York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 26th March
Time: 9:00am – 12:15pm
Venue: York Hospital Board Room, 2nd Floor, Administration Block

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	-	9:00
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 26 February 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	14	
6.	**Chair's Report** To receive the report.	Chair	Report	15	9:05
7.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	22	9:10
8.	**Quality Committee Report** To receive the March meeting summary report.	Chair of the Quality Committee	Report	53	9:30

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Resources Committee Report** To receive the March meeting summary report.	Chair of the Resources Committee	Report	55	9:40
10.	**Group Audit Committee Report** To receive the March meeting summary report.	Chair of the Group Audit Committee	Report	57	9:50
11.	**Trust Priorities Report (TPR)** February 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	59 62 102 121 132 138	10:00
Break 10:50					
12.	**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	151	11:00
13.	**Annual In-Patient Nurse Staffing Review** To consider the report.	Chief Nurse	Report	170	11:15
14.	**Staff Survey Annual Report** To consider the report.	Director of Workforce & OD	Report	184	11:30

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Mortality Review (Learning from Deaths) Q3 Report** To consider the report.	Medical Director	Report	**190**	11:55
Governance					
16.	**Vascular Hybrid Theatre Equipment Business Case** To approve the business case.	Chief Operating Officer	Report	**208**	12:05
17.	**Corporate Governance Update:** • Group Audit Committee Annual Report • Committee Terms of Reference Amendments • Board of Directors Work Plan • Modern Slavery Act Statement To consider the report.	Associate Director of Corporate Governance	Report	**230**	12:10
18.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
19.	**Time and Date of next meeting** The next meeting held in public will be on 30 April 2025 at 9:30am at Scarborough Hospital.				
20.	**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.				
21.	**Close**				12:15

Minutes
Board of Directors Meeting (Public)
26 February 2025

Minutes of the Public Board of Directors meeting held on Wednesday 26 February 2025 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.08pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Mr Jim Dillon
- Ms Jane Hazelgrave
- Dr Stephen Holmberg
- 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 & 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 Sascha Wells-Munro, Director of Midwifery (For Item 14)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
There were no observers at the meeting.

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting, with a particular welcome to Jane Hazelgrave who was attending her first meeting as a new Non-Executive Director.

2 Apologies for absence

Apologies for absence were received from:

Mr Mike Taylor, Associate Director of Corporate Governance

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 29 January 2025

Mrs Parkes referred to Item 15 on page 8 of the minutes and asked for a correction to the phrase “informal patient pathway system inspection”, which should read “System Pathway Pressures Inspection”.

Dr Boyd referred to Item 9 and requested a change to the second bullet point, which should read:

- the senior leadership team from the Cancer, Specialist and Clinical Sciences (CSCS) Care Group had presented to the Committee and had highlighted the development of new pathways for vulnerable patients to bypass Emergency Departments (EDs).

With these amendments, the Board approved the minutes of the meeting held on 29 January 2025 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 45 *Send Mr Barkley the report on the timeliness of discharges which was referred to in the TPR.*
Ms Hansen advised that an update on discharge work would be provided in the Private Board meeting. The action was closed.

BoD Pub 46 *Check that the Health Inequalities data on the average Referral to Treatment waiting times by Multiple Deprivation Quintile is accurate.*
Mr Hawkins confirmed that the data was correct. It was agreed that this would be discussed under Item 10 Trust Priorities Report. The action was closed.

BoD Pub 47 *Circulate the action plan for improvement in waiting times for the Rapid Access Chest Pain clinic.*
Ms Hansen advised that the action plan needed to be reviewed with the Care Group before it was shared with the Board. The action was deferred to March.

BoD Pub 48 *Investigate the reason why the outsourcing of diagnostics leads to longer reporting times than in-house diagnostics.*
Ms Hansen explained that the delay in reporting times was due to outsourced reports needing to be transferred to the in-house system. This was the bottle neck causing the delays. She noted that cancer and urgent cases were always processed in-house, to avoid these delays. The action was closed.

BoD Pub 50 *Share the second response letter to the CQC after the meeting.*
This had been shared and the action was complete.

BoD Pub 51 *Confirm that the problems with the Head and Neck Service phone line are now resolved.*

Mrs Parkes advised that the problem with the phone line was now resolved. The action was closed

With reference to the action **BoD Pub 26**, Mr Hawkins advised that unvalidated data on operations cancelled on or after the day of admission would be included in the next version of the TPR.

6 Chair's Report

The Board received the report.

7 Chief Executive's Report

The Board received the report.

Mr Morritt referred to the NHS England Planning Guidance for 2025/26 which had already been discussed at the recent Board development seminar. He highlighted the establishment of the Trust's Anti-racism Steering Group, which he would chair, and advised that reports on its work would be brought to future Board meetings. Mr Barkley added that a Board seminar had been allocated to review progress in tackling racism.

Mr Barkley commented on the extremely high quality of the Star Award nominations and highlighted a number of examples. Directors noted the value of the programme to Trust staff.

8 Quality Committee Report

Dr Holmberg highlighted the key discussion points from the meeting of the Quality Committee on 18 February 2025. The Family Health Care Group had presented to the Committee, highlighting pressures on its services. Care Group leaders reported that concerns raised by the CQC regarding paediatric patients in York Hospital Emergency Department were being addressed. The long waits for paediatric autism assessments were discussed by the Committee. Care Group leaders reported that the demand on community services outweighed capacity, and a review was underway to consider how services might be restructured. In gynaecology, there had been an improvement in waiting times, although the Colposcopy Service had been impacted by staff absence.

Dr Holmberg advised that the Committee had undertaken a deep dive of the Board Assurance Framework risk relating to partnership working. There were as yet untapped opportunities for effecting improvement, such as the Trust being more proactive in driving agendas, but there was evidence of progress in this area.

Dr Holmberg reported that a number of echocardiography scans were being repeated due to competency concerns involving outsourced support. The issue had been identified rapidly and any risk to patients was therefore considered to be low.

Dr Holmberg observed that an improvement in governance measures had led to a better understanding of clinical risks.

Mr Barkley asked if the Trust was seeking recompense for the echocardiography scans which were being repeated. Dr Stone explained that the external company responsible was repeating the scans free of charge. Once these were complete, the matter would be reported to the CQC if required.

9 Resources Committee Report

Mr Dillon highlighted the key discussion points from the meeting of the Resources Committee held on 18 February 2025:

- the Committee continued to monitor and discuss performance in Urgent and Emergency Care;
- the Committee had been apprised of the financial challenges faced by the Trust in 2025/26; the efficiency target was again challenging particularly given the level of non-recurrent savings from this year's Cost Improvement Programme;
- on a more positive note, there continued to be significant progress in reducing the use of agency staff, and there was evidence of a flourishing recruitment pathway for Nursing staff from universities; retention rates for HCAs were much improved thanks to the Trust's Health Care Academy;
- the Trust remained in Tier 2 for Cancer and Diagnostics.

Mr Barkley queried whether the December sickness absence rate had been discussed by the Committee. Mr Dillon confirmed that it had, as it had been rising since August. Miss McMeekin cautioned that the rate for January was likely to be similar to that of December. The Committee had discussed the lack of engagement in the influenza vaccination programme; as yet, there was no national benchmarking available but regional peers reported a similar reduction in uptake since the pandemic. Dr Stone added that high rates of influenza in the community had replicated themselves amongst staff.

Dr Boyd noted that influenza accounted for less than half of sickness absences and questioned whether the reasons for the majority of sickness absences were being addressed. Miss McMeekin advised that a significant proportion were related to planned sickness absence, for example for surgical procedures. Some absence related to staff not well enough to work and waiting for treatment. She advised that, whilst improvements could still be made to the process around return to work after a sickness absence, the Occupational Health team had increased the number of available appointments to accelerate the process. Next year's focus would be on reducing the number of Occupational Health appointments missed. Board members agreed that it would be helpful to see a breakdown of reasons for missed appointments.

Action: Miss McMeekin

Ms Charge advised that the sickness absence rate amongst staff working for York Teaching Hospitals Facilities Management (YTHFM) had risen to 8.6%, with stress and anxiety and musculoskeletal (MSK) conditions being the main reasons. Work was underway to address the absence rates, including the development of business cases for example, for new beds which would lessen the risk of musculoskeletal issues.

There was some discussion on the appropriateness of giving waiting list priority to staff for clinical procedures, which would enable them to return to work sooner and impact positively on patients. It was noted that waiting lists were organised according to clinical priority.

10 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Dr Holmberg brought to the Board's attention that the term "12 hour trolley waits" covered patients in ED receiving ward level care, and often in beds. Ms Hansen confirmed that this

was the case, but as patients were under the care of ED consultants, they were counted under this metric. Work was underway to restructure the ED areas and workforce, which would impact on how patients were recorded in the data. Mrs Parkes agreed that the term could be misleading, as it suggested risk to the patient, but the Board should be assured that patients were receiving the appropriate level of care.

Mr Barkley asked Ms Hansen if she was confident that the March target of 70% of patients waiting less than 62 days for first cancer treatment could be achieved. Ms Hansen agreed that it was challenging but she remained reasonably confident that it was achievable.

Mr Barkley noted that the 4 hour performance in ED for Type 2 and Type 3 patients was excellent. Ms Hansen drew attention to the metric for median time to initial assessment in ED which was particularly improved to 4 minutes. This reflected the work on acute flow, as did the improvements in transferring appropriate patients from ED to the Same Day Emergency Care area (SDEC).

