, and support recruitment and retention across professions. The Trust is committed to the wider benefits which being engaged in research and innovation can bring to the health of the nation and the effective working of the NHS.

Our vision for Research and Innovation at the Trust is simple: to bring research and innovation opportunities to all our patients and staff.

This strategy builds on the notable achievements across our Trust over the past ten years. The Trust has areas of significant strength; 3,000 patients per year recruited on to trials, a growing commercial research arm, and hosting and sponsoring major NIHR studies. These achievements bring additional income streams to the Trust, allowing growth and investment in research infrastructure. For a Trust of our size, we are high achievers in research and innovation.

Providing an excellent experience for our patients is our ambition, and being an organisation that supports research and innovation, alongside our outstanding patient care makes us an excellent Trust to work in and be cared for in.

York and Scarborough are both great places to deliver research and be innovative. There are unique challenges and opportunities facing these populations and the Trust is best placed to identify and address these through research and innovation. Our geography covers coastal, rural, and urban areas which offers a range of socio-economic and demographic attributes lending itself to the empowering benefits of innovation. Over the years the R&I team have actively connected with our academic partners, and they shall build on this as the department expands. The Trust has committed research active staff across all professional groups and many specialties and has clinical leaders who are at the cutting edge of innovation and research in specialties such as gastroenterology and ophthalmology.

We are excited to work with our patients, carers, staff, and partners in implementing this strategy.

Simon Morritt
Chief Executive

Dr Karen Stone
Medical Director

1.0 A Trust and a locality which is perfectly placed for impactful research and innovation

This document sets out the strategic direction for Research and Innovation for York & Scarborough Teaching Hospitals NHS Foundation Trust for 2025–2028 which focuses around our mission and vision.

Mission

To create a healthier future for our community and beyond through research, collaboration, and innovation.

Vision

To bring research and innovation opportunities to all our patients and staff.

The Trust is a research active, acute and community care provider delivering a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire, and Ryedale — an area covering 3,400 square miles.

The Trust manages eight hospital sites and provides community health services for the population of the Vale of York. Our workforce is around 10,000 staff working across our hospitals and within the community.

Our well-established partnerships at a local and national level including academia and VCSEs (Voluntary, Community, or Social Enterprise organisations) have a shared goal to improve the health of our diverse population at York and Scarborough, and to understand the health challenges that have historically been under-represented in terms of research activity specifically in our coastal community.

The size and structure of our Trust and our catchment population bring opportunities for us to deliver meaningful clinical research and innovation to the population we serve. The Trust has patient cohorts in coastal, rural, and urban areas with a mixture of backgrounds including, differing health accessibility, health engagement, as well as varied socio-economic and demographic characteristics.

From the iconic medieval architecture of York Minster to the charming cobblestone streets of the Shambles, every corner of York breathes life into centuries of stories. However, a changing demographic is evident with an ageing population, which will lead to a: 4% increase in hospital use per annum, a 10% increase in social care use, and 2.5% increase in GP use over the coming 5 years.

Scarborough and the East Coast have idyllic views, medieval castles, and a historically bustling tourism and maritime industry, but it has economic challenges with a lack of employment opportunities and areas of high deprivation. Scarborough has a significantly higher rate of hospitals admissions than the national average, a life expectancy 10 years lower for men and 7.7 years lower for women in the most deprived areas, and an ageing population.

Both York and Scarborough therefore provide a valuable opportunity to investigate health inequalities and deliver research based care to improve the outcomes of those in urban, coastal and rural areas.

The R&I team work to a set of definitions (appendix 1) which allow for continued success of the Trusts Research. The R&I team will bring together the right disciplines that can support research in the populations the Trust serves. Our workforce, our greatest asset, is committed to the people it serves and is ideally placed to identify and support research and innovation for patient benefit. This means that we are an excellent Trust and community in which to conduct research and innovation. This is demonstrated through our Trust having recruited over 50,000 patients to clinical trials over the past 12 years.

2.0 Building on achievements – The impact from our research and innovation

In the last three years, as part of the last research strategy, the Trust has achieved excellent research outputs and supported impactful innovations that demonstrate the strengths of our Research and Innovation department in the delivery of this strategy. The department has an efficient, responsive and embedded capability that is underpinned by a enthusiastic leadership and a small, committed workforce that develops and delivers research and innovation. Importantly this has included innovations that have arisen from our home grown locally developed research.

Our key highlights as a centre of excellence in research development, delivery and innovation are as follows:

2.1 Research Activities

01

Clinical Academics

In recognition of their success in driving research with real world, positive impacts on patients both Professor Richard Gale (Consultant Ophthalmologist) and Dr Simon Davies (Consultant Anaesthesiologist) have been appointed to clinical academic posts jointly with Hull York Medical School and the University of York.

02

Clinical Directorship

In acknowledgement of his continued participation in the academic activities, Professor James Turvill has been appointed the Trust's Clinical Director of Research and Innovation, and the regional Clinical Research Network for SPED Lead (Screening, Prevention, and Early Diagnosis). Professor Turvill has also been awarded an honorary appointment with the Hull York Medical School.

03

Research and Innovation in Scarborough

Created the new Scarborough Coastal Health and Care Research Collaborative (SHARC) based in Scarborough Hospital to work alongside the community with multiple health and care needs. The research collaborative was established to champion research on the Yorkshire Coast and to increase our capability and capacity to conduct research and innovation in Scarborough.

04

Continued Collaboration

Continue to grow strong collaborations with the Institute for Health and Care Improvement at York St John University, and SeeChange (a Voluntary, Community, and Social Enterprise organisation in Scarborough). This has funded joint research posts and PhD studentships to strengthen these research relationships.

05

Dedication to Career Development

Continue to work innovatively to provide research development opportunities and mentoring for all our staff and have offered PhDs, Masters qualifications, research nurse bank and secondment opportunities throughout the years.

06

Increased Research Activity Time

Through our collaboration with Hull York Medical School the Trust has provided research activity time to several consultant colleagues who are looking to develop Trust research for the future.

07

Critical Friend Review

Undertook a critical friend review of our Trust's research activity with another Trust in the region of similar size and learnt from their feedback.

08

Continued to Communicate Metrics

Ensured that our research metrics are reported at Trust Board level and Care Group level regularly, to evidence research activity and value for money.

09

Continued to Grow Sponsorship

Grown our sponsorship activities even further to support our home grown researchers, to harness and support the expertise of researchers.

10

Substantially Increased Grant Applications

Routinely submit five times more research grant submissions than in previous years, with many applications being successful and funded.

2.2 Delivery Activities

01

Recruited 12,000 Patients into Trials

Over the past three years we have recruited approximately 12,000 patients into clinical trials, these include several COVID-19 trials and a COVID-19 vaccine trial.

02

Secured a Dedicated Research Space

The Trust has created a dedicated research space to see research participants in both our Scarborough and York sites.

03

Helped to Shape National Policy

Recruited 60 children to the Harmonie vaccine study under Doctor Dominic Smith. The study investigated Respiratory Syncytial virus (RSV), one of the leading causes of hospitalisation in all infants worldwide and affects 90% of children before the age of two. The study found that 80% of hospitalisations can be prevented with this vaccine. In 2023, the Joint Committee on Vaccination and Immunisation (JCVI) advised that an RSV immunisation programme should be developed in the UK, thanks to this trial.

04

Continued Public Involvement

Strengthened our research lay panels, ensuring they are well trained and supported to assist with our research endeavours at both York and Scarborough.

05

Top 10 Nationally for Recruitment

Over the last three years the Trust have consistently ranked within the top 10 highest nationally recruiting trusts for Gastroenterology and Ophthalmology.

2.3 Innovation Activities

01

The ColoCap Study

The Trust has secured our biggest research grant to date via Professor James Turvill's National Institute for Health and Care Research (NIHR) bid, receiving just over £3M to evaluate colon capsule endoscopy across Great Britain. The ColoCap study commenced set up in April 2024 and runs for three-and-a-half years. This will see our Trust lead a study of national importance across 30 sites.

02

Strategic Recruitment

Recruited a Commercial Research Manager and a Grant Writer, two strategic posts that have seen our research activities grow.

03

First Global Recruitment

Our commercial research portfolio continues to grow and in 2023/2024 the Trust gained a 1st Global recruit, a 1st European, and a 1st UK recruit to commercial studies.

04

2,000 BaBi York and Scarborough Participants

Opened the long-term BaBi (Born and Bred in) York & Scarborough study; all mothers and babies born in York and Scarborough are eligible to participate. This study captures routine data from all babies born in our Trust, which will later be joined up with wider linked data sources throughout the child's development. The R&I team have already started collaborative work with researchers and other health and care partners to prioritise the use of the BaBi data set to inform future research and commissioned services.

05

The DAISY Robot

The Trust has supported home grown innovation, including the Diagnostic AI System for Robotic and Automated Triage and Assessment (DAISY) project. This is a Diagnostic AI system for a Robot-Assisted A&E Triage robot that will be trialled to collect its first real-world data in Scarborough Hospital's Emergency Department

3.0 Our Objectives for 2025–2028

These achievements have occurred in the face of our Trust having significant operational challenges in terms of workforce recruitment and retention, acute and emergency care provision, and the recovery of elective services. This Research and Innovation strategy recognises these difficulties, it outlines our objectives which will contribute to the path the Trust is taking to address these challenges. Committing to research and innovation complements and enhances the core service delivery of the Trust. Therefore, the key to achieving this strategy is the ambition and commitment of every member of the Trust to make it happen. The workforce needs to have the opportunity to develop ideas in research and innovation and an infrastructure in which to support their implementation.

The R&I Department is in a unique position to support the Trust in the delivery of their strategy, building on the R&I opportunities, investment, and track record of recent years. The R&I Department has an existing operational structure, experience and connectivity that can provide expertise. This can ensure efficient, cohesive, and streamlined oversight in workforce and infrastructure investment.

To bring R&I opportunities to all our patients and staff the R&I team will work closely with our quality improvement and clinical effectiveness teams to:

- Continue to make it easy for staff to present ideas around research and innovation.
- Support staff within the R&I team to realise these ideas quickly and efficiently.

The Trust is committing to five overarching objectives described in this strategy, which are:

1) the development of the workforce, 2) R&I infrastructure, 3) building collaborative partnerships, 4) R&I excellence, and 5) financial sustainability. The key measures for these deliverables are included in Appendix 2.

These objectives align with our Trust strategy, local Universities', and Institutes' research objectives and the Integrated Care System's refresh policy of 2024, that states they wish to drive delivery improvement through research and innovation.

Workforce

To develop a research skilled workforce ensuring it is central to everything the Trust wishes to achieve over the next few years.

Infrastructure

To work with our Care Group Leads and Executive Team to develop our research and innovation infrastructure and capacity and capability.

Partnerships

To foster new relationships and build on pre-existing collaborative partnerships to strengthen our research and innovation portfolio.

Excellence

Continue to deliver research and innovation excellence both commercially and non-commercially.

Finance

To secure sustainable funding for future research and innovation activities.

3.1 Workforce

Development of our workforce is central to everything the Trust wants to achieve over the next few years to take research and innovation within our hospitals and community to the next level. Opportunities for research and innovation must become seamlessly integrated to develop the Trust workforce.

To improve the quality and value of the services the Trust provides, and to enhance the attractiveness of the Trust as a place to work, the Trust needs to increase its workforce capacity and capability to engage in and support research and innovation. This includes an enhanced ability to support staff who have new ideas about doing things better and solving problems.

The R&I team will work with senior colleagues within our Care Groups and Executive Team to create a research skilled workforce across all our professional groups (nurses, midwives, and AHPs for example), rather than just in the medical workforce. Our ambition is to create a workplace where research and innovation are embraced, and staff feel empowered to make a difference.

To do this the Trust will offer creative and attractive job opportunities with research time allocated. This will enhance and increase our research active workforce within our hospitals. Our aim as a Trust is to attract and retain talented, passionate and enthusiastic clinical staff who will boost our Research and Innovation agenda within our Trust.

In addition, the Trust will develop career pathways that offer and support R&I career development opportunities to our staff, and to support them to understand how they can embed research and innovation in their everyday roles.

This will include opportunities such as:

- Associate Principal Investigator schemes
- AHP and Nurses and Midwives (including Student Nurses) research development opportunities
- Academic Clinical Fellow schemes
- NIHR career development schemes
- MSc and PhD opportunities
- Strategic Consultant appointments
- Clinical Academic appointments
- Strategic AHP Consultant appointments
- Research and innovation champion roles
- Developing our research bank to be multi professional and disciplinary
- Internships and Apprenticeships
- Further develop the Clinical Research Practitioner role

The Trust will provide and support training and professional development opportunities in research for our staff by utilising national and regional training courses (and funding schemes). The R&I team will also create online resources such as training modules, that can be accessed freely by all our staff.

The R&I team will ensure opportunities for research career development and innovation support are advertised widely and are easily accessible to all staff and will work with our Care Group operational teams to ensure they know of the different roles and opportunities available to their staff.

The Trust will embed research and innovation opportunities into every stage of workforce career development in the Trust. The Trust will focus on a joined-up approach that takes us from trainee support to growing our own researchers through to attracting and nurturing potential researchers for the Trust.

This will affect the way the Trust advertise for substantive posts in all areas, subsequently interview and induct appointees, and support their onward career development through job planning and appraisal.

The R&I team will work closely with our local Universities to build strategic clinical academic roles, in both medical roles and Nursing, Midwifery, and Allied Health Professional roles. Our ambition is to create a workforce of research academic roles throughout our Trust.

There is a national structure to support innovation in the form of Health Innovation (Yorkshire and Humber) and the Trust has an ongoing relationship with Medipex – the healthcare innovation hub for NHS organisations. The R&I team will work with these organisations closely to develop innovation champions roles and an Innovation Manager. So staff feel empowered to innovate in their place of work, and work with the R&I team to deliver innovative projects to our patients. The R&I team will create a clear process map to support staff with their innovation ideas and create an innovation champion role that will work within our Care Groups to identify those staff with innovative ideas and support them in developing them.