Referring to the information about the Optimal Care Service (OCS), Mrs McAleese questioned whether the number of patients who could be treated by this Service each day was overoptimistic, given the current data. Ms Hansen responded that in fact the number of patients streamed to the OCS could and should be even larger. Work was in progress to create a stronger evidence base for streaming more patients to the OCS, and coaching sessions for staff were being introduced to support them in this.

Dr Holmberg asked about the reduction on non-type 1 attendances in ED. Ms Hansen explained that ED attendances overall were now reducing in part due to strategies in the community to prevent attendances, for example, greater use of GP out of hours services and Urgent Treatment Centres. The number of patients overall had not reduced but they were attending more appropriate settings for their needs.

There was some discussion on metrics relating to SDEC attendance and the number of non-elective admitted patients with zero day length of stay.

Mr Barkley noted that the Discharge to Assess model described in the TPR was very positive.

With regard to Referral To Treatment (RTT) performance, Dr Holmberg asked if long waits for treatment were specific to certain specialties. Ms Hansen confirmed that this was the case, with Neurology being the most challenged service. Improvement plans were in place to address waiting lists, supplemented by specialty deep dives. Ms Hansen provided details of the six new targets in the Planning Guidance for Referral to Treatment metrics. Directors discussed the significance to the Trust of these metrics, in terms of the areas of greatest challenge.

Ms Hansen drew the Board’s attention to the excellent theatre utilisation rate which was above 82%.

Directors considered the information relating to Health Inequalities. Mr Barkley expressed frustration that accurate data could not be reported as insufficient data on ethnic group was being collected. Ms Hansen confirmed that clerks had been instructed to collect this information but the field on the patient database was not mandatory, neither was it a requirement of the patient to record their ethnicity. Changing the database to ensure that the field was mandatory was not a current priority, as it was due to be replaced by the new Electronic Patient Record.

Mrs Parkes observed that the section on Health Inequalities was largely unhelpful for the Board. She was now chairing a new Health Inequalities Group, whose work was being supported by a clinical fellow. She would consult with the Group and bring a proposal to the Board for more valuable data and information.

Action: Ms Hansen/Mr Hawkins

Mrs McAleese referred to the number of missed outpatient appointments and asked if a system of overbooking was in place to ensure that clinician time was not wasted. Ms Hansen confirmed that appointments were managed by services and the rate of missed appointments was taken into account.

Quality and Safety

Mr Barkley noted that the number of cases of *C.difficile* infections was above the monthly trajectory. Mrs Parkes responded that this not unexpected given the number of outbreaks; overall, rates of *C.difficile* infections were decreasing and this was evidence of the focus Infection Prevention and Control (IPC) work in key areas. Dr Holmberg agreed that the governance of IPC was improved, and the results were beginning to be more apparent. Mrs Parkes reported that there was evidence of better IPC practice on wards.

The Board was pleased to note the reduced number of complaints received by the Trust in January.

Maternity

A query was raised about the "year-end target/baseline" metric for 3rd/4th degree tears in assisted births at Scarborough. The question would be asked of Ms Wells-Munro when she joined the meeting.

Workforce

The Board recorded its congratulations to the Occupational Health service on its SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation.

Professor Morgan asked about the new anonymous reporting tool which had accompanied the Trust's No Excuse for Abuse campaign. Miss McMeekin explained how reports could be made and advised that the tool had received positive feedback.

Miss McMeekin advised that Staff Survey data would be reported in Quarter 4. The national benchmark report had been received on 25 February and the embargo on publication would be lifted in March. Her team were currently working to theme the free text comments. Miss McMeekin would circulate the Staff Survey outcomes to the Board.

Action: Miss McMeekin

Ms Grantham asked when the Board would be apprised of the action plan to address the deteriorating outcomes from the national Staff Survey. Miss McMeekin reported that areas were working on local improvement plans with a deadline of 1 March. She outlined the process for the development of the full improvement plan. Mr Barkley noted that the Trust needed a systemic approach to quality improvement. Mr Morritt agreed that this was a key action which would begin in March with the "State of Readiness" assessment.

The Board was pleased to note the positive progress in eRostering, with almost all nursing, midwifery and Allied Health Professional staff now on Healthroster.

Digital and Information Services

Mr Barkley highlighted that a third of calls to the Service Desk had been abandoned. Mr Hawkins agreed that this was concerning and advised that he would oversee the development of an improvement plan.

Action: Mr Hawkins

Finance

Mr Bertram referred to the Month 10 position detailed in the report, noting that the focus now was on the year-end position. It had been acknowledged that neither the Trust nor the ICB would achieve a balanced position, although the NHS England Protocol had not been invoked. The Trust was forecasting a year-end deficit of £18m, which contributed to the ICB's forecast deficit of £34m. Mr Bertram was confident that the year-end position would not deteriorate further. The improvement from the year-end deficit forecast last month was due to Elective Recovery Fund income, technical adjustments, and reductions in expenditure. Mr Bertram cautioned that there would be a requirement for the ICB to pay back its deficit over future years.

Dr Holmberg queried the large negative variance to Employee Expenses. Mr Bertram explained that this was composed of a number of different elements, both positive and negative. It was positive that the Trust was operating consistently below the agency cap.

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

Ms Wells-Munro presented the report and highlighted:

- a Postpartum Haemorrhage (PPH) sprint audit had been undertaken in January on 13 cases from November and December and the details of the findings were contained in the Section 31 submission;
- the CQC Maternity Services 2024 survey had been published in December and an action plan had been developed;
- there continued to be pressures on the Perinatal Mental Health team, due to staff sickness absence and the level of demand; support had been sought from the ICB and the Tees, Esk and Wear Valleys NHS Foundation Trust; the team were now receiving clinical supervision;
- the Local Maternity and Neonatal System (LMNS) had undertaken an assurance visit on 12 February; the report was expected soon;
- a requirement to deliver a three year Maternity Services improvement plan had been included in the 2025/26 national Planning Guidance; work was underway to establish the content;
- key achievements in December included the appointment of two full-time community midwives for equitable health, funded by the LMNS, and a timeout day for the Midwifery Senior Leadership Team;
- current risks included the number of overdue guidelines, although this was an improving picture, and the lack of a substantive audit midwife which was now a mandatory role.

Mrs Parkes underlined the importance of the inclusion of maternity services improvement in the national Guidance; this would be considered as part of a system-wide approach.

Dr Boyd alerted the Board to her concerns around the delivery of the Single Improvement Plan which was being stalled due to lack of resource.

In response to a question, Ms Wells-Munro reflected on the LMNS visit: the improvements made by the Trust had been recognised, alongside the resource challenges. The report would be brought to the next meeting.

Ms Wells-Munro responded to the query raised earlier regarding the "year-end target/baseline" metric for 3rd/4th degree tears in assisted births at Scarborough. She clarified that there was no "expected" rate of tears and in fact, the target was to have no incidences of tears at all. Mr Barkley noted that for each unit the figure was less than one per cent. The target in the TPR report should therefore be less than one per cent.

Action: Mr Hawkins

Mr Barkley asked if the outcomes from the CQC Maternity Services 2024 survey had been reviewed by the Quality Committee. Ms Wells-Munro responded that the highlights had been reported to the Committee and a more detailed report had been presented to the Patient Safety and Clinical Effectiveness Sub-Committee. Mrs Parkes noted that Ms Wells-Munro had led valuable sessions for staff which could be replicated in other areas. It was agreed that the feedback from the survey should be presented to the Council of Governors' Patient Experience Group.

Mrs Parkes provided a brief update on proposals to provide further resource for Maternity Services which were progressing through governance routes. She hoped to report on the outcomes before May.

The Board approved the CQC Section 31 Update.

12 January CQC Inspection Update

Mrs Parkes presented the paper and reported that all data requested by the CQC had now been submitted, with each report accompanied by a high-quality front sheet which had received positive feedback from the CQC. Gaps in data and documentation identified through this process would be mapped and addressed.

Board members recorded their appreciation of the team behind this work and there was some discussion on the feedback provided to the CQC. Mrs Parkes highlighted that the CQC inspectors had raised no immediate safety concerns during the inspection which was positive.

13 Research and Innovation Strategy

Dr Stone presented the paper, noting that the cover sheet detailed the amendments made to the strategy since it was last presented to the Board. She commented that the strategy needed to be viewed as a working document, as it would be refreshed on an annual basis. It was recommended to the Board by the Executive Committee for approval.

Board members agreed that it was much improved from the first version. In response to a query about income, Mr Bertram advised that the growth in research income from external funders was material for the Trust and reflected the Trust's growing reputation in research and innovation.

The Board approved the Research and Innovation Strategy 2025-28.

14 Emergency Preparedness Resilience and Response (EPRR) Core Standards Update Report

The Board received the report.

In response to Mr Barkley's question about training requirements, Ms Hansen advised that there was clear guidance on EPRR training which related to job roles. Training compliance was checked by the ICB's EPRR team; the Trust was fully compliant.

15 Committee Effectiveness reports

Quality Committee

Dr Holmberg highlighted the requirement of the Committee's Terms of Reference for representatives of each Care Group to attend meetings. Ms Hansen advised that this was being progressed with Care Groups.

Mr Barkley noted that the lowest score related to the information received by the Committee. Dr Holmberg observed that the Committee received a number of papers which adhered to a set format which tended to be information based, and which lacked a context in which the information could be interpreted. Mrs McAleese added that the information received by the Committee was often not timely; this was an area for improvement.

Resources Committee

Mr Dillon reported that the effectiveness report had been discussed by the Committee; there had been a suggestion that the workplan be included as a standing agenda item so that it was used as a working document to address priorities as they arose.

16 Risk Management Strategy and Policy

The Board received the Risk Management Strategy and Policy, which had been recommended for approval by the Group Audit Committee and the Executive Committee. The amendments to the previous version were detailed in the paper. Mr Hawkins raised a query about definitions of specific terms used in the policy which he would progress with Mr Taylor.

The Board approved the Risk Management Strategy and Policy, subject to any minor amendments to the definition of terms used in the policy.

17 Questions from the public received in advance of the meeting

There were no questions from members of the public.

18 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 26 March 2025 at 9.00am at York Hospital.

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 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	Update 26.02.25: Ms Hansen advised that the action plan needed to be reviewed with the Care Group before it was shared with the Board. The action was deferred to March.	Mar 25 from Feb 25	Amber
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 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	Amber
BoD Pub 53	26-Feb-25	9	Resources Committee Report	Provide more detailed information on the reasons for missed Occupational Health appointments.	Director of Workforce and OD		Mar-25	Green
BoD Pub 54	26-Feb-25	10	Trust Priorities Report	Explore options to provide more accurate ethnicity data for the Health Inequalities section of the TPR	Chief Operating Officer/Chief Digital and Information Officer		Mar-25	Green
BoD Pub 55	26-Feb-25	10	Trust Priorities Report	Circulate the Staff Survey outcomes to the Board	Director of Workforce and OD		Mar-25	Green
BoD Pub 56	26-Feb-25	10	Trust Priorities Report	Oversee the development of an improvement plan to address the level of abandoned calls to the IT Service Desk.	Chief Digital and Information Officer		Mar-25	Green
BoD Pub 57	26-Feb-25	11	Maternity and Neonatal Report (including CQC Section 31 Update)	Change TPR to show target for 3rd/4th degree tears in assisted births as less than one per cent	Chief Digital and Information Officer		Mar-25	Green

Report to:	Board of Directors
Date of Meeting:	26 March 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 March 2025	

Chair's Report to the Board – March 2025

1. I have continued to visit various wards and services at Bridlington, York, and Scarborough Hospitals. Through conversations with colleagues during these visits I pick up valuable insight and issues which I share with relevant Executive Directors as appropriate

2. The Council of Governors approved the appointment of Helen Grantham as a NED for a 3 year term commencing 1st July, and a further but final year in respect of Lorraine Boyd. The recruitment process has started to appoint a suitably qualified and experienced NED to succeed Dr Stephen Holmberg when his term of office ends. With the Chief Executive, we have an informal meeting with another candidate for the Insight Programme we have received from Gatenby Sanderson taking place at the end of March.

3. Attached is a report I have drafted for consideration following the joint Trust Board/Council of Governors workshop held in October where we discussed and shared ideas how the Trust can use its role as an Anchor Institution to reduce existing health inequalities and prevent ill health. The Governors received this at the meeting of the Council of Governors that took place earlier this month. If the Board is content with this report, it will form the basis for the development of an implementation plan, elements of which will be in our forthcoming annual plan for 2025/26 and beyond.

4. On 6th March, the Trust held its first East Coast Constituency event to enable the local elected Public Governors to meet with the Members who live in that constituency. It was held at Scarborough General Hospital and was attended by 30 people – the most of any of our first round of constituency meetings. We followed the same format as the three previous meetings (Selby, York, Hambleton/Ryedale and East Riding), and this time there were a lot of questions raised which I and the Governors did our best to answer. I thought it was a very worthwhile meeting and I hope that those attended also considered it was worthwhile investing their time to attend. We will start the second year of constituency meetings (probably) in May, and this year they will all be held in British Summer Time so that attendees can travel in daylight, given the 6.30pm start to each meeting.

5. The Chair, Sue Symington, of Humber and North Yorkshire resigned from that role on 10th March 2025. Sue is well known to many in this Trust, given that she was Chair here until she became Chair of the ICB. Mark Chamberlain is the interim Chair of the ICB, who similarly is well known here as he was the Trust's interim Chair for 5 months until November 2023 when I became Chair.

6. I will be attending the third Maternity and Neo-Natal engagement event that is taking place on 20th March. I will give an update at the Board meeting.

Martin Barkley
Trust Chair
14.03.2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Role of the Trust in relation to preventing inequalities and reducing existing ones.

1. Introduction

At the joint Trust Board/ Council of Governors workshop held on 16th October 2024, the Trust began to consider what the Trust can, and should be doing to help prevent inequalities from arising in the first place and tackling existing ones.

The Board of Directors were joined by the Directors of Public Health from City of York and North Yorkshire local authorities (the Director from East Riding was unable to attend).

2. Prevention

Given the evidence which led to Sir Michael Marmot to conclude that the most important policy priority to prevent inequalities is giving children the best possible start in life. His six policy recommendations were published in the seminal report 'Fair Society, Healthy Lives' published in 2010. The second policy objective is to enable all children, young people and adults to maximise their capabilities and have control over their lives.

2.1 Further evidence states that it is the **first 1000 days** which is so crucially important with day one starting at the time of conception. The role of the Trust therefore in preventing inequalities is:

a) Brilliant antenatal care which includes identifying high risk families, not only due to excessive alcohol or drug consumption but inadequate housing and extreme poverty, for example, being unable to afford a cot. It is very important that such families, or women, are signposted to the appropriate relevant service or local authority so that issues to do with housing and poverty can be addressed.

b) Further reducing smoking by pregnant women.

c) Supporting women to breastfeed.

d) To ensure the best possible maternity outcomes with regard to low birth weight babies, preventable disabilities etc.

e) To ensure that there is an excellent birth experience for women as this will help bonding.

f) Quality of community midwifery support for the first 10 days of the lives of babies prior to health visiting providing ongoing support.

g) To ensure that all colleagues really understand the crucial importance of the first 1000 days and what their role is to contribute to that vital period in a baby's life.

2.2 With regard to children another important priority is **educational attainment**:

a) To provide a responsive high quality Paediatric service in recognition of the very important role it has in minimising the impact of ill health on educational attainment.

b) The paediatric service has a crucial responsibility of reporting safeguarding concerns and indeed colleagues who work in Emergency Departments and Urgent Treatment Centres. The Trust will ensure Safeguarding training is of a high standard and colleagues receive the level of training commensurate with their role.

2.3 Additional roles re prevention

a) Providing accessible information to patients and the public in different languages and in ways that people who are hard of hearing or blind can access

b) To consider what the role is of our specialists in reducing hypertension

c) To ensure the Trust is a healthy and positive place to work where colleagues feel valued and supported to do a good job which will maximise the esteem staff feel by working for the NHS and in their local health service/hospital and enhance their well-being.

d) To equip our patient facing colleagues to promote health by 'making every contact count'.

e) To develop a staff narrative, for example, 'we want every child to thrive and minimise the impact of ill-health and disability'.

3. Reducing existing inequalities

The Trust is an **'anchor institution'** meaning that the Trust has a big role to play and can make a big contribution to reducing inequalities. We can do this in five ways:

a) Our role as a provider of health services

b) Contributing significantly to the leadership of the Health and Social Care systems in which the Trust is part of.

c) Our role as an employer

d) Our role as an owner of buildings and information assets

e) Our role as significant purchaser of goods and services

3.1 Provider of health care

a) To encourage our staff to identify, where for example, damp housing is a cause that patients, both adults and children presenting with ill health and then escalating that issue to the relevant local authority so that help can be provided to the individual/family.

b) Reduce smoking – our clinicians have a unique position to be able to help with this and it is important given that smoking is the main cause of health inequalities.

c) We intervene with family members of patients when they have been diagnosed with lung cancer, as statistically family members who are close to the diagnosed patient often smoke themselves, and at the time of their being a shocking and senior diagnosis it is a time when family members may be ready and willing to receive support to give up smoking.

d) To ensure that the post discharge from hospital support to patients is good to help patients make a good recovery following their period in hospital.

e) Providing information by ethnicity and post code which in turn can be mapped against the Index of Multiple Deprivation to help the Trust identify issues that need attention, for example maternity outcomes; utilisation of each of our services; non utilisation of our services; who is not turning up to appointments – DNAs, differences in waiting times for surgery and out-patient appointments etc.

f) To consider what the benefits would be of the Trust employing its own consultant in Public Health, or on a shared basis with Local Authorities.

g) Help patients to become experts in the management of their long term conditions.

h) Help carers to know how best to help and support their loved ones who have a long term condition, for example COPD, diabetes etc.

i) Provide elective, cancer and diagnostic services that meet NHS Constitutional standards as a maximum regarding waiting times.

j) Provide out-patient and diagnostic services on a local basis where it is safe and practical to do so to improve ease of access and reduce travel emissions.

3.2 Employer

a) Provide career pathways and support for young people and adults living in deprived areas.
b) Our role as a supportive employer especially for members of our workforce who themselves live in deprived areas.

c) Our role as a supportive employer as we have a very diverse workforce which is a great asset and can play a big part in their role as members of the communities in which they live.