NHS CLINICAL ENTREPRENEUR PROGRAMME

Access to NHS Clinical Entrepreneur Programme

Humber and North Yorkshire Health and Care Partnership

Participation in Humber & North Yorkshire ICB IRIS Innovation Community of Practice

Innovation Champion Network

Medipex Innovation Champion Network

Health Innovation Yorkshire & Humber

Access to Medipex and Health Innovation Yorkshire & Humber Introduction to Innovation Workshop

3.2 Infrastructure

The R&I Team will work with senior colleagues within our Care Groups and Executive Team to further develop the existing research infrastructure already in place within our Trust, across all our hospital sites to support an expanded research and innovation strategy. This is key to building capacity and capability to develop and deliver research and innovation across our Trust in a disciplined and structured way with appropriate oversight and metrics. Co-ordinating and signposting, quality assurance and impact are essential elements to a supportive but purposeful strategy. This will include an operational framework to support our research active workforce and support staff in developing their innovation ideas.

The priority within this objective is to work to our strengths and focus on our challenges by growing our research and innovation on the East Yorkshire Coast to address the health inequalities seen there. The Trust will secure a physical site for a dedicated centre for Scarborough Coastal Health and Care Research Collaborative (SHARC), that will house our research team, and offer dedicated research facilities for our researchers and the community. Integral to this development is to further develop the research infrastructure within the VCSE sector of Scarborough, and to widen our community research champions effectively. This will allow us to build on our strengths, develop research themes and support research opportunities including collaborations with partners and commercially funded research.

With the development of our infrastructure, the R&I Team aim to create an innovation manager role to support our staff to develop their innovative ideas and conduct research to support them, and innovation champions embedded in each Care Group.

Commercial Research

The R&I team will create an innovative bespoke commercial research team, that will be housed alongside our Care Group research nurses, but they will solely work on commercial research. This will speed up our commercial study set up time (crucial to commercial companies) even further to increase our credibility with commercial partners as well as offering local patients access to novel treatments. The R&I team will aim to gain more 1st Global, 1st European, and 1st UK recruitment opportunities and increase overall commercial activities which will also generate more financial income streams into the Trust.

Digital Health Technologies

Supporting innovation across the healthcare system is central to meaningful transformation and improved patient outcomes. Creating the conditions for more collaborative approaches to innovation and enabling the fast adoption of cost – effective new technologies is very important. The Trust will embrace digital health technologies further and promote research, innovation, and transformation in healthcare.

Born and Bred In: York and Scarborough

The R&I team will develop further and capitalise on the data collected from the Born and Bred in (BaBi) study being run at both York and Scarborough sites. This will see us working regionally and nationally to support the development of a Safe Data Environment (SDE) across our Integrated Care Board and to develop collaborations and grant applications to utilise the data the Trust collects in research applications. The BaBi dataset is an innovative project as it will generate new insights, which in turn fuel new research questions, motivations for funding, research studies, and subsequent outputs to better deliver our services. The availability of this data will allow us to work innovatively embracing AI tools and bioinformatics to develop methods to better understand the data and draw meaningful conclusions to improve health and care. This in turn will generate more data and interest in BaBi, fuelling a virtuous cycle of research and innovation projects to better our care.

BORN & BRED IN Scarborough

BORN & BRED IN York

3.3 Partnerships

The R&I team will continue to develop strategic collaborations and partnerships, to purposefully strengthen our research and innovation portfolio, and to remain a trusted partner for our collaborators to work with. These will be based on the opportunities brought by our workforce and infrastructure, and our commitment, to bringing research to our community.

The R&I team have already built up a large network of collaborative partners and they will continue to strengthen these relationships by developing and writing new grant opportunities together.

The R&I team will also go wider and include any new research entities that may come into the research field (such as Health Determinants Research Collaborations (HDRCs), and the Yorkshire and Humber Research Delivery Network (RDNs). The R&I team will also reach out to new partners to support Born and Bred In (BaBi) initiatives and ideas.

The R&I team already work closely with our two local Universities and will strengthen these relationships further during this strategy. One key aim is to build a network of clinical academics in a variety of posts across our Trust, jointly funded by ourselves, HYMS, University of York and York St John University.

Contributing to national and regional innovation strategies which encourage health care innovation as an economic driver for our region and county is important to the Trust. The R&I team aim to strengthen our ties with local Innovation structures who support innovation in the form of Health Innovation (Yorkshire and Humber) and Medipex. The R&I team will look to partner on joint innovation initiatives and develop joint posts within the R&I team to develop the innovation portfolio of our Trust further.

Strategic Alliances

Strategic alliances will be built with Contract Research Organisations (CROs) and pharmaceutical companies, to ensure the R&I team capitalise on all the commercial opportunities, and to retain our excellent track record of commercial research delivery. The R&I team will strive to make the Commercial Research Team within our hospital regionally and nationally recognised as the place to go for commercial research.

SHARC

The Scarborough Coastal Health and Care Research Collaborative (SHARC) is critical to our research development on the Yorkshire Coast. As such the Trust needs to continue to grow our strategic partners within Scarborough and its rural surroundings. The R&I team need to continue to develop their relationships with York St John University and VCSE contacts. The R&I team will support, develop, and fund PhDs with our local universities and Research Fellows under SHARC. The Trust also needs to strengthen its links in primary care so it can offer innovative research delivery options to the community and support vaccine trials within our region.

Patients are always included in our research development and ideas and as such the R&I team have already developed two research lay panels, one for York and one for Scarborough. Their involvement will continue, and the R&I team will strengthen their involvement, especially on the Yorkshire Coast as SHARC develops over the coming years.

Our Innovation Partners

The R&I team also have many partners supporting us in our innovation work, including many collaborations with the University of York and York St John University (supporting multiple innovation projects), Medipex, Health Innovation Yorkshire and Humber and our strategic partnerships with Innovation, Research & Improvement System (IRIS) at Hull and North Yorkshire Integrated Care Board. The Trust will continue to develop and strengthen our innovation opportunities with these partners throughout the coming years.

3.4 Excellence

The R&I team are well established at delivering our suite of clinical trials and the Trust regularly recruits over 3000 patients every year to our clinical trials. The Trust also takes on sponsorship responsibilities for many of these trials to develop or own staff research ideas further. The Trust has excellent relationships with Universities across the UK, so allowing our staff to contribute to the cutting-edge ideas of our university colleagues that will hopefully lead to future medical interventions. The R&I team will continue to develop and maintain productive partnerships regionally and nationally with our Integrated Care Board, industry, universities and VCSEs

The Trust will continue to develop and deliver research and innovation excellence and be a centre of excellence for our research delivery, both commercial and non-commercial. The Trust will continue to support clinical trials and evidence-based practice by facilitating participation in clinical trials across our Care Groups and by identifying and setting out the Trust's unmet needs. The Trust will also continue to grow our sponsorship activities and ensure the Trust are an effective and thorough sponsor organisation which supports our home-grown researchers. The R&I team will continue to provide assurance to our Executive team around Care Quality Commission (CQC) research standards and Medicine and Healthcare Regulatory Agency (MHRA) regulatory.

The R&I team will continue to promote and support 'home grown' research and innovations from our staff through training, encouragement of ideas, offering tangible R&I team support, raising awareness of funding needs and opportunities and remaining open to the ideas and solutions of other requirements.

Community

The R&I team will work with our community to develop research ideas that meet the community healthcare needs of our population. The R&I team will do this through a series of research prioritisation exercises that will involve a wide range of stakeholders, our patients, and our community. Once research priorities are identified these will be worked on with our partners to develop grant submissions.

The R&I team will develop and promote mechanisms to support home-grown innovation, supporting research initiatives, and promoting innovative solutions to healthcare challenges. The Trust will provide resources and support for staff to explore new ideas.

External Research

The Trust will continue to develop a clear external research and innovation profile, through a wide range of communication and dissemination activities and will support dedicated posts within Research and Innovation to act as our communications officer and develop them to ensure they can utilise all formats in our communication endeavours.

ColoCap

Finally, the Trust aims to strengthen our Innovation portfolio by creating, developing, and adopting evidence-based innovations to deliver our care and will create and disseminate the evidence to demonstrate the benefits of colon capsule endoscopy (ColoCap Study).

3.5 Finance

Securing sustainable funding for future research and innovation activities is critical to our future success. Our strategy both recognises the financial difficulties facing our Trust and the opportunities that it can bring. The direct and indirect financial benefits, in terms of accessing new funding streams and quality and safety improvements, brought by this strategy, will accrue rapidly from this strategy, and offset the investment for our future that is required.

Through our excellent clinical trial delivery, the Trust will also continue to receive our Research Delivery Network funding to support our research delivery activities.

Commercial Research Portfolio

In addition to this, the R&I team will strengthen our commercial research portfolio to ensure an increase in commercial funding, that will be distributed following our commercial research funding model, which ensures that the income follows activity, wherever that is within the Trust.

Research Capability Funding

Through increased National Institute for Health and Care Research (NIHR) grant applications the R&I team will see an increase in our Research Capability Funding (RCF), that will be distributed amongst partners, to further develop NIHR grant submissions.

The R&I team will also continue the work innovatively on the in-house data management system, EDGE, to develop our invoicing capabilities, ensuring all research income that can be invoiced for is received, and distributed internally to the areas of the Trust where the trial activity has taken place.

Innovation

The R&I team will improve awareness and utilisation of local innovation funding. This will increase the Trust's innovation portfolio, and result in funding and intellectual property opportunities in the long term.

In addition, the R&I team will increase our applications and success to innovation-related funding e.g. InnovateUK. The team will use our strategic partnership with Health Innovation Yorkshire & Humber, to broker connections with innovators in relation to joint grant applications, giving the Trust access to national funding pots requiring innovator-led applications, e.g. UK Research and Innovation, InnovateUK and Small Business Research Initiative (SBRI). The R&I team will also improve awareness and utilisation of local innovation funding. This will increase the Trust's innovation portfolio, and result in funding and intellectual property opportunities in the long term.

4.0 What Next?

I am so proud of what the Trust and the department have achieved over the past few years and for all the work the Trust aspires to do within this new strategy. The Trust is driven to achieve our Mission (to create a healthier future for our community and beyond through research, collaboration, and innovation) and our Vision (to bring research and innovation opportunities to all our patients and staff).

The Trust will ensure that the research and innovation activities for York & Scarborough Teaching Hospitals NHS Foundation Trust will continue to develop, so expanding our research and innovation portfolio over the coming years. This strategy is accompanied by a detailed action plan that is the framework that will drive this strategy forward. The action plan will be reviewed by the core team of R&I staff and the Clinical Director for R&I quarterly.

See appendix two for an overview of the Performance Operating Framework that will be reported to the Board of Directors annually.

The Trust will continue to offer greater opportunities to get involved with research and innovation for our patients and staff and to ensure, through our growing partnerships and collaborations, the Trust will achieve its aspirations.

Thank you to all the team, staff, and our patients who support the research and innovation endeavours of our Trust, I look forward to seeing what we can achieve in the coming few years.

Lydia Harris
Head of Research and Innovation

Appendices


NHS
York and Scarborough
Teaching Hospitals
NHS Foundation Trust

Appendix 1

For clarity the Trust uses these definitions:

Research	is about finding new knowledge which can be generalised. This new knowledge may lead to a change in services, care, treatments, or policies, broadly intended to improve outcomes of people receiving health or social care. Research is one means to provide the evidence required to make improvements, finding better ways of preventing, diagnosing, or treating disease or conditions, testing these and providing the evidence to enable Quality Improvement (QI) - see below.
Quality Improvement	involves the systematic use of methods or tools to continuously improve the quality of care and outcomes for patients. Research evidence feeds into the QI process. QI is about testing whether an intervention, possibly proven elsewhere or reported in the literature, can also work locally and supporting adaptation and ongoing evaluation in the local context.
Innovation	is about driving transformative change and involves identifying, developing, evaluating, and adopting innovative products or services. This may include (but is not limited to) medicines, medical technologies or devices, digital and/or diagnostic technologies. Identifying and developing innovation and subsequently gaining evidence to support (or otherwise) the innovation through evaluation would most likely come under the umbrella of Research & Innovation. Adopting locally and ongoing evaluation to continuously improve is likely to fall under QI.

Research and Innovation are distinct yet complementary activities that give the opportunity to improve patient care. Research provides patients access to new treatments and builds an evidence base for better future care, while innovation fosters new ways of thinking and reimagining practices from inception. By closely aligning these efforts, the Trust can increase the benefits for its researchers, practitioners, and innovators, and this strategy aims to facilitate this.

Appendix 2

Performance Operating Framework for the 2025–2028 Research and Innovation Strategy

R&I Innovation Strategy Scorecard	2025–2026	2026–2027	2027–2028
Number of patients recruited into clinical trials	3,500	*4,000*	*4,500*
Number of research champions and innovation champions trained	5	*10*	*15*
Number of home grown innovation ideas received Digital ideas Device ideas Model of Care ideas Other innovations	4 1 2 0 1	10 *2* *2* *2* *4*	20 4 3 5 8
Number of Innovation grants submitted to external funders where a Trust member of staff is an applicant	2	*4*	*5*
Number of home grown research ideas sponsored by the Trust	18	*20*	*22*
Number of home grown research ideas received	5	*7*	*10*
Number of Research grants submitted to external funders where a Trust member of staff is an applicant	30	*35*	42
Number of clinical academic posts	2	*3*	*5*
Amount of research income awarded from external funders	£1,462,272	*+10%*	*+10%*
Innovation projects supported	15	*18*	*22*
Amount of commercial research income awarded	£267,318	*+10%*	*+10%*

OUR RESEARCH AND INNOVATION STRATEGY

2025–2028

WORKFORCE DEVELOPMENT

Provide training opportunities to all staff, ensuring career development in research roles.

Increase the number of staff participating in research career pathways (e.g., PhDs, MScs, internships).

Develop and fund hybrid research/clinical roles to integrate research into daily practice.

Create R&I champion roles across departments to foster engagement.

Promote R&I opportunities at recruitment and staff on-boarding stages.

RESEARCH AND INNOVATION INFRASTRUCTURE

Expand digital health capabilities to support clinical trials and data collection.

Establish as a dedicated research centre at Scarborough Hospital, to address health inequalities on the Yorkshire Coast.

Build a commercial research team to improve study setup times and increase participation in global studies.

Develop a Safe Data Environment for research applications and data sharing within the Integrated Care Board (ICB).

PARTNERSHIPS

Deepen partnerships with our academic collaborators to drive our research and innovation projects.

Collaborate with Contract Research Organisations (CROs) to attract more commercial research opportunities.

Strengthen ties with local universities and fund PhD studentships to boost research and innovation.

Develop partnerships with the Voluntary Community and Social Enterprise (VCSE) sector to engage hard-to-reach communities.

RESEARCH AND INNOVATION EXCELLENCE

Deliver high-quality research recognised through peer-reviewed publications.

Grow sponsorship activities.

Continue to recruit patients for clinical trials and ensure PPI.

Strengthen the communications strategy for dissemination.

Promote innovation in healthcare by supporting new ideas and research-led solutions.

FINANCIAL SUSTAINABILITY

Pursue external R&I grants and commercial research opportunities.

Increase commercial research income through expansion of our commercial portfolio.

Improve EDGE system usage for invoicing and financial tracking to ensure timely and accurate distribution of funds.

Apply for innovation grants (e.g., Innovate UK) to support cutting-edge research and innovation technology development.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust
Research and Innovation Department

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Report to:	Board of Directors
Date of Meeting:	26th February 2025
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 ☐ A Regulatory Requirement ☒

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☐ Quality Standards
☒ Great place to work, learn and thrive	☒ Workforce
☒ Work together with partners	☒ Safety Standards
☐ Research, innovation and transformation	☐ Financial
☒ Deliver healthcare today without compromising the health of future generations	☒ Performance Targets
☒ Effective governance and sound finance	☒ DIS Service Standards
	☒ Integrated Care System
	☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Summary of Report and Key Points to highlight:

The Board of Directors is asked to:

- Note that the Executive Committee endorsed this report on 5th February 2025.
- Note that following a self-assessment process against the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) Standards, the Trust has rated itself as "Non" compliant. This is the same grading as last year. The Trust is "fully" compliant in 35 of the 62 applicable standards (56%). This is an increase of 139.1% in the compliance rating from last year.
- Note that the increased time spent on incident response and winter operational pressures by the Emergency Preparedness, Resilience and Response Team is impinging on core business being completed in a timely manner. A review of the approach for winter next year and the resources required in the team will be conducted in 2025.
- Note that the scale and scope of maintaining plans is a challenge that will endure through 2025. Testing and training completed plans also remains challenging as operational tempo and financial constraints are preventing the release of staff for events.
- Note that in 2025 a significant project will be undertaken to review all Business Impact Analyses and Business Continuity Plans for all operational departments that provide critical services.

The Accountable Emergency Officer (AEO) has signed the Certificate of Compliance (pending submission of the report to the Board of Directors) that can be found at Appendix 1.

An action plan to remediate the partially and non-compliant standards can be found at Appendix 2.

Recommendation:

The Board of Directors is requested to:

- To approve the report and assurance rating of "Non" compliance with the NHS England EPRR Core Standards.

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	Date	Outcome/Recommendation
Executive Committee	5th February 2025	Endorsed
Resources Committee	18th February 2025	

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).

The assessment process was reviewed by NHS England in 2023. The review did not signal a material change or deterioration in preparedness across England but it was seen as a revised and more rigorous baseline of assessment to improve plans for preparedness, response and recovery. The "rigorous baseline" has been maintained this year however the review of the self-assessment evidence has been delegated for the first time to Integrated Care Boards by NHS England. The governance and assurance timetable to finalise submission was as follows:

Date	Action
By 30 Sep 24	Trust submit 1st draft to Integrated Care Board
08 Oct 24	Trust submission subjected to peer review
31 Oct 24	Trust final submission to Integrated Care Board
15 Nov 24	Integrated Care Board and Trust Accountable Emergency Officers confirm Trust submission
19 Nov 24	Local Healthcare Resilience Partnership confirm all Trust submissions in Integrated Care Board
20 Nov 24	Integrated Care Board submit report on system compliance as part of Regional Emergency, Preparedness, Resilience and Response Team assurance process
02 Dec 24	Regional Healthcare Resilience Partnership confirm final Integrated Care Board submissions in the North East and Yorkshire Region
20 Dec 24	Regional Emergency Preparedness, Resilience and Response Team submit North Region Emergency Preparedness, Resilience and Response Core Standards report to NHS England national team
By 28 Feb 25	Trust to have taken this report to Board of Directors

2. Core Standard Self-Assessment Observations

In 2023 the Trust was assessed as "Non Compliant" against the 62 core standards with 14 graded as fully compliant (23%). This year the Trust remains "Non Compliant" against the 62 core standards with 35 graded as fully compliant (56%). This is an increase of 139.1% in the compliance rating from last year.

Significant work has been completed across the Integrated Care Board to comply with the Core Standards following the review of the assurance process and the resetting of the evidence requirements in 2023. The work conducted by the Trust Emergency Preparedness, Resilience and Response Team has been benchmarked against partner providers by the Integrated Care Board as follows:

Organisation	Final Self-Assessment 23/24	Compliance Rating 23/24	Final Self-Assessment 2024/25	Compliance Rating 24/25	Increase of Compliance Rating %
Humber and North Yorkshire ICB	32%	Non-compliant	60%	Non-compliant	87.5%
Northern Lincolnshire and Goole Foundation Trust	40%	Non-compliant	90%	Substantially Compliant	125%
Hull University Teaching Hospitals	18%	Non-compliant	69%	Non-compliant	283.3%
Harrogate and District Foundation Trust	10%	Non-compliant	45%	Non-compliant	350%
York and Scarborough Foundation Trust	23%	Non-compliant	56%	Non-compliant	139.1%
Care Plus Group	43%	Non-compliant	45%	Non-compliant	4.6%
City Health Care Partnership	17%	Non-compliant	62%	Non-compliant	264%
NAVIGO	12%	Non-compliant	41%	Non-compliant	241%
Humber Teaching Foundation Trust	24%	Non-compliant	60%	Non-compliant	150%

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

The Emergency Preparedness, Resilience and Response Core Standards Self-Assessment comprises of 62 standards that are grouped into 10 domains. A breakdown of compliance by domain is as follows:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	4	2	0
Duty to risk assess	2	0	2	0
Duty to maintain plans	11	6	3	2
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	1	3	0
Cooperation	4	2	2	0
Business Continuity	10	5	5	0
Hazmat/CBRN	12	4	8	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	35	25	2

To better understand the progress made in each domain, observations and comments are as follows:

2.1 Governance

The governance domain has 4 x fully and 2 x partially compliant standards.

Although the Trust complies with the EPRR Board Reports (Standard 3) standard, the regional Emergency Preparedness, Resilience and Response team have directed that the grading remain “partial” until this report has been to Board of Directors in their preferred format that follows the Core Standard headings. This standard will be fully compliant next year.

The EPRR Resource standard (Standard 5) requires confirmation that there is sufficient resource for the Trust to discharge it’s EPRR duties. This standard has been declared as partially compliant to acknowledge that the scale and scope of the portfolio remains challenging for a team of 2 staff. Partial mitigation of the training risk has been identified by providing the Emergency Preparedness, Resilience and Response Team with support from clinical educators however the increased time spent on incident response and winter operational pressures is impinging on core business being completed in a timely manner. The action plan for 2025 contains actions to further review these shortfalls.

2.2 Duty to Risk Assess

The duty to risk assess domain has 2 x partially compliant standards.

These standards relate to the requirement to risk assess and risk manage (Standards 7 & 8). This is currently being undertaken under the supervision of the Emergency Planning Steering Group however that group has directed that these functions are migrated onto the DATIX system that the Trust use to assess and manage risk. Until this work has been completed, planned for 2025, this standard will remain “partially” compliant.

2.3 Duty to Maintain Plans

The duty to maintain plans domain has 6 x fully, 3 x partially and 2 x non-compliant standards.

This is one of the largest domains that contains a total of 11 standards that relate to the policies, plans, aide memoires, contingency plans and action cards that the Emergency Planning Team have either direct responsibility for authoring or a coordinating function for refreshing and hosting. This breaks down to directly responsible for authoring 2 x policies, 16 x plans, 8 x aide memoires, 3 x contingency plans and 10 x action cards. The team are responsible for coordinating and hosting 934 x action cards in emergency planning and business continuity. The majority require refreshing and revising on an annual basis.

The 2 non-compliant standards are the New and Emerging Pandemic Plan (Standard 13) and the Countermeasures Plan (Standard 14) which outline the arrangements for administration, reception and distribution of prophylaxis and mass vaccination. Both plans are on the work schedule for completion this year and both will require significant input from external stakeholders i.e. UKHSA, Local Authorities and the Integrated Care Board which may result in external barriers for timely completion.

The 3 partially compliant standards are the Lockdown Plan (Standard 17), the Protected Individuals Plan (Standard 18) and Excess Fatalities Plan (Standard 19). The Lockdown Plan requires major revision, the Protected Individuals Plan is work in progress to be written

and the Excess Fatalities Plan is nearing completion in liaison with Cancer, Specialist & Clinical Services Care Group.

2.4 Command and Control

All standards in the command and control domain are fully compliant. This is expected to endure for the next 12 months and therefore holds no risks.

2.5 Training and Exercising

All standards in the training and exercising domain are fully compliant however testing and training contingency plans remains challenging as operational tempo and financial constraints prevent the release of staff in large numbers for events. The Emergency Preparedness, Resilience and Response will continue to work with Care Groups to try and release staff, to utilise less staff heavy training events such as table tops and to make more use of internet based learning.

2.6 Response

All standards in the response domain are fully compliant. This is expected to endure for the next 12 months and therefore holds no risks.

2.7 Warning and Informing

The warning and informing domain has 1 x fully and 3 x partially compliant standards.

The 3 partially compliant standards are warning and informing (Standard 33), incident communications plan (Standard 34) and media strategy in an incident (Standard 36). A meeting with the Director of Communications has taken place and a work schedule has been agreed to deliver an Emergency Preparedness, Resilience and Response Incident Communications Plan this year. There are no barriers to completion.

2.8 Cooperation

The cooperation domain has 2 x partially compliant standards.

The 2 partially compliant standards are Local Health Resilience Partnership engagement (Standard 37) and mutual aid arrangements (Standard 39). The mandated Trust attendance at the quarterly Local Health Resilience Partnership meetings was narrowly missed due to operational pressures and will be addressed during 2025. The mutual aid arrangements have already been added to the command and control plan to meet full compliance.

2.9 Business Continuity

The business continuity domain has 5 x fully and 5 x partially compliant.

The 5 partially compliant standards are Business Impact Analysis (Standard 46), Business Continuity Plans (Standard 47), business continuity management system monitoring and evaluation (Standard 50), business continuity management system improvement process (Standard 52) and assurance of commissioned providers business continuity plans (Standard 53).

Formal Business Impact Analyses (BIA) and Business Continuity Plans (BCP) are held by all BRONZE Commands and the departments/services operate to over 800 action cards. There is now a requirement to conduct a review of the business continuity management system. The review will identify critical services that will be required to produce formal BIAs that will inform their BCP and will then make clear which service disruptions will require action cards. This should bring more coherence to responses to incidents and allow improvements to be made to the business continuity management system. The aim is to complete this work in 2025.

2.10 Hazardous Material (HAZMAT) and Chemical, Biological, Radioactive and Nuclear (CBRN)

The hazardous material and chemical, biological, radioactive, and nuclear domain has 4 x fully and 8 x partially compliant.

The 8 partially compliant standards are HAZMAT / CBRN risk assessments (Standard 56), HAZMAT / CBRN planning arrangements (Standard 58), decontamination capability availability 24/7 (Standard 59), equipment supplies (Standard 60), HAZMAT / CBRN training resource (Standard 63), staff training – recognition and decontamination (Standard 64), PPE access (Standard 65) and exercising (Standard 66).

The process for assessing this domain has changed from previous years. Instead of self assessment with evidence, as implemented for the other 9 domains, the CBRN lead for the ICB (Yorkshire Ambulance Service Special Operations Manager) has conducted the assessment. The result has been that the assessor has identified several minor omissions and provided recommendations that prevent a fully compliant grading. All the partially compliant standards are achieving a 90% plus compliance level for the external assessment and there are no concerns regarding the availability of a 24/7 decontamination capability at both sites. The minor omissions and recommendations will be actioned in 2025.

3. Action Plan

The actions to address the partial and non-compliant standards is included in the action plan at Appendix 2. In addition, the plan includes actions to sustain fully compliant standards and some actions that have been carried over from the 2023/2024 action plan that still require attention.

Progress reporting will be conducted throughout 2025 by the Head of Emergency Preparedness, Resilience and Response to the Resource Committee on behalf of the Accountable Emergency Officer.

4. Conclusion

Significant progress has been made over the last 12 months increasing the number of standards that are fully compliant. Progress over 2025 will be possible however the rate this will be achieved will be dependant on the time available to the small Emergency Preparedness, Resilience and Response team to engage with core business.

Appendices:

1. EPRR Core Standards Assurance – Statement of Compliance.

2. EPRR Core Standards Assurance – Action Plan 2024-2025.

Date: 27 January 2025

Appendix 1 – EPRR Core Standards Assurance – Statement of Compliance

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-25

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 V2.

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 Non-compliant (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 board/governing body along with the enclosed action plan.