3.3 As a partner organisation in local Health and Social Care Systems

a) Contributing significantly to the leadership of the Health and Social Care systems in which the Trust is part of, being a consistent and reliable partner.

b) To have a sustainability strategy which amongst many things must identify how the Trust can reduce air pollution caused by the Trust's activities

c) Share training with local social care providers, voluntary organisations etc.

d) Ensure the Trust provides the right membership at meetings with consistent attendance who positively contribute leading to positive outcomes.

e) Support good governance and accountability

3.4 Owner of buildings and information assets

a) We have physical assets/facilities that could be used by local communities in which those facilities are based to provide additional amenities to local people and improve the quality of our interface with local people leading to greater trust and confidence in the services that the Trust provides.

b) Provide information that will help identify priorities for improving health and well-being

c) Buildings to be well maintained, safe and welcoming

d) Maximise use of the Trust's buildings to consolidate the estate to release funds for health gain.

e) Reduce carbon footprint

3.5 Purchaser of goods and services

a) Purchase of goods and services where possible from local suppliers and producers

b) Explore working with other local institutions to have a better negotiating position with suppliers.

c) To have a social value clause in procurements leading to local benefits

d) For services and construction have a clause which stipulates importance of employing local people

Report to:	Board of Directors
Date of Meeting:	26 March 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 ☐

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 (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. National and regional NHS system changes

As Board members will be aware there has been a series of recent announcements relating to a major reshaping of how the NHS operates at system level, amounting to the most significant reforms in over a decade.

On 13 March the Prime Minister announced that NHS England (NHSE), the organisation that oversees the NHS in England, is to be abolished and integrated into the Department of Health and Social Care. There will also be changes to Integrated Care Boards (ICBs), who will be required to cut their running costs by 50% by Quarter 3 of 2025/26.

On the same day as these announcements, I attended a meeting in London with chief executives from across the country, where NHS England's incoming Transition Chief Executive Sir Jim Mackay talked about the need for all NHS trusts to reduce their running costs to meet the financial challenge facing the NHS.

Jim Mackay is replacing NHSE's Chief Executive Amanda Pritchard, who announced her resignation earlier this month followed by several key members of her senior team. A new transition team has subsequently been announced.

Wes Streeting, Secretary of State for Health and Care, has said that the aim of these reforms is to remove bureaucracy and duplication and better hold to account providers for reducing waiting times and managing finances responsibly.

Detail is still emerging about what this means for us as a Trust and as a local system, however it is clear that this is moving at pace. We will keep the Board updated as plans develop.

2. National NHS Staff Survey results published

The results from the 2024 National NHS Staff Survey have now been published.

The questions in the survey are aligned with the NHS People Promise, which sets out the things that would most improve our working experience. It also includes the two themes of Staff Engagement and Morale.

All trusts are required to undertake the survey once a year, and the results provide valuable insight and enable us to see how our results compare not just with previous years but also with other acute and community provider trusts.

For is, the results are disappointing and do not reflect where we want to be as a Trust. Whilst in many ways the feedback in the report mirrors the hugely challenging environment we are working in, the message from our colleagues is loud and clear that we have a long way to go.

The overall response rate of 36% means we are not hearing from almost two-thirds of our staff. We have also seen a decline in our overall engagement score, and the extent to which colleagues would recommend our Trust as a place to work and to receive treatment. The responses also suggest that people are not confident that they can influence improvement or drive change.

We know from comments made in the survey that some of the factors influencing how people are feeling are not within our control or are not quick or easy to resolve, for example nationally-determined NHS pay rates or the quality of our estate.

However, much of the answer is not about what we do, but how we do it. Not just how we behave with each other and our patients, but also how we run the organisation in such a way that embeds a culture of continuous improvement.

We know that the solutions will not arrive in the form of significant new investment in our services or our workforce, which means we need a fundamental shift in our thinking towards how we use what we already have. This means listening to our colleagues when they tell us how we can reduce waste, work differently, or be more productive, and make sure our managers and the governance structures we work within enable and encourage this, rather than being a barrier to improvement.

Our new Trust strategy gives us the framework to work towards this, and to deliver our ambition to provide an excellent patient experience every time. Our focus must now be on building a shared purpose and vision, developing compassionate leadership behaviours, and embedding improvement into our everyday processes. Moving forward in this way, supported by our ongoing leadership development work, provides the best way for us to see a positive shift in how it feels to work for our Trust.

The full report is available to read here.

3. Scarborough Urgent and Emergency Care Centre opening

Our new Urgent and Emergency Care Centre in Scarborough is now just weeks away from opening.

Our priority has always been to ensure that we do not move in until we are confident that the building is safe and functional for staff and patients. I am delighted to say that we have received assurance from our contractors that this is now the case.

Handover of the building is scheduled towards the end of March 2025, allowing for a planned and phased approach to final testing, intensive cleaning, and occupation. This also gives us ample time for clinical teams and other support services to arrange rotas and undergo induction into the new building.

We are now working towards starting the clinical moves in the last week of April, with a view to being fully operational at the start of May.

This marks a hugely important milestone for Scarborough, and I know Board members will join me in congratulating all of the teams involved in this momentous project.

4. 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. March's nominations are in **Appendix 1**.

Date: 26 March 2025

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

March 2025

Jeanette Husband, Generic Therapy Assistant | **Community** | **Nominated by relative**

Jeanette has been incredibly helpful and patient in helping my husband who has Parkinson's and broke his hip after a fall. She is unfailingly cheerful and positive and has been instrumental in helping my husband get back on his feet and learning to walk more confidently. We both look forward to her visits to our house, and we feel she is a star.

Tunde Oyeledun, Energy Manager | **York** | **Nominated by colleague**

Tunde works tirelessly to secure funding for sustainability projects over the course of the year and deliver them. He is an unsung hero and the impact this work has produced benefits for our environment and the Cost Improvement Programme. To date he has secured over £3.6m. A fantastic achievement for our Trust and the environment.

Beccy Wilson, CAMHS Liaison Nurse | **York** | **Nominated by colleague**

Beccy is a fantastic advocate for the CAMHS team and the patients she cares for. She is a positive influence on her colleagues. She always has a big smile on her face and is happy to help.

Beccy has just run a bake sale for Mental Health Awareness Week. She is always thinking of new and innovative ways to work in support of the individual needs of patients. Beccy is a shining star! She is an extremely valued member of the team.

Helen Lamb, Sister | **York** | **Nominated by colleague**

Helen has been managing paediatric ED in the absence of the substantiative sister since 2024. Managing an additional area in addition to her own has been a huge challenge and a big ask!

Helen has not only done an exceptional job, but she has made significant improvements in the ED. She has been an advocate for the team and the department while keeping patient safety at the centre of her decision making. I speak on behalf of myself and the wider team. She deserves this recognition.

Ward 15 **York** **Nominated by relative**

I was deeply touched and impressed by the fantastic job the staff of Ward 15 did over the extended stay of my father, in coping with the daily needs of the patient and in being aware of changing circumstances and reacting with efficiency and speed.

Having arrived on the ward after a fall, he then contracted flu, followed by pneumonia. My brother and I live abroad and so I phoned to get updates and information. The staff I spoke with on the phone and the colleagues they consulted were informative and professional, generous with their precious time, and kindly went to great lengths to answer questions and explain the plan for my father's recovery and care.

We have heard of the difficulties of the NHS from abroad, but my experience of the care, both medical and therapeutic, was excellent - five stars! The personal touch was beyond the call of duty. I thank you for it.

North Community Nursing Team **Community** **Nominated by colleague**

During a Saturday shift, the North team faced immense patient contact demands, on top of routine care, and limited staffing. They embraced every patient need, managed a range of acute concerns and deterioration, and never complained. They worked exceedingly well as a team, and their dedication, kindness, and commitment to delivering excellent care should be recognised.

Russell Jones, Senior Orthopaedic Practitioner **York** **Nominated by patient**

Russell Jones went above and beyond to ensure I received a thorough diagnosis and treatment. He was extremely professional and helped in any way he possibly could. His kindness eased what was a worrying time and my husband and I were grateful. Mr Jones is a credit to the department.

Adewale Adekimoye, Specialist Registrar **York** **Nominated by colleague**

I have worked with Ade on a few occasions, and he has never failed to be kind, knowledgeable, and attentive. However, this Star Award nomination is for a night shift we recently worked together where I had concerns regarding a patient who was deteriorating.

Ade was no longer the specialist doctor in charge of this patient's case, but he listened to my concerns and was more than happy to help. He completed a thorough assessment, competently performed specialist examinations and tests, and helped me escalate appropriately. He was effective in his communication, both with the patient, myself, and other members of the clinical team, and made me feel respected and listened to.

Great teamwork is vital, especially in the fast-paced environment of the Emergency Department, and it was such a pleasure working with him. He demonstrated the Trust values, especially regarding his kindness and excellence.

Eliza Kirk, Staff Nurse **York** **Nominated by colleague**

Eliza is good at her job, polite to staff and patients, and goes above and beyond for her team.

Robert Hitchman, Patient Administration Officer **York** **Nominated by colleague**

Robert has been with our team for six months. He has settled into the team well and is an amazing addition. He always goes the extra mile for patients and has picked up the role quickly.

Abigail Rescorle, Critical Care Outreach Sister **York** **Nominated by colleague**

Abi goes the extra mile for staff and patients, demonstrating the Trust values of kindness, openness, and excellence. We had an unwell patient who deteriorated and needed the medical emergency team. She immediately sprang into action to do everything she could for the patient.