Signed by the organisation's Accountable Emergency Officer:

Date signed: 05 February 2025

Date of Board/Governing Body meeting: 25 Feb 25	Date to be presented at public Board: 25 Feb 25	Date published in Annual Report: In board report 2025

Appendix 2 – EPRR Core Standards Assurance – Action Plan 2024/25

Ref	Domain	Standard name	Standard Detail	NHS E Final Grading 2023	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Remarks / Updates
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	A	3 – The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation. (R)	Nil	1 – The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation. (R)	RC	Q4 – 24	3 – (03/04/2024) This will not change until Board report is submitted. 3 – (14/11/2024) – Carry forward to next years action plan.
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	Nil	Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO	2 – Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	RC	Q4 – 24	
7	Duty to Risk Assess	Risk Assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	A	A	12 – Review EPRR Risk Register and introduce a Risk Assessment form for each serial on the register and include as a thumbnail. Include a check sheet as the first sheet to record checks conducted at the EPSG. (R) 13 – Check that EPRR Risk escalation process is included in the Trust Risk Framework specifically. (R)	Migrate EPRR Risk Register to DATIX - Corporate Ops area	3 – Review EPRR Risk Register and introduce a Risk Assessment form for each serial on the register and include as a thumbnail. Include a check sheet as the first sheet to record checks conducted at the EPSG. (R) 4 – Check that EPRR Risk escalation process is included in the Trust Risk Framework specifically. (R) 5 – Migrate EPRR Risk Register to DATIX – Corporate Ops area (R)	RC / CR CR CR	Q3 – 25 Q4 – 24 Q3 – 25	12 (19/12/2023) – Accept that all risk assessment forms will take 2024 to complete therefore EPRR Core Standards likely to remain AMBER with evidence of progress. 12 (03/04/2024) – RC / CR to conduct initial risk assessment on RACC and then review what the target completion against dates should be. 12 & 13 (14/11/2024) – Carry forward to 2025 action plan.
8	Duty to Risk Assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	A	A	Please see comments for core standard 7	Nil				
13	Duty to Maintain Plans	New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	A	R	20 – Review the Pandemic Plan in line with national guidance, the national IPC manual and relevant lessons identified from COVID-19. (A)	Write New and Emerging Pandemic Plan	6 – Review the Pandemic Plan in line with national guidance, the national IPC manual and relevant lessons identified from COVID-19. (A) 7 – Write New and Emerging Pandemic Plan (R)	RC RC	Q3 – 24 Q3 – 25	20 (03/04/2024) – RC obtained best practice New and Emerging Pandemic Plan and is amending for Trust use and will then authorise through ID WG. 20 (14/11/2024) – Carry forward to 2025 Action Plan.
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	A	R	21 – Capture specific Countermeasures Training in the central training log. (R) 22 – Write a new policy to consider mass vaccination and issue of prophylaxis. (R)	Nil	8 – Capture specific Countermeasures Training in the central training log. (R) 9 – Write a new policy to consider mass vaccination and issue of prophylaxis. (R)	CR RC	Q3 – 24 Q4 – 25	21 & 22 (14/11/2024) – Carry forward into 2025 Action Plan.
15	Duty to Maintain Plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	A	G	23 – Publish the Mass Casualty Plan. (A)	Nil	10 – Publish the Mass Casualty Plan. (A)	RC	Q3 – 25	23 – (12/01/2024) this plan is on the MI working group agenda on 24/01/2024. 23 (14/11/2024) – Mass Casualty Aide Memoire published as an interim solution. Carry forward to 2025 Action Plan.
16	Duty to Maintain Plans	Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	A	G	24 – Publish the Evacuation & Shelter Plan. (R)	Nil	11 – Publish the Evacuation & Shelter Plan. (R)	RC	Q4 – 24	24 (14/11/2024) – carry forward to 2025 Action Plan.
17	Duty to Maintain Plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	A	A	25 – Implement lockdown training and exercises to include: a) Both EDs exercising. b) Table Top exercise for BC Leads and Security. (R)	Update the Lockdown Plan	12 – Implement lockdown training and exercises to include: a) Both EDs exercising. YTH / SGH. b) Table Top exercise for BC Leads and Security. (R) 13 – Update the Lockdown Plan (R)	CR RC	Q2 – 25 Q1 – 25	25 – (07/02/2024) Included on EPM work schedule. Query – delay SGH exercise to conduct in new ED. 25 (14/11/2024) – Carry forward to 2025 Action Plan. 12 – (04/12/2024) – SGH Training completed as part of UECC induction.
18	Duty to Maintain Plans	Protected Individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	A	A	26 – Write Trust Protected Individuals Policy. (R)	Nil	14 – Write Trust Protected Individuals Policy. (R)	RC	Q2 – 25	26 (14/11/2024) – Carry forward to 2025 Action Plan.
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	A	27 – Write Trust Excess Fatalities Policy. (R)	Nil	15 – Write Trust Excess Fatalities Policy. (R)	RC	Q2 – 25	27 (14/11/2024) – Carry forward to 2025 Action Plan.
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	G	38 – Include exercising of SITREP process in LIVEX 24 exercise objectives. (R)	Nil	16 – Include exercising of SITREP process in LIVEX 24 exercise objectives. (R)	RC	Q2 – 24	38 (14/11/2024) – Carry forward onto 2025 Action Plan.
33	Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	A	Nil	Determine 24/7 Comms capability and include in Incident Comms Plan	17 – Determine 24/7 Comms capability and include in Incident Comms Plan (R)	RC	Q3 – 25	
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	40 – Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (R)	Write Incident Comms Plan	18 – Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (R) 19 – Write Incident Comms Plan (R)	Comms Team RC	Q2 – 24 Q3 – 25	40 (14/11/2024) – Carry forward onto 2025 Action Plan.
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	Nil	Write Incident Comms Plan	20 – Write Incident Comms Plan (R)	RC	Q3 – 25	
39	Cooperation	Mutual Aid Arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	A	A	43 – Review Trust IRP to include a table under mutual aid that defines by Incident Level (1-4) how, who, when and for long mutual is requested. (R)	Include mutual aid arrangements into Command and Control Plan and include MACA guidance.	21 – Review Trust IRP to include a table under mutual aid that defines by Incident Level (1-4) how, who, when and for long mutual is requested. (R) 22 – Include mutual aid arrangements into Command and Control Plan and include MACA guidance. (G)	RC RC	Q4 – 24 Q4 – 24	43 – Carry forward onto 2025 Action Plan.

Ref	Domain	Standard name	Standard Detail	NHS E Final Grading 2023	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Remarks / Updates
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	A	46 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (A) 46A - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 47 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (R)	Separate project required to develop BIAs	23 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (A) 24 - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 25 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (R) 26 - Seperate project required to develop BIAs. (R)	CR CR CR CR	Q2 - 24 Q2 - 24 Q2 - 25 Q4 - 25	46, 46A & 47 (14/11/2024) - Carry forward to 2025 Action Plan.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	A	A	48 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 49 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (R)	Separate project required to develop BCPs	27 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 28 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (R) 29 - Seperate project required to develop BCPs. (R)	CR CR CR	Q2 - 23 Q4 - 25 Q3 - 26	48 & 49 (14/11/2024) - Carry forward to 2025 Action plan.
50	Business Continuity	BCMS Monitoring and Evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	A	Nil	Review required of process and included in Trust BC Plan	30 - Review required of process and included in Trust BC Plan. (R)	CR	Q2 - 25	
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.	A	G	52 - Confirm and develop the process for conducting BC audits. Include any audits to be completed in the TNA & BCP - Testing & Audit section. (A)	Nil	31 - Confirm and develop the process for conducting BC audits. Include any audits to be completed in the TNA & BCP - Testing & Audit section. (A)	CR	Q2 - 24	52 - (12/01/2024) meeting with internal auditors on 18/01/2024. 52 (14/11/2024) - carry forward onto 2025 Action Plan.
52	Business Continuity	BCMS Continuous Improvement	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	A	Nil	Review required of process and included in Trust BC Plan	32 - Review required of process and included in Trust BC Plan. (R)	CR	Q2 - 25	
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	Nil	Review required of process and included in Trust BC Plan	33 - Review required of process and included in Trust BC Plan. (R)	CR	Q2 - 25	
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G	G	Nil	Update CBRN Plan to include guidance provided CBRN Audit	34 - Update CBRN Plan to include guidance provided CBRN Audit	RC	Q3 - 25	
56	Hazmat/CBRN	Hazmat/CBRN Risk Assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	A	Nil	Complete CBRN Tent & PRPS Suit Risk Assessment Complete a Risk Assessment around minimum staffing numbers to respond to a CBRN incident Complete actions provided in the CBRN Audit guidance.	35 - Complete CBRN Tent & PRPS Suit Risk Assessment. (R) 36 - Complete a Risk Assessment around minimum staffing numbers to respond to a CBRN incident. (R) 37 - Complete actions provided in the CBRN Audit guidance. (R)	EC-S EC-S EC-S	Q3 - 25 Q3 - 25 Q3 - 25	
57	Hazmat/CBRN	Specialist Advice for Hazmat/CBRN	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	G	Nil	Update CBRN Plan to include guidance provided CBRN Audit	38 - Update CBRN Plan to include guidance provided CBRN Audit. (R)	RC	Q3 - 25	
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	A	A	55 - Review CBRN Plan. (R)	Nil	39 - Review CBRN Plan. (R)	RC	Q3 - 25	55 (14/11/2024) - carry forward to 2025 Action Plan.
59	Hazmat/CBRN	Decontamination Capability Availability 24/7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	A	A	Nil	Design an automated system for annotating who is CBRN trained when a incident occurs. Amend CBRN Plan to include guidance provided in CBRN Audit	40 - Design an automated system for annotating who is CBRN trained when a incident occurs. (R) 41 - Amend CBRN Plan to include guidance provided in CBRN Audit (R)	EC-S RC	Q3 - 25 Q3 - 25	
60	Hazmat/CBRN	Equipment and Supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients	A	A	57 - Review CBRN Plan to include equipment husbandry to include registers, audits and fault finding flow charts. (R) 58 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (R)	Submit a full and detailed CBRN equipment inventory to YAS.	42 - Review CBRN Plan to include equipment husbandry to include registers, audits and fault finding flow charts. (R) 43 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (R) 44 - Submit a full and detailed CBRN equipment inventory to YAS.	RC RC EC-S	Q3 - 25 Q3 - 25 Q3 - 25	57&58 (14/11/2024) - carry forward onto 2025 Action Plan.

Ref	Domain	Standard name	Standard Detail	NHS E Final Grading 2023	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Remarks / Updates
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	G	G	Nil	Ensure a preventative maintenance contract is in place for the tent and associated ancillaries.	45 - Ensure a preventative maintenance contract is in place for the tent and associated ancillaries. (R)	EC-S	Q3 - 25	
62	Hazmat/CBRN	Waste Disposal Arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	G	G	Nil	Ensure CBRN Plan contains relevant waste and water legislation	46 - Ensure CBRN Plan contains relevant waste and water legislation. (R)	RC	Q3 - 25	
63	Hazmat/CBRN	Hazmat/CBRN Training Resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	A	Nil	CI CBRN to comply with guidance provided in CBRN audit.	47 - CI CBRN to comply with guidance provided in CBRN audit.	EC-S	Q3 - 25	
64	Hazmat/CBRN	Staff Training - Recognition and Decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	A	A	Nil	Undertake a full review of the current training course once the TNA has been undertaken.	48 - Undertake a full review of the current training course once the TNA has been undertaken. (R)	EC-S	Q3 - 25	
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	A	A	Nil	Ensure the PRPS suits size selection for individuals aligns to manufacturers guidance.	49 - Ensure the PRPS suits size selection for individuals aligns to manufacturers guidance. (R)	EC-S	Q3 - 25	
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	A	Nil	Complete actions as per CBRN Audit guidance	50 - Complete actions as per CBRN Audit guidance. (R)	EC-S	Q3 - 25	

Report to:	Board of Directors
Date of Meeting:	26 February 2025
Subject:	2024 Committee Annual Reports and Effectiveness Reviews
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care	☒ Quality Standards
☒ Great place to work, learn and thrive	☒ Workforce
☒ Work together with partners	☒ Safety Standards
☒ Research, innovation and transformation	☒ Financial
☒ Deliver healthcare today without compromising the health of future generations	☒ Performance Targets
☒ Effective governance and sound finance	☒ DIS Service Standards
	☒ Integrated Care System
	☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The Board of Directors is asked to consider the Committee Annual Reports and Effectiveness Reviews.

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
Quality Committee	18 February 2025	Approved
Resources Committee	18 February 2025	Approved

Committee Annual Reports and Effectiveness Reviews

1. Introduction and Background

Annual Committee reviews are an important process to reflect on the achievements of the Board of Directors Committees and where they could improve in the future.

Section 4.2 of the Trust's Standing Orders refers to delegation of functions from the Board of Directors to Committees and this report provides assurance that the roles and responsibilities of the Committee are being effectively delivered.

The Board should consider on an annual basis a review of its Committees, their terms of reference and work programmes.

2. Committee Annual Reports and Effectiveness Reviews Process

The Board of Director's Quality and Resources Committees have been reviewed for the period January - December 2024 and comprises:

- Review of the Committee terms of reference and work programme
- Delivery of work programme papers to the Committee
- Attendance by members
- A Committee Effectiveness Self-Assessment review

Section 5.1 of the Trust's Standing Orders refers to the appointment of Committees, the Board of Directors annual review of these Committees, and the delegation provided to them. The NHS code of governance for NHS Providers at section 4.5 states that 'there should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors'.

3. Committee Annual Reports and Effectiveness Reviews

The 2024 Committees Annual Reports and Effectiveness Reviews are provided at appendix 1 for the Quality Committee and appendix 2 for the Resources Committee.

At the March Committee meetings terms of reference and work programmes will subsequently be reviewed, informed by the Committee Annual Reports and Effectiveness Reviews. The March Group Audit Committee and Digital Sub-Committee will do likewise in considering its Annual Reports and Effectiveness Reviews, with any amends to all Committee terms of reference and work programmes to be reported to the March Board of Directors.

The results of the Committees Annual Reports and Effectiveness Reviews will be summarised in the 2024/25 Trust Annual Report and Accounts submitted to NHS England and laid before Parliament.