After the event, I wanted to go back to the ward and ask if Abi was OK but got sidetracked by the busy x-ray waiting room. Then she appeared out of nowhere to check in on me and ask if I was OK! Not just on this occasion, but every time we have worked together, she has been helpful and is the first person on the ward to help when we go up to do portable x-rays for her patients. It is really appreciated!

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

Over the past few months, we have had difficult times within the oncology gynae department. Lynne and Claire’s support and guidance has invaluable. They have both showed continues support to both me and the wider team, making time for weekly meetings to review and advise patients on a case-by-case basis. They have provided an open-door policy for any queries outside of the scheduled meetings and nothing ever feels a hassle to ask. All queries are answered promptly, and plans are made together so everyone has a say. It feels like a great team effort.

Their knowledge and awareness of each individual patient shines through. They are both so dedicated and helpful despite been stretched themselves as they have taken on additional tasks such as a nurse clinic to plug gaps in the service. The oncology team and I are grateful for their ongoing support.

Victoria Clark, Community Team Leader, Amy Jacks, Midwife, Emily Clarkson, Sister, Eric Morales, Staff Nurse, and Laura Wilson, Sister | **Scarborough** | **Nominated by colleague**

I would like to recognise Victoria Clark, Amy Jacks, Emily Clarkson, Eric Morales, and Laura Wilson for supporting the recent CQC Joint Targeted Area Inspection for Safeguarding Children (Unborn to age sever years). All practitioners demonstrated professionalism, knowledge, and understanding of the key line of the enquiry, truly representing the Trust values. The Safeguarding Children Team would like to praise them for their hard work during and prior to the inspection. The Safeguarding Children Team recognise the pressure these inspections bring and commend them for a successful day.

Colorectal Cancer Nurse Specialist Team | **York** | **Nominated by colleague**

The Colorectal CNS team has worked exceptionally hard over the past six months to improve cancer follow-up for their patients. Previously, the follow-up process relied on multiple paper slips with handwritten instructions for each patient. Now, 800 patients have been successfully transferred to a robust electronic system, significantly enhancing safety, efficiency, and sustainability.

This quality improvement work has been undertaken alongside the team's usual responsibilities in running the service, yet they have still achieved the ambitious goals set at the outset. Led by Ruth and Suzanne, the team has not only embraced the new software but has also identified innovative ways to further support their patients. As a result, the workload has become more sustainable than ever. Patients' follow-ups are now safer, and the administrative time required per patient has been reduced, allowing the team to dedicate more time to direct patient care.

Additionally, the team has worked collaboratively with the project team and patient representatives to update and create patient information leaflets and surveys. This ensures that patients receive accurate and up-to-date information throughout their follow-up journey, improving their overall experience and care.

Beyond their own service, the team has gone a step further by supporting other teams in adopting the system. They have acted as advocates, demonstrating the benefits, and providing training to colleagues to help improve care across departments. Through their dedication, innovation, and commitment to excellence, this team has made a profound impact on patient care. Their efforts truly deserve to be recognised with a Star Award.

Charlotte Hamilton, Operating Department Practitioner | **York** | **Nominated by colleague on behalf of a patient**

I have been asked to pass this message on from a grateful family about Charlotte who had stayed late after a long shift:

“Every staff member I encountered at York was so supportive and kept me and my partner calm. I will never be able to thank all the staff enough for the birth of my daughter who was born after a long induction and other complications resulting in an emergency c-section. My c-section experience was brilliant, and I have never felt so safe and cared for.

“I especially remember Charlotte, who held my hand and explained everything to me to put my mind at ease; little things like this mean a lot. She was patient and supportive to my partner as well. Her exceptional care has made an experience which would typically be nerve-wracking an extremely positive one. Thank you!”

Eye Surgery Day Unit | **York** | **Nominated by relative**

We are nominating the Eye Surgery Day Unit team for their outstanding care and kindness. From the very beginning of what was a very scary time, Anne, Miss Mitrut, and the team made my partner and I feel completely comfortable and supported. We felt we had time to ask questions, making sure we understood everything, and felt at ease.

After what we thought would be my partner’s final surgery, Anne took the time to come up to the ward to check on him, which meant so much to us. Seeing a familiar face gave a huge sense of comfort. When we heard that he would need further surgery, it was such a relief knowing it would be Anne and her team taking care of him. Their compassion and dedication really helped ease our minds and continued to do so during an incredibly stressful time.

Urology One Stop Clinic | **Malton** | **Nominated by relative**

The One Stop team went out of their way to support my dad though his appointment. They showed great kindness and compassion to him (he was in a lot of pain) and to me as his carer. They explained everything clearly for him to understand. From reception staff, healthcare assistants, and ultrasound, to Sarah, Specialist Advanced Nurse Practitioner, James, Charge Nurse, and Dr Mumtaz, they were all brilliant with my dad.

I am nominating them to recognise how much difference they made to us on a difficult day. They kept the Trust values of kindness, openness, and excellence in what they all did. Thank you.

Ward 31 | **York** | **Nominated by relative**

They are providing excellent care for my husband. Nothing is too much trouble. They give 100% every day.

Rachel Graham, Ward Clerk, Sarah Bradish, Ward Clerk, and Vicki Patrick, Admin Coordinator **York** **Nominated by colleague**

An additional ward opened with no administration support in place. This was unforeseen as bed capacity was extremely short, so patients from the medicine and surgical care groups were transferred to this ward awaiting discharge home. Vicki was unable to provide a member of staff to be located on the ward permanently, however, a plan was put in place to support the ward and ensure all the discharges and follow ups for the patients were completed.

Daily, the ward clerks from AMU, Rachel and Sarah, went to the ward and collected all the paperwork for discharges from the day before and provided basics for the doctors to review the patients for discharges. This was achieved daily, going above and beyond in their duties. Sarah has been with the Trust since the beginning of December and Rachel for more than ten years. This showed great teamwork and a good work ethic.

Considering the short fall of staff in the department, Vicki showed great leadership skills on this occasion and warrants the recognition alongside two of her team members.

Histopathology Team **York** **Nominated by colleague**

The Histopathology team support the Oculoplastic team to provide a gold standard service to patients with eyelid skin cancers. This service allows the cancers to be removed with a narrower margin of normal skin compared to those from elsewhere on the body, protecting the eye function and patient appearance.

The histopathology team reliably provide results within a very rapid timeframe of a few days, so patients can come back for reconstruction when the cancer is known to be safely fully cleared. When there are issues, they communicate quickly and clearly, allowing patients to remain informed. The team achieve this for us and our patients despite an enormous workload of other cases and the high level of detail needed for these high-risk specimens. We could not offer this high standard of care without our excellent histopathology colleagues and their hard work, particularly Dr Bratten, Drs M and S Toy, and Dr Abdul-Kadir.

Caitlin Pollard, Student Nurse **York** **Nominated by patient**

It was Caitlin’s first day on the ward, and she was confident and made everyone feel comfortable. She was pleasant and polite. She coped with some of the more difficult patients on the ward with a professional attitude.

Nicola Fox, Laura Jade Peck and Kayleigh Parkin, Theatre Support Workers	**York**	**Nominated by colleague**

Niki, Kayleigh, and Laura are perfect examples of everything good at the Trust. Every day they come to work with a smile and can-do attitude. They are an asset to the Head and Neck Theatre team and to the wider department. No task is too big for them, and they take everything in their stride, always working to the highest of standards. They are supportive of their colleagues, whether it be teaching new starters, helping the practitioners in busy lists, or assisting in the anaesthetic room.

When they truly shine is when they are interacting with patients. Most patients coming to theatre are scared, vulnerable, and apprehensive, but Niki, Kayleigh, and Laura are always there to offer a comforting hand or a listening ear and provide an encouraging chat. They are supportive of the patient in the anaesthetic room and an asset to the anaesthetic practitioners and anaesthetist, especially if the patient is paediatric. The patients are forever grateful for their presence and hard work, often commenting how they have improved their experience of their surgery.

It is a pleasure to work alongside all of them, they have a positive impact on the team's day when they are present. They are shining stars!

Heather Lovitt, Deputy Sister, Georgia Miles, Healthcare Assistant, and Alicja Wos, Specialty Trainee Doctor	**Scarborough**	**Nominated by patient**

While undergoing a recent hysteroscopy, I could not have asked for better care. The staff went above and beyond to make me feel at ease. Their calm approach and reassuring nature made an incredibly stressful procedure easier. Georgie, you were made for the job. Thank you for all you did.

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

From the moment that I joined the Trust in 2024 to my last day in February 2025, I have been impressed with the helpfulness and kindness of the ID and Car Parking team at York. As a new starter back in 2024, the team helped me to quickly navigate the parking process, which can be a real point of stress and anxiety. This support helped my onboarding and equally as I leave the Trust, the team have once again stepped up to make this as painless as possible.

I have recently onboarded a new staff member to the Outpatient Services team, and he has also experienced a high level of service from the ID and Car Parking team. The culture within this team is amazing and is an example of what good looks like. Nothing is too much for any of the individual staff within the team, and they deserve to be recognised for this. Thank you for the great work you do!

Luke Patterson, Speciality Registrar **York** **Nominated by colleague**

Dr Patterson is an amazing person and doctor with the care he shows his patients and colleagues. He treats everyone with the utmost respect, and you can see he genuinely cares. He goes above and beyond and follows the Trust values. He is an asset to the Trust.

Rachel Chard, Senior Healthcare Assistant **Scarborough** **Nominated by colleague**

Rachel is a kind, caring, and helpful person. She cares about the patients that she works with, the staff, and everyone around her. She is willing to help anyone and always with a smile. Her kind attitude and friendly manner make her approachable.

I am grateful for the help and support that she has given me recently. She shows kindness, caring, and a positive attitude.

Echocardiography Team **York** **Nominated by colleague**

The York echocardiographers are an exceptional team who all, with great humility, demonstrate the Trust values of kindness, openness, and excellence daily. They are always available to contact and are consistently flexible with their own workloads to support with urgent clinical scans at little notice. All team members also show exceptional communication skills, at once flagging any findings of concerns to appropriate clinicians. Countless times their quiet and humble values, skills, and communication are lifesaving for our patients.

Despite the huge disruption of having to relocate their base to a distant location in the hospital, Elise Martin went out of her way to respond to my request for help with an echocardiogram for a patient I was concerned about. Elise's skill and communication with me following this resulted in an urgent CT scan, admission to the intensive care unit, and referral to cardiothoracic surgery. Without Elise's willingness to add to her already heavy workload late on a Friday afternoon, a critical diagnosis would not have been made for this patient.

The exceptional skill, patient care, willingness to help, and timely and open communication Elise demonstrated, which is replicated in every single member of this team, deserves to be recognised and celebrated.

Kate Gordon, Domestic Assistant **Scarborough** **Nominated by colleague**

Kate has shown compression and kindness towards a patient living with dementia. The patient had a doll with them that she looked after like a child. They became upset at the idea that they had nothing to feed the baby. Kate, acting on her own, sourced bottles, blanket, a nappy, and baby socks from Rainbow Ward for the patient so they could care of their doll.

She has shown true kindness and compassion towards that patient, thinking outside of the box to ensure this patient was made to feel safe and happy.

Thomas Pinnock, Registrar **York** **Nominated by colleague**

One of our patients needed an urgent CT and the radiology team would not accept the patient without a cannula. Our team tried three times and failed, and we were desperate. I called Thomas, who came in five minutes, just as he told me over the phone, and cannulated the patient.

I am extremely grateful that he went out of his way today. Despite being extremely busy, he came and helped the Ophthalmology team in a timely manner. This is an example of teamwork and exemplary care for our patients. Thank you.

Ward 29 **York** **Nominated by patient**

I have recently spent time in Ward 29. Georgina and her team were amazing. They were organised, calm, friendly, and helpful. The staff were patient when dealing with rude patients, many of whom had dementia. They took it in their stride, and I was impressed. I did not like being in hospital, but the staff were so kind that it was bearable, and the food was nice too. The cleaner was always cleaning and kept it all nice.

Anthony Sanderson and Alex Rowntree, Healthcare Assistants **York** **Nominated by relative**

My husband attended ED following a hip replacement and advice from Nuffield Hospital. He was seen on arrival, which was a blessing due to his pain. The ED doctors we were seen by were excellent, but the most outstanding service we received was from two healthcare assistants, Alex and Anthony. They both gave an amazing service to their patients and relatives. The service provided was given with great care and professionalism and nothing was too much trouble.

Alex and Anthony are a credit to the department and the Trust, and my husband and I wanted to acknowledge the way in which they went about their jobs.

Nicola Whitehead and Alisha Hardaker, Clinical Associate Educators **York** **Nominated by colleague**

Nikki and Lisha are committed to their role, and both strive to ensure they provide our new starters with the support they need to settle into their new roles. They go above and beyond their roles as educators and this is shown by the respect the healthcare support workers show them when out and about in the hospital. The surgical wards and Healthcare Academy would be lost without them.

Kim Locking, Deputy Sister **Scarborough** **Nominated by colleagues**

Due to reduced senior staffing in Outpatient Department, Kim has stepped up and taken on the lead of general outpatients. This is on top of her own role as Deputy Sister in Ophthalmology. She has supported all the healthcare assistants, and we want Kim to know how much we have appreciated her over the last few weeks.

Peter Sykes, Ultrasonographer	**York**	**Nominated by patient (1) and patient (2)**

Nomination 1:

I had my 20-week US obstetric fetal anatomy scan, and I want to say how lovely Peter was throughout my scan. He had a way of letting me know what he was doing and why that was clear and easy to understand without putting any worry across. My scan was completely clear, and baby is fine and healthy, but some people will not get such good news, and the way he goes about his job is reassuring and will comfort a lot of people when they will feel most on edge. I just want to say thank you to him.

Nomination 2:

Arriving for my 20-week scan, we did not know we would be coming out of that room with literally a broken heart and a completely different pregnancy. Peter was our ultrasonographer for our scan. He started scanning and at first everything seemed normal, until he got to my baby's heart. Peter was not too sure and did not want to say, but he recommended that I go for a walk and to empty my bladder in case baby was lying funny. After multiple times scanning over his heart, he got a second opinion from his colleague, and they agreed there was something not quite right.

I would like to nominate Peter as the heart defect my baby has could have easily of been missed, and, if it had been, their arrival into the world would be slimmer. Peter showed nothing but empathy and compassion towards us. He said he has been doing this for over 30 years and his eye to detail is absolutely perfection, I could not have asked for anything more. He is an absolute asset to the team at York and he is a star.

Michaela Quinn, Deputy Service Manager	**Bridlington**	**Nominated by colleague**

Michaela always demonstrates the Trust values and goes above and beyond to help patients and colleagues. Recently a patient came from Filey to Bridlington Hospital twice to collect their hearing aid, which was not yet fixed.

Although hearing aids are not managed by the Outpatient Admin Team, Michaela drove to the patient's house on Friday evening in her own time, to drop off the hearing aid to the patient so they were not without it over the weekend. The patient was extremely grateful.

Security Team	**Scarborough**	**Nominated by colleague**

Security officers had been called to Resus for an aggressive patient. Upon arrival, officers were met by a patient holding a needle as a weapon. With selfless disregard for their own safety, they bravely disarmed the patient of their weapon and restrained them.

Through teamwork, professionalism, and communication, officers ensured the safety of all staff in the department. Police arrived and left, while security remained and continued to support staff who were doing their best to care for the patient.

Alex Ward, Specialist Physiotherapist | **York** | **Nominated by colleague**

Alex came in over a weekend and spent a significant period working with one of the critically ill patients in the intensive care who had recently been weaned from mechanical ventilation. She worked with them on several occasions over the course of the day, helping them to cough and clear their secretions (which they were unable to do on their own), staying late to ensure the patient's safety and best chance of recovery. She then ensured that there was ongoing physio review overnight and for the rest of the weekend.

Were it not for Alex's input (and the rest of the physiotherapy team), I believe this patient would have needed reintubation and would have ended up with a more prolonged intensive care stay.

Breast Screening Health Promotion Team | **York** | **Nominated by colleague**

The Health Promotion team have been going to various locations across North Yorkshire to raise awareness around breast screening and breast awareness. This is a new initiative, and there has already been a lot of positive feedback to say how helpful their presence has been. They have worked hard, visiting different groups and trying to get the breast screening message to as many people as possible.

It has been so encouraging to see how enthusiastic the team are about improving patient experiences and making sure everyone has access to the information they need.

Emma Scott, Healthcare Assistant | **Community** | **Nominated by colleague**

I am nominating Emma in recognition for her dedication and hard work. I have worked alongside Emma for six years. She is well known by all our patients for her caring and compassionate personality. She will go out of her way to help me or other team members and will never say no.

Emma provides holistic care to every patient she visits without seeing it as just a task, which proves she really cares for the patients we have on our caseload. She is constantly engaging with all the nurses and coming up with new ideas for wound care and healing. Mention Emma's name to anyone on the caseload and they will give you nothing but beautiful words.

I want you to know, Emma, that your hard work does not go unmissed, and I appreciate all your hard work and help over the years. Not only are you a work colleague, but we have become true friends.

Jackie Shilleto, Midwife **Scarborough** **Nominated by colleague**

Jackie provided care to a woman in labour who had needed transfer from York. The woman experienced mental health problems and required enhanced care to deal with anxiety. She describes being terrified about going to another hospital, and about labour and birth. Jackie looked after her and the woman said:

“From the beginning, Jackie was perfect. She cared for me perfectly and I cannot imagine how I would have coped if it was not for her. She knew what I meant, and just seemed to understand me. I felt she really listened to me and cared about what was important to me."

Jackie made such an impact on this woman, and she has asked to ensure that she is recognised for her kindness and professionalism.

Eve Bennett, Midwife **York** **Nominated by colleague**

Eve provided care to a woman who accessed maternity triage at York Hospital on several occasions. The woman explained she had significant mental health conditions, and often felt people did not understand her or take her concerns seriously. She was cared for by Eve on several occasions, and each time states that Eve reassured her and made her feel safe.

The woman said, "Knowing there was a midwife like Eve at the hospital made me feel safer. She listened to me and took time to make sure that she understood what I was worried about."

District Nurse Admin Team **Community** **Nominated by colleague**

Over the last few months, the team has been depleted in staff numbers due to a variety of reasons, but they have pulled together remarkably and without question. Staff have moved areas to support our nursing colleagues, worked extra hours, and provided remote support to the nursing teams across the whole of our locality.

This has ensured the admin function for district nursing has been fully covered seamlessly. I am lucky to have such a dedicated, flexible, and friendly team!

Ward 25 **York** **Nominated by relative**

I am so grateful for the exceptional support Ward 25 has given during my mum’s time on the ward. Thank you for your unwavering dedication to patient care. I cannot thank you enough for keeping her comfortable and well cared for, nothing has been too much trouble. All your expertise and compassion have made a significant impact on her stay.