Quality Committee Annual Report and Effectiveness Review 2024

1. Introduction

This report has been prepared to provide the Board of Directors with a summary of the work of the Quality Committee and its effectiveness during the period January 2024 – December 2024, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

The Board of Directors approved the revised terms of reference for the Committee in January 2024 and this also forms the annual report of the Committee over this period.

2. Governance

The membership of the Quality Committee is as follows:

- Non-Executive Director (Chair)
- 2 x Non-Executive Director
- Medical Director
- Chief Nurse
- Chief Operating Officer

Attendees of the Committee are:

- Deputy Medical Director
- Associate Medical Director
- Deputy Chief Nurse
- Director of Quality, Improvement and Patient Safety
- Chief Clinical Information Officer
- Chief Pharmacist
- Chief of Allied Health Professionals
- Deputy Director of Infrastructure
- Senior quadrumvirate representation from each Care Group

Attendees (as and when required)
Senior representation from each Care Group when presenting divisional reports (For Care Groups of Medicine, Surgery, Family Health, Cancer, Specialist and Clinical Support Services this will be the Care Group Director, Associate Chief Operating Officer and Associate Chief Nurse or Associate Chief Allied Health Professional.)

The Associate Director of Corporate Governance has a standing invitation to the Committee.

Table 1: Quality Committee Attendance

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Total
Steven Holmberg - Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Jenny McAleese	✓	✓	✓	✓	Ap	✓	✓	✓	✓	✓	Ap	✓	10/12
Lorraine Boyd	✓	✓	✓	✓	✓	✓	✓	Ap	✓	✓	✓	✓	11/12
Karen Stone	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Ap	✓	11/12
Dawn Parkes	Dep	Dep	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/12
Claire Hansen	Dep	✓	✓	✓	✓	✓	Ap	✓	✓	✓	✓	✓	10/12

Ap - Apologies, Deputy - Deputy provided, ✓ - in attendance

The Quality Committee met on 12 occasions during 2024 and all meetings were quorate.

The Committee received secretarial and administrative support from the Chair and Chief Executive Office with minutes taken of all Resources Committee meetings. The Chair provided an escalated items log of those matters that the Committee considers should be drawn to the attention of the Board.

The Chair of the Quality Committee is also a member of the Group Audit Committee.

3. Duties of the Committee

On behalf of the Trust Board, the Quality Committee will:

- Oversee the writing and revision of the Quality Strategy.
- Review the Quality Strategy Dashboard and use information from several sources to inform the Committee of how well the Trust is performing and the quality-of-care patients receive.
- Monitor delivery and seek assurance that the Trust's Quality Strategy is being fully implemented.
- Seek assurance from the Patient Experience Sub-Committee regarding patient feedback including information obtained via complaints, contacts with the PALS service and Friends and Family Test returns. Identify areas for improvement based on this information.
- Consider and review the Trust's compliance with the statutory Duty of Candour, and to be satisfied that the Trust is being open, honest, and effectively engaging and supporting patients and their relatives who have been involved in a notifiable patient safety incident.
- Obtain assurance of the Trust's maintenance of compliance with the Care Quality Commission registration through assurance of the systems of control, with particular emphasis on the Fundamental Standards of Care, quality and safety

including assurance on external assessment systems, professional bodies and regulatory bodies' requirements with subsequent action plans.

- Seek assurance from the Patient Safety and Clinical Effectiveness Sub-Committee regarding serious incidents including identification of themes and trends and actions taken to ensure learning has taken place.
- Seek assurance that the production of an annual clinical audit plan has been overseen by the Patient Safety and Clinical Effectiveness Sub-Committee including participation in national audit reports, and that the implementation of the plan has been kept under review at quarterly intervals.
- Receive and oversee the production of the Trust's Quality Account for presentation to the Trust Board.
- Seek assurance that the Patient Safety and Clinical Effectiveness Sub-Committee has ensured that agreed best practice, as defined in the national clinical audit framework, is reviewed and delivered where relevant in the context of the Trust's services. This will include, for example, NICE clinical guidelines and NHS frameworks as well as the guidance that emerges from national confidential enquiries, high level enquiries and other nationally agreed guidance.
- Receive a bi-monthly exception report from each of the care groups and escalate issues and risks as appropriate to the Trust Board.
- Implement the Learning from Deaths Policy and embed reporting arrangements.
- Receive a monthly Chair's report from the Patient Experience Sub-Committee and escalate issues and risks highlighted as appropriate.
- Receive a monthly Chair's report from the Patient Safety and Clinical Effectiveness Sub-Committee and escalate issues and risks highlighted as appropriate.
- Oversee care group governance and reporting arrangements.
- Undertake a quarterly review of the Board Assurance Framework and ownership of specific principal risks on behalf of the Board.

4. Delivery of the Work Programme

A work plan to deliver the duties of the Committee was drafted at the outset of the year and reports presented to the Committee by the Executives or subject matter experts responsible for each report.

Over the year Committee reporting has included:

- Care Group Deep Dive assurance presentations from each Care Groups leadership: Medicine, Surgery, Cancer, Specialist and Clinical Support Services (CSCS) and Family Health.
- Sub-Committee escalation reporting from:
  - Patient Experience Sub-Committee
  - Patient Safety and Clinical Effectiveness Sub-Committee
- Maternity and Neonatal Reports including the Maternity Section 31 submission
- CCQ Compliance Update Reporting
- Overall Quality Strategy progress
- Nurse Staffing Reporting
- Infection Prevention and Control Reporting
- Patient Experience Reporting
- Risk Management Reporting

5. Assessment of Effectiveness

The membership of the Committee was asked to conclude a self-assessment of the committee's effectiveness with the following identified.

Highest self-assessment scores

- The committee have written terms of reference that clearly describe the purposes and duties of the Committee.
- The outcomes of each meeting and any escalations are reported effectively to the Board.
- Executive officers and attendees are well prepared in presenting reports.
- The committee has devised a comprehensive year-round plan to address all necessary matters.
- The quality of committee papers received allows committee members to perform their roles effectively.
- Committee members contribute regularly to the matters discussed.
- The committee is aware of the key sources of assurance and who provides them.

Lowest self-assessment scores

- At the end of each meeting the committee discuss the outcomes and reflect on decisions made, identifying successes and areas to develop.
- The committee has set itself a series of objectives for the year.
- The committee receives information that is accurate, complete and timely supporting the committee to gain assurances on the subject matter.

The Committee's terms of reference and work plan will subsequently be reviewed by the Committee at its March meeting. Any amendments will be reserved for Board approval in preparation for delivery during 2025/26 in the context of the Trust's new strategy - Towards Excellence: Trust Strategy 2025-2030.

6. Assurance Statement

Our work has encompassed patient safety, patient experience, clinical effectiveness and performance, seeking to understand how we are optimising the use of our available resources to minimise patient harms and maintain best possible patient experience.

Quality improvement is an important driver of the work of the Trust and key to this is the encouragement of learning and sharing when things have gone well and not so well and collaborating with and learning from partners and external sources.

The Trust continues to experience major challenges in delivering timely planned and urgent care. The Committee continues to have a major focus on minimising the harm associated with long waiting times. The Committee continues to develop assurance derived from front-line services and also triangulates findings from internal audit investigations

In this context the Quality Committee will continue to seek assurance that patient safety and experience remains a constant guiding principle for the patients at the Trust.

I would like to thank the members of the Committee and their teams and the Board of Directors for their support during the year.

I would also like to thank the Care Groups for their contributions and look forward to continuing to develop strong Ward to Board assurance in the coming year.

Stephen Holmberg, Chair of the Quality Committee
February 2025

Resources Committee Annual Report and Effectiveness Review 2024

1. Introduction

This report has been prepared to provide the Board of Directors with a summary of the work of the Resources Committee and its effectiveness during the period January 2024 – December 2024, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

The Board of Directors approved the revised terms of reference for the Committee in January 2024 and this also forms the annual report of the Committee over this period.

2. Governance

The membership of the Resources Committee is as follows:

- Non-Executive Director (Chair)
- 2 x Non-Executive Director (inc Associate Non-Executive Director)
- Director of Finance
- Chief Operating Officer
- Director of Workforce and Organisational Development
- YTHFM Representative
- Chief Nurse
- Medical Director
- Chief Digital Information Officer

Attendees of the Committee are:

- Chief of Allied Health Professionals

The Associate Director of Corporate Governance has a standing invitation to the Committee

Table 1: Resources Committee Attendance

	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Total
Lynne Mellor (Chair)	Ap	Dep	✓	✓	✓	✓	Ap	✓	✓	✓	✓	✓	9/12
Jim Dillon (Deputy Chair)	✓	✓	✓	✓	✓	Ap	✓	✓	✓	✓	✓	Ap	10/12
Matt Morgan	Dep	✓	✓	✓	✓								4/5
Helen Grantham					✓	✓	✓	✓	✓	✓	✓	✓	8/8
Andrew Bertram	✓	✓	Dep	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/12

Claire Hansen	Dep	✓	✓	✓	✓	✓	✓	✓	✓	✓	Dep	✓	10/12
James Hawkins	✓	✓	Dep	✓	✓	✓	✓	✓	✓	✓	✓	Dep	10/12
Karen Stone	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Polly McMeekin	✓	✓	✓	✓	✓	✓	✓	Ap	✓	✓	✓	✓	11/12
Dawn Parkes	Ap	Dep	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/12
YTHFM Representative	Ap	Ap	Ap	✓	✓	Ap	✓	✓	Ap	✓	Ap	✓	6/12

Ap - Apologies, Deputy - Deputy provided, ✓ - in attendance

The Resources Committee met on 12 occasions during 2024 and all meetings were quorate.

The Committee received secretarial and administrative support from the Chair and Chief Executive Office with minutes taken of all Resources Committee meetings. The Chair provided an escalated items log of those matters that the Committee considers should be drawn to the attention of the Board.

The Chair of the Resources Committee was also a member of the Group Audit Committee for 2024.

3. Duties of the Committee

On behalf of the Trust Board, the Resources Committee will receive reports across Finance, Performance, People and YTHFM as follows:

Finance

- To consider the Trust's financial strategy, in relation to both revenue and capital.
- To consider the Trust's annual financial targets and performance against them.
- To review the annual budget, before submission to the Trust Board of Directors.
- To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.
- To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.
- To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and contractual safeguards.
- To oversee and receive assurance on the financial plans of significant programmes.
- To seek assurance on delivery of the Trusts efficiency programme.
- To review performance indicators relevant to the remit of the Committee.
- To monitor the risk register and other risk processes in relation to the above.

Performance

- To require regular operational performance reports from management which enable the Committee to consider the operational risks involved in the Trust's business and how they are controlled and monitored by management.
- To obtain assurance that the Trust delivers services which are consistently meeting nationally defined minimum standards and performance and key standards required by the Trust's regulator.

- To obtain where performance is below the standard required, robust recovery plans developed and implemented for nationally defined minimum standards and performance and key standards required by the Trust's regulator.

People:

- To consider organisational development and strategy relating to organisational development and workforce (including recruitment, retention and organisational culture).
- To provide assurance of management recommendations in relation to local pay and contractual arrangements in support of NHS service modernisation.
- To take an overview of the equality and diversity and inclusion policy and achievement of goals (WRES/WDES).
- To review key workforce performance indicators, including: sickness absence, vacancy data, bank/agency usage and expenditure, training, appraisal, staff turnover (stability) and achievement of key performance indicators.
- To provide assurance to the Trust board that HR initiatives in support of strategic workforce development are making appropriate progress against agreed measures.
- To gain regular assurance on the results of the Trust's Staff Surveys, the annual staff survey, the GMC survey and Staff Engagement, and to link this to the delivery and outputs required of associated People Strategies.
- To provide assurance to the Trust Board that the Trust is compliant with relevant HR legislation and best practice, for example nursing and medical revalidation regulations.
- To provide assurance employee relations issues are proportionate and timely.
- To gain regular assurance on the quality of medical and non-medical education and training within the organisation, including student satisfaction, the delivery of action plans to address any gaps identified through feedback, and feedback on quality of placements.
- To gain assurance that the Trust is meeting its regulatory requirements as an education provider (GMC/NMC) and education and training standards (HEE framework, HEI programme requirements)
- To consider statutory and mandatory training processes to ensure all staff remain compliant.
- To receive assurance in relation to erostering implementation against the national Levels of Attainment framework
- To receive the Trust's Workforce Plan
- To support the Trust's organisational development and work on leadership, staff engagement, staff culture and becoming a learning organisation, through review, action planning and assurance processes
- To assure that the statutory duty of revalidation for doctors and nurses is delivered effectively and for other professionals as this is mandated.
- To maintain an oversight of the Raising Concerns Policy (including the Freedom to Speak Up guardians) and the effectiveness of the policy.
- To review the associated risks from the Board Assurance Framework and Corporate Risk Register

YTHFM

- To receive quarterly updates to include performance
- To monitor the implementation of the YTHFM estates and facilities management strategy and plans

- To seek and provide assurance to the Board on the strategic performance of the YTHFM.
- To agree and monitor key performance indicators for the assessment of the YTHFMs performance through the receipt of the minutes of the YTHFM Executive Performance Assurance Meeting (EPAM)

4. Delivery of the Work Programme

A work plan to deliver the duties of the Committee was drafted at the outset of the year and reports presented to the Committee by the Executives or subject matter experts responsible for each report.

Over the year Committee reporting has included:

- Trust Priorities Report (TPR) reporting on:
  - Finance - Income and expenditure, efficiency programme update and cash and capital
  - Operational Performance - Performance to national standards and recovery plans
  - People Update – Workforce and Organisational Development update
- YTHFM Assurance Quarterly Reporting: Operational Performance, Estates and Facilities Management, Sustainability Reporting
- Nursing Workforce Reporting
- Medical Workforce Reporting
- Annual Reporting of Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Staff Survey Results, Freedom to Speak Up, Equality Delivery System (EDS) and Health and Wellbeing Reporting
- Risk Management Reporting

5. Assessment of Effectiveness Self-Assessment by Committee Members

Highest self-assessment scores

- Committee members contribute regularly to the matters discussed.
- The Committee is aware of the key sources of assurance and who provides them.
- The Committee integrates with other Board Committees in escalation, reviewing and assurance.
- The committee have written terms of reference that clearly describe the purposes and duties of the Committee.
- All executive officers and attendees that you would expect to attend present at meetings.
- Executive officers and attendees are well prepared in presenting reports.
- The Board of Directors challenges and understands the reporting from this committee.