As her daughter, I am grateful for the exceptional support you have provided, not only to her but also to me during her time on the ward. Thank you once again for your unwavering dedication to patient care. You are all amazing and deserve a Star Award.

Prince Ngwenya, Healthcare Assistant | **York** | **Nominated by patient**

I was admitted to SDEC at York hospital and Prince was amazing. He was always offering a drink and some food and making sure I was OK. He made everyone laugh and feel at ease. When he did my canular and bloods, he made conversation with me, told me it would be OK, and I did not feel it.

If everyone was like Prince, the NHS would be amazing! He deserves this recognition. The following morning, he asked how my evening was and if he could do anything more to help. The laugh he gave along the way made my stay much easier. York Hospital should be proud to have him.

Nicola Wilson, Outpatients Administrator | **York** | **Nominated by colleague**

Nicola took a phone call from a patient who was enquiring about their appointment that day. It became obvious to Nicola that this patient was suffering from severe anxiety about their appointment and possible outcomes.

Nicola talked to them at length, offering what reassurance could. She arranged to meet the patient on arrival at the hospital prior to their appointment and escorted them to the department where their appointment was to take place. Nicola also alerted the consultant that the patient was due to see about the patient's anxiety and mental state.

Steven Crane, Consultant in Emergency Medicine, Sadie Walsh, Staff Nurse, and Hollie Anderson, Staff Nurse | **York** | **Nominated by patient**

On arrival at ED, we handed over the paperwork from our GP and within a minute we were ushered through to the Resus side of ED. Once in a cubicle, two nurses, Hollie and Sadie, reassuringly took care of Helen, and a consultant by the name of Steven Crane was soon in attendance.

We cannot speak highly enough of Dr Crane. His manner, the questions he asked, and the reassurance and confidence he showed me when I was suffering with a supraventricular tachycardia. He was present much of the time I was in Resus and when he did leave, he returned to reassure me that I would be better soon. All the staff we encountered on in York ED were excellent.

Megan Dutton, Clinical Educator **York** **Nominated by colleague**

Megan is an exceptional nurse and teacher. She shows patience, compassion, and care in everything she does. The time she spends with newly qualified nurses, going outside her working hours and going the extra mile to make sure they feel safe and comfortable in their new role, is one of the many reasons why she is great at her job.

No matter what time of day, Megan is there to support you and be there for you. Whenever I am unsure of something, she is only a phone call or a knock on the door away. Her passion for teaching and for surgery make her an asset to the education team and surgery.

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

I am a domestic on SCBU. I have complex illness, and this ward treats me like a team member, always checking on me, making me a drink, and asking how I am. I once had a seizure on the ward and a Deputy Sister sat with me until I got help. Nothing is too much trouble for them. I have always been treated with respect and friendliness on this ward.

Porters **Scarborough** **Nominated by colleague**

We have introduced a new digital booking system, Softfm, for the porters to be allocated patient moves to the Radiology department in Scarborough. This has seen a change to the long-standing existing working pattern and has required all the portering staff and facilities operatives to learn a new system to allow the use of mobile devices for booking and managing jobs.

This change has seen an improvement in the efficiency of both the portering service and the Radiology inpatient service. The change has been met by positivity from all staff concerned and the transition has gone smoothly, with constructive feedback given and a willingness to learn the new system demonstrated by all.

Adele White, Staff Nurse **Scarborough** **Nominated by relative**

My son had a respiratory and cardiac emergency that led him to have to be intubated and flown to Sheffield Hospital from Scarborough. He was admitted the day before this and showed signs of deteriorating overnight. Adele came on shift in the morning, and from the outset was kind and calm.

As the morning continued, and my son's condition got worse, Adele remained professional, calm, and proactive, working with her colleagues, including guiding a trainee, and providing my son with the appropriate care he needed right up to him being flown by Embrace. She kept me informed and demonstrated an ability to think and act quickly and appropriately with a wider team in a deeply stressful situation. She could clearly identify the severity of the situation from the outset and took all the appropriate steps to make sure my son got all the appropriate care from herself and the other relevant people needed.

I am in no doubt Adele was central to saving my son's life that day. She is an incredibly compassionate, professional, and experienced nurse that I am grateful to have had overseeing my son's care that day. She deserves to be recognised for her outstanding excellence.

Lucy Hyde, Generic Therapy Assistant **York** **Nominated by colleague**

Lucy continues to go above and beyond in all she does at work and is a valued member of the team. She stays late at work to make sure that everything has been done for her patients and shows care and love for the work she does.

This can be supported by a recent patient she has had who was completely deaf, but no one knew sign language. Lucy took it upon herself to learn some BSL in her lunch break to be able to communicate. This bought the patient so much joy, knowing Lucy had taken the time to learn this. Lucy works so hard, and she truly embodies the Trust values and what we stand for in healthcare. Her kindness and compassion shines from inside.

Rehab Community Response Team **Selby** **Nominated by patient**

I have had carers each morning to help me wash and dress and a nurse each day to give me an injection. All of them have been kind, cheerful, and helpful and have made me feel more positive about my recovery. They have gone the extra mile to help me.

Rowena Coleman, Frailty Practitioner **York** **Nominated by colleague**

Rowena has gone above and beyond to educate me. She has taught me with empathy and kindness, and nothing was too much for her as she supported me as a student. She has made my placement days fun and exciting for a third-year student who is scared about qualifying. She has gone the extra mile to support me and make sure I feel well prepared for when I qualify. She is open with me as a student and is an amazing example of the Trust values.

Rowena has fed into my love of frailty and the elderly and has allowed me to explore my skills. She has helped me gain confidence by answering all my questions the best she can and providing support to me while allowing me to work independently. She is an excellent teacher and such an asset to the team and the Trust.

Ward 28 **York** **Nominated by relative**

My mother died in York Hospital following a six-week stay. Throughout her time on Ward 28, the staff were exceptional from the cleaners and the catering staff to the healthcare assistants, the nurses, and the doctors. My mum praised the staff, the quality of the food, the care taken by nurses in helping make her comfortable, and the information given to her by the doctors.

In her final weeks and days, when it became clear she would need palliative care, the compassion shown by the Dr Hanson was exceptional. The ward allowed my sister and I to remain with mum 24/7 up until the last moment. The palliative care team, in particular Lizzy (apologies if I have got her name wrong), were remarkable, offering honest guidance on what to expect.

From the bottom of our hearts, we would like to pay tribute to the amazing staff of Ward 28 and thank them for the remarkable job they do.

Gemma Kane, Orthoptist **York** **Nominated by relative**

Gemma has been my daughter's Orthoptist for nearly a decade, and we have had the pleasure of seeing her every three to six months. She has done an amazing job with my daughter, enabling her to have her eyes tested through games. My daughter now knows what to expect and completes the tests needed without hesitation. This has not always been the case, especially in the early days, but Gemma's patience and consistency has been second to none. In the car on the way to the hospital, my daughter said she was looking forward to seeing Gemma that day.

Gemma has told us she is going on maternity leave. Leaving Gemma's clinic room for what might have been the last time this morning was emotional as we think by the time Gemma is back, my daughter may be ready for high street opticians. I wanted to nominate Gemma for this award because of how amazing she has been with my daughter. She wears her glasses most of the time and does not complain when we come for her eye tests. It is the amazing work and patience that Gemma has given to my daughter and to us as parents over the years that has helped to get us to where we are today.

I want to take this opportunity to thank Gemma from the bottom of our hearts for being kind, caring, and understanding and for always answering our questions, and now my daughter's questions, about her eyes when we come to clinic. Everyone who has Gemma as their orthoptist is lucky. Good luck with everything.

Daniel Robinson and Katie Smallwood, Administrative Assistants | **York** | **Nominated by colleague**

Katie and Dan have consistently gone above and beyond to support me since I started last year, especially during the challenging period over Christmas. They were always available to assist with emails in Scarborough, promptly answering any questions and providing support whenever I needed it, all while maintaining a positive and friendly attitude.

Their dedication and willingness to help has continued ever since and I know I can rely on them for further support whenever required. Their kindness, openness, and commitment to excellence have made a tangible difference to my experience, and I am grateful for their ongoing support. Thank you!

Joshua Thompson, Administrative Assistant | **Scarborough** | **Nominated by colleague**

Josh has been an invaluable support throughout my training, always going the extra mile to ensure I feel confident and capable in my role. No matter the question, he is always calm, patient, and clear in his explanations, making sure I fully understand the information. On top of that, when technical issues arise, such as my printer breaking, he is always quick to help, often fixing the issue with ease. His patience, especially when I ask the same questions multiple times, demonstrates his commitment to helping me succeed.

Josh's kindness, openness, and excellence in all his interactions have made a real difference to my experience, and I am incredibly grateful for his ongoing support.

Carly Salt, Senior Healthcare Assistant | **Scarborough** | **Nominated by patient**

I attended the Bronte Unit in Scarborough Hospital. Carly made me feel welcome and at ease, from greeting me in the corridor on arrival to when I left. I was nervous about the procedure, but she made me feel comfortable and answered my questions, and when she did not know the answer, she would find out the answer for me. She was attentive and reassuring throughout the time I was there and ensure I was comfortable and OK.