Lowest self-assessment scores

- At the end of each meeting the committee discuss the outcomes and reflect on decisions made, identifying successes and areas to develop.
- The committee has set itself a series of objectives for the year.

The Committee's terms of reference and work plan will subsequently be reviewed by the Committee at its March meeting. Any amendments will be reserved for Board approval in preparation for delivery during 2025/26 in the context of the Trust's new strategy - Towards Excellence: Trust Strategy 2025-2030.

6. Assurance Statement

The Resources Committee covers the operational Performance, Financial well-being and all matters relating to People including organisational development, employment, workforce planning and staff welfare. It also provides an oversight of the performance of YTHFM and the trust's Digital challenges through the Digital sub-committee.

The operational challenges over the past year have necessarily provided a key focus on the work of the Committee especially the flow of patients in through ED and critical care. Significant increases in demand have placed enormous pressure on the ability to ensure appropriate and timely care is provided to patients. The Committee has challenged and supported a number of initiatives introduced to help reduce the pressures being faced.

Improving staff morale within a high pressure and diverse working environment has been an ongoing challenge and the Committee has sought to better understand and support the issues and initiatives aimed at improving staff performance, development and wellbeing. There have been tangible improvements in the recruitment, retention and efficiency of staff in some areas of the Trust especially through the success of the Health Care Academy and increased utilisation of e-rostering practices.

In common with other Trusts and sectors within the NHS both regionally and nationally, the financial challenges have been particularly significant with the requirement to deliver efficiency targets and operational savings whilst ensuring patient care and safety remains the priority. The Committee has sought to provide the Board with assurance that the Trust takes responsibility to best strive towards the delivery of its financial targets without compromising the needs of patients, staff and the wider community.

I would like to thank the members of the Committee and their teams and the Board of Directors for their support during the past year and look forward to working together to provide support and assurance to the Board in the year ahead.

Jim Dillon, Chair of the Resources Committee
February 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item

Report to:	Board of Directors
Date of Meeting:	26 February 2025
Subject:	Risk Management Strategy and Policy
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ A Regulatory Requirement ☐

Trust Objectives	**Board Assurance Framework**
☒ Timely, responsive, accessible care ☒ Great place to work, learn and thrive ☒ Work together with partners ☒ Research, innovation and transformation ☒ Deliver healthcare today without compromising the health of future generations ☒ Effective governance and sound finance	☒ Quality Standards ☒ Workforce ☒ Safety Standards ☒ Financial ☒ Performance Targets ☒ DIS Service Standards ☒ Integrated Care System ☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction.

This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The Board of Directors is asked to approve the revised Risk Management Strategy and Policy following review.

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
Group Audit Committee	10 December 2024	Endorsed
Executive Committee	5 February 2025	Recommended for approval

Risk Management Strategy and Policy 2025-2027

Version: 3.0

Summary	The Risk Management Strategy and Policy describes what the Trust aims to deliver in its management of risk and how this is implemented.	
Keywords	Risk Management, Trust Strategy, Corporate Strategies, Care Group Strategies, KPIs	
Target audience	All staff employed by the Trust	
Date issued	March 2023	
Approved & Ratified by	Board of Directors	**Date of meeting:** March 2023
Next review date	February 2027	
Author	Associate Director of Corporate Governance	
Executive Director	Chief Executive	

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust Intranet is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
February 2023		1		New Version
August 2023		2		Board risk appetite included
November 2024		3	Title 11, 20 12 13 13-16 22	Amended to reflect the Policy and Strategy timeframe 2025-2027 Section 7.5 – Updated Committees risk assurance responsibilities Section 7.11 – removal of Head of Risk responsibilities, now with the Associate Director of Corporate Governance Section 8 – Training delivery methods and responsibility updated Section 9 – Amendments to the risk management process to enable more effective data capture in the Datix Risk Management system Board Assurance Framework – 2025-2030 Strategic Objectives amended

Reviewers/contributors

Name	Position	Version Reviewed & Date
Mike Taylor	Associate Director of Corporate Governance	V0.1-0.2 – February 2023
Mike Taylor	Associate Director of Corporate Governance	V3.0 – November 2024

Glossary of Definitions

Action Plan	Sets out the activities that will address the identified gap and reduce, eliminate, or minimise the risk.
Action Owner	The individual responsible for concluding mitigating actions in the management of risks.
Assurance	Evidence that control measures are working effectively to manage risk.
Board Assurance Framework (BAF)	The Board Assurance Framework defines and assesses the principal strategic risks to the Trust's objectives and sets out the controls and assurances in place to mitigate these.
Control	Process/plan/measure in place to assist in the prevention of risk occurring.
Impact	Result of a particular threat or opportunity should it occur
Issue	A risk that has already happened.
Likelihood	Measure of probability that the threat will happen including a consideration of frequency with which it may arise.
Operational risk	A risk that has the potential to impact on the delivery of business, project or programme objectives.
Risk	The combination of the probability (likelihood) of an event and its consequences (impact/severity) to achieve objectives.
Risk appetite	The level of risk that the Trust is prepared to accept.
Risk assessment	The process used to evaluate the risk and to determine. whether controls are adequate or more should be done to mitigate the risk.
Risk Lead	Nominated lead for managing the review and update of either an individual risk or risk register.
Risk management	The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse threats.
Risk owner	The member of staff responsible for managing the risk.
Risk register	A record of all risks that may threaten the achievement of objectives. It is a living document on Datix which is populated through the Trust's risk assessment process.
Risk type	A risk may impact on several areas of business, for example finance or health and safety. The risk type reflects the main impact of the risk and the area that planned actions will be based on.
Strategic risk	A risk that has the potential to impact on the delivery of the Strategic objectives.

Contents

1 Introduction

York and Scarborough Teaching Hospitals NHS Foundation Trust (The Trust) acknowledges that the services it provides carry risks. The business of healthcare can by its nature be a high-risk activity and the process of risk management is an essential control mechanism.

Effective risk management processes are central to providing the Trust's Board of Directors with assurance that services are delivered safely, effectively and in line with corporate strategic objectives. The Trust's aim, therefore, is to promote a risk awareness culture in which all risks are identified, assessed, understood, proactively managed and regularly reviewed. The identification and recognition of these risks together with proactive management and mitigation, is essential for the efficient and effective delivery of safe and high quality of care for patients and staff.

This will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices, and management systems.

The benefits of managing risk include:

- Supporting the safe delivery of care to our patients
- Supporting the achievement of Trust objectives
- Avoiding or mitigating the impact of failure
- Supporting the cost efficiency and value for money
- Compliance with legal and regulatory frameworks
- Management of external impacts and changes
- Exploiting opportunities encouraging innovation.

This Policy applies to all Trust Staff, agency staff and contractors, engaged on Trust business in respect of any aspect of work.

2 Policy Aim & Objectives

The aim of this strategy and policy is to strengthen the existing risk management framework, further embed risk management at a Care Group and Corporate level and ensure appropriate escalation of the risks throughout the organisation to the Board.

In addition, the greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements will support the delivery of improved risk management. The strategy and policy is aided with objectives to support the achievement of the aims, as outlined below. The strategy and policy aims and objectives will be monitored by the Group Audit Committee.

The key objectives of this Risk Management Strategy and Policy are to:

I. Embed risk management at all levels of the organisation
II. Create a culture which supports risk management
III. Provide the tools and training to support risk management

IV. Embed the Trust's risk appetite in decision making
V. Measure the impact of implementation

3 Embedding Risk Management at all levels of the organisation

One of the key aims of this strategy and policy is to ensure greater local ownership of risks. To achieve this,Corporate Governance will aim to strengthen risk registers at Corporate, Care Group and Department/Specialty level, supported by clear criteria and timeframes for escalation of risks. This is across the following key areas of operational services to the Trust Board of Directors – Ward to Board.

3.1 Wards and Clinical Departments reviewed at team meetings will be required to identify, assess, and monitor risks as they arise or are anticipated. Risks can be identified as a result of:

- Staff raising and/or reporting risks
- Risk Assessments
- Incidents
- Issues
- Complaints
- Claims
- Serious Incidents Requiring Investigation and Never Events
- External and internal reviews, inspections and assessments
- External and internal audit activity

All such risks will be referred to and recorded on Care Group/Specialty Risk Registers and Issue logs on Datix which will then be used to ensure the effective management of those risks and issues.

3.2 Care Groups at their Board meetings will be required to maintain Risk Registers, comprised of all risks escalated from the Specialty Risk Registers in that Care Group or service, plus such other risks as have been identified as relevant to the Care Group or service as a whole. Specialty Risk Register risks managed originally at specialty/department team meetings may be amalgamated on the Care Group Risk Register if their management will be more effective when addressed at Care Group level rather than Specialty/Department level. Care Group Risk Registers will be owned by the appropriate Care Group owner and reviewed at Care Group Board meetings.

3.3 Corporate services (including Human Resources, Finance, DIS, Integrated Governance, Corporate Nursing and Medical Director) will also be required to develop and maintain Risk Registers which reflect the risks relevant to their services which are not incorporated into any of the other Risk Registers identified above. The Corporate Services Risk Registers will be owned by the individual Service Management teams and reviewed at team meetings.

3.4 The Corporate Risk Register will be comprised of all risks on the Care Group and Corporate Services Risk Registers which are identified as likely to affect the organisation as a whole or as best managed at an Executive level (15 or above) owned by Executive leads. Care Group and Corporate Services Risk Register risks may be aggregated onto the Board Corporate Risk Register where appropriate for effective oversight and/or management.

4 The Role of Risk Management

The role of risk management at the Trust involves the managing of strategic risks as threats and opportunities to the Trust strategy and priorities linked to the top operational risks on the Corporate Risk Register and that throughout the organisation on Care Group, Specialty/Department and Ward level risk registers.

4.1 The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Uncertainty of outcome helps to define risk. Risk management includes identifying and assessing risks and responding to them in an effective and resilient manner.

4.2 The Trust's Board Assurance Framework (BAF) is a key mechanism which boards should be using to reinforce strategic focus and effective management of risk.

4.3 The risks to the achievement of the strategic objectives are identified by the Board each year and are recorded in the Board Assurance Framework (BAF). The BAF is the key mechanism that the Board uses to gain assurance around the management of the identified risks to the corporate objectives and to determine whether the risk is sufficiently controlled and mitigated.

4.4 The Trust's governance framework shall be supported by an effective risk management system that delivers continuous improvements in safety and quality and maximises opportunity for growth and development.

5 Defining Risk Appetite

Risk appetite is described as the level of risk that an organisation is willing to accept in pursuit of its strategic objectives before action is required to mitigate the risk. It provides a balance between the potential benefits of innovation and the threats that change inevitably brings. Different levels of appetite may be set for different risks which may also vary over time.

Risk appetite is usually designed to:

a) clearly express the extent to which an organisation's willingness to take risk in order to meet their strategic objectives i.e., define a firm's 'fight or flight' response to risk

b) discharge the organisation's corporate governance responsibilities more effectively

c) understand an organisation's propensity to take risk compared to exercise control

The Risk Appetite is owned and approved by the Trust Board. Once approved, it is built into the processes and culture of the Trust. Target risk scores should be determined to reflect the risk appetite of the Trust and recorded in the organisation's risk registers. Risk appetite metrics are used to monitor adherence to risk appetite.

Actions should be taken where risks are outside appetite to bring them back within agreed levels. Monitoring adherence to risk appetite will be tracked and reported through the governance structure. Risk appetite helps to inform and direct decision-making. Once determined, the risk appetite should be reviewed on an annual basis.

Risk appetite therefore goes to the heart of how the Trust operates and how it wishes to be perceived by key stakeholders including employees, regulators, ratingagencies and the public.

Risk appetite, tolerance and capacity is illustrated in diagram 1. The appetite for each area of risk at the Trust is as follows in table 1:

Category	**Board Defined Appetite**	**Executive Lead (at an operational level)**
Quality of Care	Low (1-6)	Medical Director/ Chief Nurse
People	High (10 12)	Director of Workforce & OD
Financial	Moderate 8-9)	Finance Director
Technology	Low (1-6)	Chief Digital Information Officer
Operational Performance	Low (1-6)	Chief Operating Officer
Sustainability	High (10-12)	Finance Director

The Trust Risk Appetite Statement by each of these categories can be found at Appendix B.

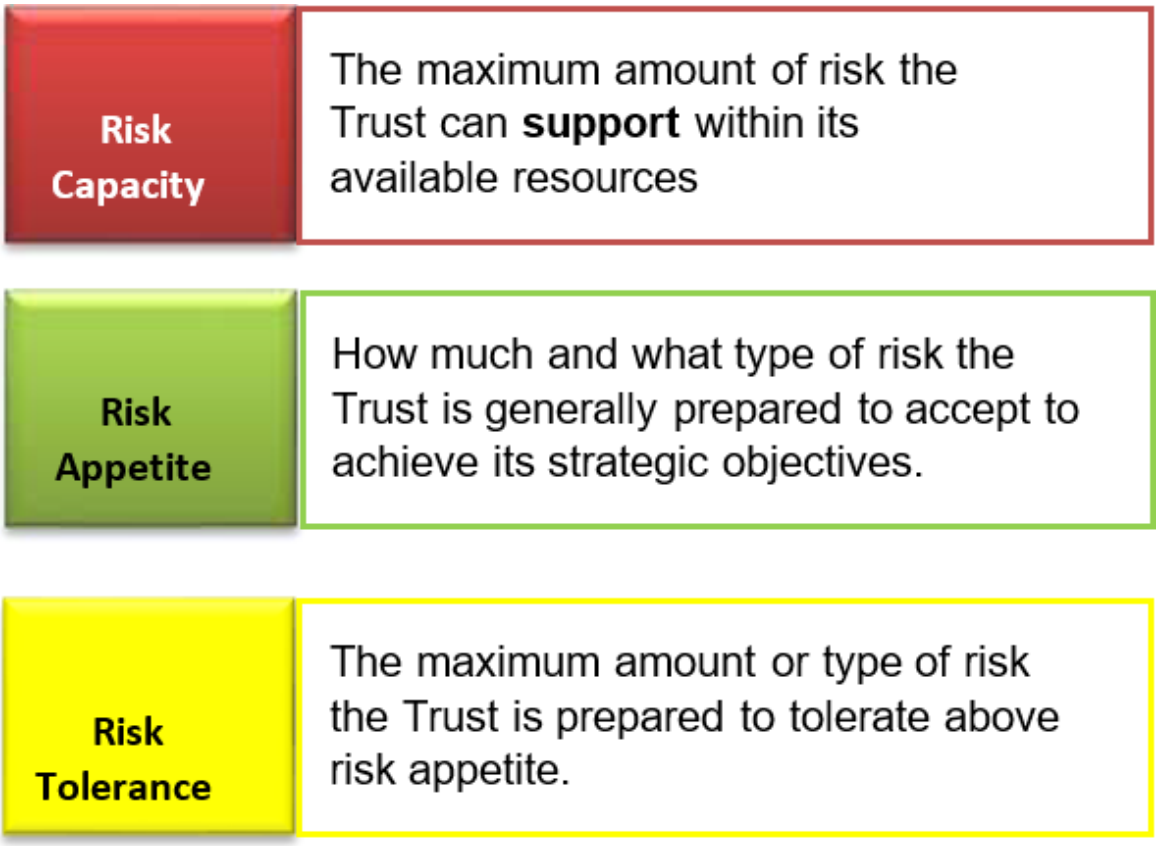
5.1 Risk Tolerance

Whilst risk appetite is about the pursuit of risk to achieve objectives, risk tolerance is about what an organisation can cope with and thresholds at which it is willing to 'accept' a specific risk. Risk appetite and tolerance both need to be considered in the context of risk capacity.

5.2 Risk Capacity

This is the amount of risk the Trust can bear. The Trust's Board may have a high-risk appetite but not have enough capacity to handle a risk's potential volatility or impact beyond it. Conversely, the risk capacity may be high, but the Trust may decide based on strategy and objectives to adopt a lower risk appetite.

Diagram 1



6 Strategic and Operational Risks

At the Trust there are two categories of risk:

- Strategic Risks - Each year a Board Assurance Framework is developed to identify and record the key strategic risks for the Trust that may impact on the achievement of its strategic priorities. Further detail regarding the Board Assurance Framework is outlined in Appendix A.
- Operational Risk - These are the identified risks that have the potential to impact on the delivery of day-to-day operational activity, projects or programme objectives. Operational risks are recorded on the Corporate Risk Register and Care Group, Specialty/Department and Ward risk registers on the Datix system. The Datix system is the only place where operational risks should be captured so the corporate governance team can identify Trust wide themes for effective Trust risk mitigation.

The Risk Management Strategy and Policy is supported by the Trust's suite of policies as listed on the Y&STHNHSFT website. There is a strong link to a range of policies including:

- Incident Reporting Policy
- Serious Incident Management Policy
- The Complaints Policy
- Suite of Health & Safety policies
- Claims Management policy
- Standing Financial Instructions

7 Roles and Responsibilities

7.1 Chief Executive

The Chief Executive is the Accountable Officer for effective risk management and the system of internal control with the organisation. The Chief Executive is also responsible for meeting all statutory requirements including health and safety and ensuring risk management systems are established, implemented and maintained.

7.2 Board of Directors

The Board of Directors has responsibility for ensuring that a framework of systems and processes for effective risk management are in place and that they are functioning appropriately. It is responsible for assuring itself that the Trust identifies and effectively manages any risks that could affect the achievement of the Strategic Goals.

7.3 Risk Committee

The Risk Committee will be Executive-led and have oversight of the Corporate Risk Register and the Board Assurance Framework. The Committee will approve any new additions and removals to and from the Corporate Register as well as being the main governance forum where risks are presented for either escalation or de-escalation.

All risks scored as 15 or above must be escalated to the Risk Committee via their Risk Committee representative for consideration and possible inclusion in the Corporate Risk Register (CRR). The Risk Committee will discuss the risk that has been escalated and the rationale for why it should be considered in either being a trust wide risk or requiring direct Executive intervention and oversight, and therefore included in the CRR.

If the Risk Committee agrees, the decision will be documented and the risk added to the CRR. If the risk is rejected for inclusion on the CRR by the Risk Committee, it will be de- escalated to its point of origin along with the rationale for why it is being de-escalate.The de-escalation will be done via the relevant Risk Committee representative. The Committee will also provide assurance that the Board of Directors is sighted on all strategic risks.

7.4 Audit Committee

The Audit Committee has responsibility to ensure that risk management systems are in place, up to date and has assurance that risk management processes are embedded throughout the Trust. It will provide assurance to the Board of Directors on the adequacy, efficiency and effectiveness of the Trust's Corporate Governance, Risk Management and Internal Control systems.

7.5 Board Assurance Sub-Committees

The Sub-Committees of the Board of Directors are responsible for providing assurance in relation to the relevant risks on the Corporate Risk Register (CRR) andthe Board Assurance Framework and receiving, managing and monitoring relevant risks within the scope of their Terms of Reference as illustrated below in table 2:

Board Sub-Committee	**Type of Risk under terms of reference**
Quality Committee	Safety Quality Statutory (CQC)
Resources Committee	Performance Finance Workforce Estates and Facilities
Digital Sub-Committee	Digital

7.6 Care Group Management (Board) Team Meetings

Care Group Management (Board) Team Meetings are responsible for identifying, receiving, managing, monitoring and reviewing relevant risks within the scope of their terms of reference. This will be facilitated by the Clinical Governance Facilitators/Clinical Governance Coordinators who will be responsible for managing the risk process at Care Group level.

7.7 Specialty/Department Management Teams

The Care Group Specialty/Department Management Teams are responsible for identifying, receiving, managing, monitoring, reviewing, escalating relevant risks within the scope of their Care Group.

7.8 Executive Directors

The Executive Directors are responsible for the implementation of risk management and its assurance mechanisms bringing together the corporate, financial, workforce,clinical, information, research and governance risk agendas and escalating where required risks to the Corporate Risk Register.

7.9 Non-Executive Directors

The Non–Executive Directors are responsible for providing independent/ objective scrutiny of the risk management structure and processes in a custodian role and for ownership with all Board of Directors members of the Board Assurance Framework.

7.10 Associate Director of Corporate Governance

The Associate Director of Corporate Governance is responsible for ensuring that all risk and assurance processes are identified and reported. The role also has responsibility for coordinating the review, update and reporting of the BAF. The role is also responsible for the development of the Risk Management Strategy and Policy and associated policies, guidance, standards and training to facilitate the effective management and oversight of risk across the trust.

7.11 Managers

Managers are responsible for the identification of risks and for implementing and monitoring any identified risk management control or assurance measures within their designated area and scope of responsibility. Managers should also ensure that all staff are aware of risks within their workplace and provide adequate information, instruction and training to enable them to work safely.

Managers should seek advice on risk management issues, as required, and liaising with relevant specialist advisors where necessary.

7.12 Staff

All staff are responsible for having a sense of ownership and commitment to:

- identifying and minimizing risk
- reporting and responding to risk
- participate in training sessions
- carry out any agreed control measures and duties as instructed.

8 Training

In addition to the mandatory training delivered and coordinated by learning and development, a programme of risk training is provided for all employees, as outlined below in table 3:

Level of Training	Staff Group	Frequency	Timeframe of training	Delivery method	Delivered by
General Risk Awareness	All staff	5 Yearly	N/A	Video Training and/or face to face	Video Training and/or Associate Director of Corporate Governance
Management of risks	Senior Management and Non-Executive Directors	As required	As required	Face to face / Teams	Associate Director of Corporate Governance
'Risk Module' Datix	Identified Risk Leads	Once	1 hour	Face to Face/ Teams	Associate Director of Corporate Governance / Datix Manager

9 Risk Management Process

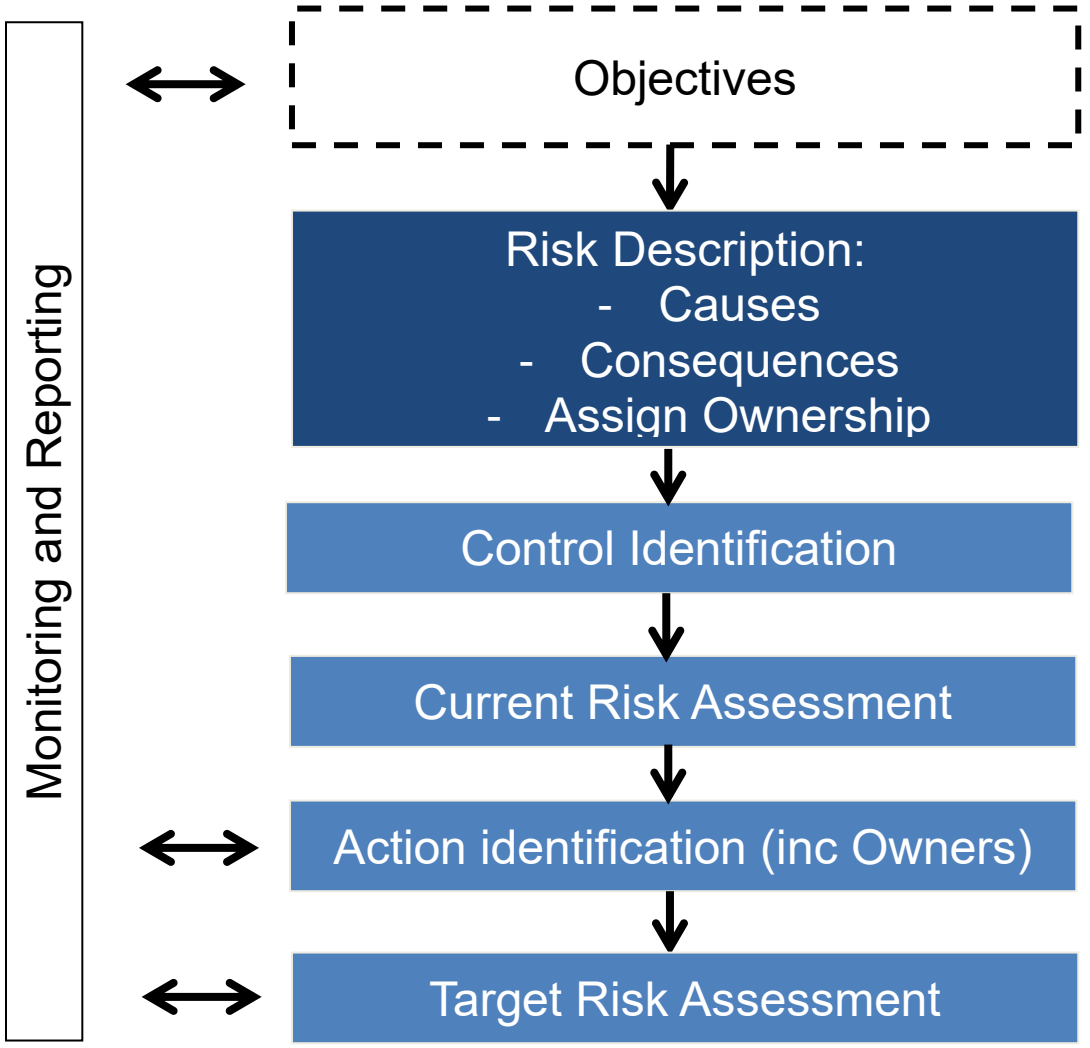
9.1 Overview

At the Trust, both a 'top-down' enterprise-level approach and a 'bottom-up' approach to risk management is in place. The top-down approach identifies and reports on Trust-wide risks – the "top risks" to the achievement of the Trust's objectives. These are captured within the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). This includes the production and reporting of risk reporting dashboards, risk heat maps and performance against agreed appetite levels to the Trust Board of Directors and Assurance Committees.

The bottom-up approach consists of business-specific risks that are unique to a particular Care Group, specialty, or corporate function (e.g., Finance, Procurement). These risks are identified and reported through localised governance structures such as business management committees or Care Group Governance meetings.

A Risk Management Process is a methodical approach to address risks to an organisation's activities. Diagram 2 below illustrates the stages of the Risk Assessment Process as defined by the ISO 31000 standard on Risk Management. This is a continuous and repeatable process which starts by establishing the context.

Diagram 2



a) **Establishing the context** – During this initial stage, **objectives** of the risk assessment should be established so that it is clear at the outset and throughout the entire process, that only risks relating to these objectives are identified. Objectives may be at a process, specialty, Care Group, functional, project, enterprise or strategic level. These considerations all help to determine the context for undertaking a risk assessment and ensuring conversations around the risk assessment process remain relevant.

b) **Risk Assessment** – Once the correct context has been established, a risk

assessment process is initiated. This consists of three stages to identify **causes** *(what has to happen for the risk to occur?)* and **consequences** *(should the risk occur what is its impact?)*, in analysing risks to the context and identifying a concise ***risk description***. This stage establishes the exposure of the Trust to risk and uncertainty which requires an intimate knowledge of the organisation and sector within which the Trust operates (the context). It highlights where, when and how events could prevent, obstruct or augment the achievement of objectives. To facilitate risk identification, considerations should remain focused on the context: that is, keeping the objectives established earlier in mind and identifying risks that threaten the achievement of those objectives.

Risk identification should take place on a continual basis, but particularly where new activities are planned, new legislation or policy requirements have been identified, at the initiation of projects or when incidents or near misses have taken place. It is vital that all risks are assessed in an objective and consistent manner if they are to be managed effectively. **Assigning of ownership** should take place at this stage in whom is the most appropriate individual to own the risk. The analysis of the risks consists of the **control identification** *(what mitigations are currently in place and are managing the risk as intended?)*.

c) **Action identification** – As the risk assessment stage completes and all potential sources of information have been explored to perform the assessment, the appropriate risk response or risk treatment should be applied. Risk treatment is presented within ISO 31000 as, 'the activity of selecting and implementing appropriate control measures to modify the risk'. Therefore, control measures are central to risk treatment with several options available. These have been highlighted below:

Treat – To mitigate the risk through current controls or future controls (future mitigations)

Tolerate – To accept the risk as the cost of mitigation may outweigh the benefits of introducing controls. The risk may also be accepted if it is deemed to be within risk appetite.

Transfer – To transfer the risk for example through insurance or outsourcing arrangements.

Terminate – To stop or avoid the activity that gives risk to the risk.

Where the risk response option to treat a risk has been selected, controls may be deemed to be ineffective, missing or newly introduced. In this case, action plans may be developed to strengthen the control environment. The action plans should clearly state the activity required to address any control deficiencies, the person responsible for delivering the action (**action owner**) and a date when the action is expected to be completed by. Details of the actions shouldbe recorded in the 'Next Steps' field within the risk register

module of Datix.

For further guidance on how to complete the risk register fields on Datix, users should refer to the 'Datix Risk Register Procedural Guide'.

d) **Current and Target Risk Assessment Scoring** – See measuring and calculating risk for both **current risk assessment** (with current mitigations) and **target risk assessment** (with future mitigations).

e) **Monitoring and Review** – This is a continuous process to provide constructive review, challenge and oversight over the Risk Management Process. It is exercised all the way from establishing the context through to risk treatment and provides an opportunity to provide feedback on the process, the decisions and the data. Any action plans should be monitored to ensure they are completed within the target dates that have been set. The risks should also be regularly monitored, reviewed and re-scored in light of any actions that are completed as these will contribute to strengthening the control environment.

9.2 Measuring and Calculating Risk

Scoring risks is achieved by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the likelihood of that harm occurring with its severity should it occur.

Likelihood score (L)

What is the likelihood of the consequence occurring?

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment and using relative frequency where this is appropriate.

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever possible to identify a frequency. Consider how likely it is that the risk will occur using the following descriptors:

	1	2	3	4	5
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Somewhat Likely**	**Very Likely**
Frequency (general) How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not	<5 per cent	6-25 per cent	26-50 per cent	51-75 per cent	76-100 per cent

Severity or Impact score (S/I)

Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Severity score (severity levels) and examples of descriptors - this is not an exhaustive list					
Domains	**1 No Harm**	**2 Minor Harm**	**3 Moderate Harm**	**4 Severe Harm**	**5 Catastrophic Harm**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days. Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death(s) Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint /inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis
Statutory duty / inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating, critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Cost increase /schedule slippage <1% over project budget /plan	Cost increase /schedule slippage >1<5% over project budget /plan	Cost increase/schedule slippage >5<10 % over project budget /plan	Cost increase/schedule slippage >10<25 % over project budget /plan Key objectives not met	Cost increase /schedule slippage >25% over project budget /plan Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results , Claim(s) >£1 million
Service / business interruption Environmental impact	Loss or interruption of >1 hour Minimal or no impact on the environment	Loss or interruption of >4 hours Minor impact on environment	Loss or interruption of >1 day Moderate impact on environment	Loss or interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriateor limited by data.

Risk Scoring: Likelihood x Severity/Impact (L x S)

Then **multiply** the two scores together from the table below.

L↓ S→	No Harm	Minor Harm	Moderate Harm	Severe Harm	Catastrophic Harm
Very Likely	**5**	**10**	**15**	**20**	**25**
Somewhat Likely	**4**	**8**	**12**	**16**	**20**
Possible	**3**	**6**	**9**	**12**	**15**
Unlikely	**2**	**4**	**6**	**8**	**10**
Extremely Unlikely	**1**	**2**	**3**	**4**	**5**

Differing Risk Scenarios

In most cases, the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. Whichever way the risk score is determined it is the highest risk score that must be referred toon the risk register.

9.3 Risk Grading, Review and Reporting

The process of risk assessment at the Trust is designed to define the grade of risk to subsequently be managed and/or escalated based on the risk criteria (likelihood x severity) with owners including whom to inform, the required forum and frequency of review as follows:

Risk Rating (5x5) Likelihood x Severity	Risk Grade	Level	Owner and to inform	Forum for review	Frequency of Risk Review
1-3	Very Low	Ward	Ward/ Departmental Management	Team Meetings	At least quarterly
4-6	Low	Ward	Inform Ward/ Departmental Manager Oversee at Ward/ Departmental Level	Team Meetings	At least quarterly
8-10	Medium	Specialty/ Department	Inform Deputy Care Group Manager and Governance Facilitator	Team Meetings Quality & Safety Meetings Workforce Meetings Finance Meetings (dependent upon risk type)	At least bi-monthly
12	High	Care Group, Corporate Team	Alert appropriate Clinical Director, Care Group Manager and Governance Facilitator	Care Group Boards	At least monthly
15-25	Extreme	Care Group, Corporate Team	Alert appropriate Clinical Director, Care Group Manager and Governance Facilitator	Care Group Boards	At least monthly
15-25 (if considered for CRR)	Extreme	Corporate Risk Register	Alert Care Group Director, Care Group Manager and Deputy Director of Healthcare Governance. Overseen by relevant Executive Lead	Risk Committee	At least monthly

9.4 Datix Risk Documenting

All risk assessment should be captured in Datix with no exception. This allows analysis across the Trust by the Corporate Governance team to identify risk themes and how risks can be managed most effectively considering risk aggregation to within the Trust's risk appetite. Click here for a step-by-step guide to documenting risks on Datix.

10 Monitoring and Reporting Arrangements

All risks are subject to continual review and monitoring by the relevant meeting:

- Board of Directors,
- Board Assurance Committees:
    - Quality Committee
    - Resources Committee
    - Digital Sub-Committee
    - Group Audit Committee
- Risk Committee
- Ward/Specialty/Department
- Care Group Board
- Executive Committee

Board of Directors

The Board of Directors will:

- Receive and overview the strategic risks (Board Assurance Framework) quarterly to drive meeting agendas
- Receive an overview of all corporate risks on a monthly basis
- Receive assurance of risk management on an annual basis via the Audit Committee

Audit Committee

The Audit Committee will review the Board Assurance Framework and Corporate Risk Register at each meeting in review of the risk management process and assurance that risks are being managed effectively.

Quality and Resources Committees and the Digital Sub-Committee

The Committees will (relevant to the scope of the Terms of Reference):

- Review all Strategic Risks (Board Assurance Framework) on a quarterly basis
- Review all the Extreme Operational Risks scoring 15 or above at each meeting

Risk Committee

The Risk Committee will:

- Consider risks for escalation from the Care Groups and Corporate Areas for those risks rated at 15 and above
- Support the Care Groups and Corporate Areas to describe, categorise and mitigate risks
- Provide assurance when required to the Board of Directors and Audit Committee that a robust risk management process is in place

Care Group Board, Corporate Team Meetings

Care Group Board Meetings will (relevant to the scope of the Terms of Reference):

- Review all risks scoring 8-10 and over (extreme) on monthly basis and consider those risks high risks scoring 12-25
- Review all risks on a quarterly basis
- Highlight to the Risk Committee risks 15 and above requiring escalation, risks as part of regular reporting to assurance committees and ad hoc reporting as and when required across the Trust

Specialty/Department Teams

The Specialty/Department Teams will (relevant to the Care Group):

- Review all risks scoring on at least a bi-monthly basis and consider those risks higher escalating to the care group boards
- Review all risks on at least a quarterly basis
- Ensure the reporting of risks at Ward and Specialty/Department level

Ward Teams

Ward teams will:

- Review all risks scoring 1-6 on at least a quarterly basis
- Review all risks on at least quarterly basis
- Highlight to Specialty/Department level those risks above 1-6

Appendix A: Board Assurance Framework

The Board Assurance Framework (BAF) defines and assesses the principal strategic risks to the Trust's objectives and sets out the controls and assurances in place to mitigate these.

Each of the strategic risks in the BAF have been aligned to the objectives within the Trust Strategy, have their original, current and target risk scores reported, and information showing the anticipated changes in scoring over time. Gaps or areas where controls can be improved are identified which are translated into actions.

The BAF is reviewed by the Board in an ongoing quarterly cycle with key risk changes highlighted, and updates provided on any ongoing actions to improve risk control and mitigation. The BAF is also used to inform the Internal Audit work programme, and audit outcomes are used to inform further actions, or are used by the Board as part of its assurance process that the risk is adequately controlled. The risks are also used to inform the Board's committees' work programmes to ensure they are focusing on the key risks to the delivery of the Trust's Strategy.

In accordance with the Annual Reporting Manual issued by NHS England, all Foundation Trusts are required to present in the Annual Report an annual governance statement signed by the Chief Executive and underpinned by a supporting Board Assurance Framework (BAF). This aims to provide the Board of Directors with assurance that systems are safe and subject to appropriate scrutiny and that the Board of Directors are able to demonstrate that they are informed of key strategic risks. The BAF contains all the strategic risks that have the ability to undermine the Trust's Strategic Objectives:

- To provide timely, responsive, safe, accessible effective care at all times.
- To create a great place for our people 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 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.

The framework is built up of the strategic risks and includes:

- Current and Target Risk scores
- Lead Assurance Committee
- Lead Director
- Key Controls intended to manage the risk
- Sources of Assurance

- Gaps in either control or assurance
- Action plan to address the gaps
- Risk Appetite

Key Controls

The key controls are the processes/procedures/delivered actions that are in place to assist in the prevention or limiting the risk occurring include:

- Operational delivered plans
- Statutory frameworks, for instance standing orders, standing financial instructions and associated scheme of delegation
- Actions in response to audits, assessments, and reviews
- Workforce training and education
- Clinical governance processes
- Claims outcomes to change processes
- Incident reporting and risk management processes
- Complaints and other patient and public feedback procedures
- Performance management systems
- Strategies/Policies/Procedures/Guidance
- Robust systems/programmes in place
- Objectives set and agreed at the appropriate level
- Frameworks in place to provide delivery
- SLA/Contracts/Agreements in place
- External Scrutiny

Sources of Assurance
Source of assurance refers where evidence can be acquired that describes how well the controls are operating and positive assurance the actual evidence. Assurance can be categorised using a 'three lines of defence' model:

- First line – operated by managers and staff across the Trust
- Second line – corporate oversight functions/governance and challenge
- Third line – independent assurance

First Line of Defence – operational management, examples include:

- Processes and procedures
- Budgets

- Risk assessments
- Work programmes of groups / committees
- Planning exercise outcomes
- Training needs assessments outcomes

Second Line of Defence – Corporate oversight, examples include:

- Performance/Quality monitoring in place and at what level, how and when
- Action monitoring reports
- Complaints and Compliments / Incident monitoring
- National returns
- Training compliance monitoring
- Routine reporting of key targets together with any necessary contingency plans.

Third Line of Defence - Independence assurances example include:

- Internal audit
- External audit

Appendix B: Risk Appetite Statement

The Trust recognises the complex nature of health care provision is an inherently risky activity. Whilst acknowledging the skills and dedication of all the team, accidents, incidents and mistakes can potentially happen.

York and Scarborough Hospitals NHS Foundation Trust makes every effort to ensure that there is a systematic approach to the identification, evaluation and control of risk and, wherever possible, risks are designed out of procedures and practice, to reduce it to the lowest possible level through the introduction of control and mitigation measures.

Risk Appetite Category Statements

Quality of Care
The definition of quality of our services are measured by clinical outcome, patient safety, wellbeing and patient experience and is at the heart of everything we do. We are committed to a culture of quality improvement and learning ensuring that quality of care and patient safety is above all else. We will put quality at risk only if, on balance the benefits are justifiable and the potential for mitigating actions are strong. We therefore have a MINIMAL (low) appetite for risk in relation to the delivery of services that are, clinically effective, safe, efficient and person centred.

People
Our People strategy identifies the current and anticipated future workforce challenges the Board needs to address, defines the kind of organisation and employer the Board aspires to be, and outlines our commitments and objectives to our people and, reciprocally, what the Board expects from its people. We have an OPEN (high) risk appetite to ensure we attract the right people with the right skills and values and onboarding them in a timely way.

Financial
We have a CAUTIOUS (moderate) risk appetite in respect to adherence to standing financial instructions, financial controls and financial statutory duties. The Trust is committed to fulfilling its mandated responsibilities in terms of managing public funds for the purpose for which they were intended. This places tight controls around income and expenditure whilst at the same time ensuring public funds are used for evidence-based purpose.

Technology
The Digital and Information Service plays a critical role in delivery systems and technology to support the effective delivery of healthcare services and the protection of sensitive patient information. Moving to more digital services has inherent risks, but also the potential benefits that digitalization brings to healthcare delivery. We aim to strike a balance between embracing innovation and ensuring the confidentiality, integrity, and availability of patient information and digital services. We have a MINIMAL (low) risk appetite tolerance for risks that directly impact patient safety, breach patient confidentiality, or significantly disrupt the delivery of critical services. We will regularly review and update this statement in line with changing technologies, emerging threats, regulatory requirements, and the organization's strategic direction.

Operational Performance

The Trust is committed through its embedded strategy, governance and performance management frameworks to deliver the Trust's activity. To achieve this we have cautious approach towards financial decisions but an open approach to quality improvements for the end result of improved service outcomes. Balanced with this the Trust has a MINIMAL (low) appetite for failing to deliver agreed performance targets.

Sustainability

We have an OPEN (high) approach in willing to consider many potential options to progress delivery of the NHS net zero agenda.

Appendix C: Due Regard Impact Assessment

A Due Regard Impact Assessment 2024/20 has been completed, recorded and saved as appropriate. A copy is available from the Patient Equality, Diversity and Inclusion Lead as required.