I brought my daughter with me and Carly also made sure she was OK as she could not be in the same room as me. She took her to find refreshments, but also offered her refreshment at the same time she was preparing them for me. There was another patient in at the same time as me who she gave the same level of care too. She was a lovely and caring person who should be recognised for her work. She makes going to hospital a pleasant experience.

Sally Duggan, Outpatient Services Administrator | **York** | **Nominated by colleague**

During a difficult week due to holidays and sickness, Sally was incredible at covering not only the main reception desk in the hospital, but also the outpatient appointments desk single handedly. She ran both desks and was smiling and positive throughout a busy and tiring day. Her willingness to jump in and help whenever needed, always with cheerful energy, is noticed and greatly appreciated.

Lynne Mills, Outpatient Services Administrator | **York** | **Nominated by colleague**

A patient had become faint after getting their blood taken. Lynne noticed the patient's condition and helped them. She got them water and ensured patient dignity was still intact as the waiting area was extremely busy.

Olorunleke Arokoyo, Trust Grade Doctor | **York** | **Nominated by relative**

Olorunleke did a wonderful job today at making our young child feel at ease. My child was nervous, but Olorunleke took time to explain the procedure at each stage, even demonstrating on them teddy and a turn with the microscope. Thank you, Olorunleke, for making them comfortable and treating them so well. They left hospital skipping!

Rose Kay, Clinical Nurse Specialist | **York** | **Nominated by colleague**

I am a student nurse currently working with the Pain Management Team, and I am honoured to nominate Rose Kay for a Star Award. Rose consistently goes above and beyond her role while maintaining a deep awareness of her professional boundaries. Her dedication to patient care and advocacy is inspiring, and I believe she deserves recognition for her outstanding contributions.

One incident stands out as a testament to Rose's compassion, attentiveness, and clinical excellence. During a routine visit to the surgical ward, she overheard distressing sounds coming from another room. Rose immediately responded, finding an adult patient with autism in severe pain. The patient's agony was in a lot of pain and their family was deeply concerned. Without hesitation, Rose took action. She approached the nurse in charge to check whether the patient had received appropriate pain relief and quickly addressed the parents' worries with genuine empathy and reassurance. As she listened to the family's concerns, Rose took the initiative to review the patient's records, discovering that a scan needed to be ordered, and blood tests needed to be taken.

Understanding the urgency of the situation, she escalated the matter to an Advanced Clinical Practitioner, who responded at once. The necessary blood tests, including a venous blood gas, were promptly conducted, revealing an elevated lactate level, potentially indicating an infection. Thanks to Rose's swift intervention, the consultant and registrar were informed, and the required scan was urgently ordered. Beyond her clinical vigilance, Rose also sought additional support by reaching out to the neurodiversity nurse for guidance, ensuring that the patient's specific needs were met. What makes this even more remarkable is that Rose was not originally there to see this patient, yet her instinct to advocate for someone in distress led to an intervention that not only improved the patient's condition but also provided much-needed reassurance to their worried parents.

Rose embodies everything that this award stands for - compassion, initiative, excellence in patient care, and a true commitment to making a difference. Her ability to recognise and respond to a critical situation, her unwavering dedication to patient advocacy, and her empathetic approach to both patients and their families make her truly deserving of this recognition. I wholeheartedly recommend Rose for the Star Award, as she exemplifies the best of what it means to be not only a nurse but an excellent mentor too.

Angela Rennison, Ward Clerk | **York** | **Nominated by colleague**

Angela has been a fantastic support for me and the Ward 11 staff base. I have recently returned from maternity leave and met Angela who was employed during my leave. She is a valued member of our ward team. She has supported me wholeheartedly with adjusting to the new working processes and done so with care, compassion, and incredible patience. Thank you, Angela.

Sonnie Smith, Facilities Operative | **York** | **Nominated by colleague**

Sonnie is a kind and caring young man who has empathy and patience. He helped me with a task on the computer that I was unsure about and helped me remember the process.

Aleksandra Szczesna, Associate Practitioner | **York** | **Nominated by colleague**

I am nominating Aleksandra (Ola) for a Star Award for her professional yet warm and friendly approach to everyone she meets and everything she does. She is always more than happy to help in such a friendly way, and it feels like nothing is ever too much for her. Ola is professional in the way that she works and is clearly passionate about her role.

I think that she demonstrates our Trust values beautifully and she is an asset to the POCT/Biochemistry team. Keep up your amazing hard work.

Tracy O'Brien, Healthcare Assistant | **Scarborough** | **Nominated by patient (1) and colleague (2)**

Nomination 1:

After a stressful wait, I have a date for prostate surgery and attended pre-op assessment at Scarborough. I was scared as I felt as though this would be used to decide my outcome before surgery.

Tracy was amazing, she put me at ease, explaining everything carefully and in detail. She took her time and was patient, overwhelmingly kind, and understanding. She chatted to me and my wife about her lovely cats which was calming and a distraction. It felt as though I was chatting to a friend. I did not feel rushed, and she answered all of my questions.

Nomination 2:

As Tracy's line manager I received an email from a patient's mother describing the care they had received by Tracy as amazing. The patients mother explained that the patient has difficulties and finds hospital appointments stressful and exhausting, but Tracy's calm manner had made the appointment pleasurable.

I would like to say a huge thank you for showing kindness and compassion, a star within our Trust.

Laura Twigge, Staff Nurse **York** **Nominated by colleague**

Laura is such a caring nurse; she always goes the extra mile to meet patients' needs. She is thoughtful and kind towards staff and patients and their families. We are so lucky to have you, Laura.

Donna Dickson, Healthcare Assistant **York** **Nominated by relative**

Donna was amazing. She is an example of someone going above and beyond and is everything the NHS stands for. My father has had two stays on the AMU at York. He has Motor Neurone Disease which means he has lost mobility and is now bedbound. Donna was amazing with not just the care she provided for Dad, but also with the respect and dignity she showed and treated my dad with. Nothing was too much, and his every need was met with a smile on her face.

Donna is a credit to the hospital and never stopped working the whole time I was by Dad's side. I hope she can be made aware of how kind, thoughtful, and professional she was. She made an ill gentleman feel comfortable and relaxed. Thank you.

Leah North, Physiotherapist **York** **Nominated by colleague**

Leah has gone above and beyond with her patient care. She identified a need for reasonable adjustments for a neurodivergent patients' care, actively sought out support services, and rearranged appointments to minimise overstimulation and increase patient attendance and engagement with service and care.

Adetola Kazeem, Healthcare Assistant **York** **Nominated by a colleague**

Adetola has been in the job for less than a year, and she appears already to be a veteran.

I was amazed by Adetola's desire to learn when she joined our team last year. She would always ask questions and be receptive to learning anything which could enable her to do a more thorough job. Adetola always finishes all jobs, and does them as efficiently as possible, yet works at the steadily fast pace required on a busy ward like ours. Interactions with patients who may suffer from confusion, anxiety, and acute physical pain, are challenging, patience, empathy, and concise communication are always needed. I have seen Adetola in many of these interactions, and I have never once fall at all short of these interactions. Regardless of factors such as stress and fatigue, Adetola always works to the highest standard possible.

Preparedness is more than ideal in this role, as personal care being necessary can mean we need a lot of individual items. Adetola is especially good at beginning a care task, only when everything required, is within reach. Nobody deserves an award more than Adetola, and I will nominate her, with pleasure.

Darren Ford, Radiographer **Scarborough** **Nominated by patient**

My daughter 18 months old, has been waiting on scans since July. Darren got in contact with myself and my partner and went absolutely above and beyond to get us in quickly and gave us all the information that we needed in order to make the decision if she was still needing the scan.

In the end, because of his help and personally going above and beyond for my little girl to help with my own confusion and ensuring she got the care needed, we ended up getting an MRI scan done at York hospital and a CT at the same time.

Despite this, Darren still called us after that phone discussion with someone else to ensure I knew everything that was going on and that I had the information I needed. Honestly without his help for one I do not believe we would have gotten an appointment so quickly but two he really did calm our nerves down at such a scary time. He has thus far been the best Scarborough NHS team member I have come into contact within years. His kindness spoke volumes even over the phone. My daughter has since been diagnosed with Craniosynostosis, something I do not think we would have discovered without him and all he did for us. Thank you.

Angela Wilford, EUC Engineer **York** **Nominated by colleague**

Angela only came down to sort out a computer that was not working, so I asked if she could move our printers and get them up and running along with our phones. With no hassle Angela just got on with it which has made our life so much easier thank you so much. I feel Angela went above and beyond.

Jon Hind, IT Desktop Engineer **York** **Nominated by colleague**

Jon came up to sort out a computer that was not working. I asked if he could sort out our printers and phone to set them up and bring them from round the corner. This has made our life a lot easier. I cannot thank Jon enough – thank you so much. I feel Jon has gone above and beyond.

Michelle Jarrett, Healthcare Systems Lead **York** **Nominated by colleague**

I have worked with Michelle for a number of years to develop the specialist palliative care unit in SystmOne. She is always so helpful and supportive in managing changes.

Recently she was working on another unit, and she was asked to upload a form that she felt would be a help on the specialist palliative care unit and uploaded this form for us. This form is essential to our service and to patients care. Having this form visible and assessable to other health professionals will assist in maintaining a patient's preferred place of care, avoid hospital admissions and ensure effective communication across services.

For Michelle to think of us while assisting another service is going above and beyond to support the care of people within the Trust and shows what a thoughtful knowledgeable person Michelle is. This has now also been identified and will be used by external organisations such as the hospice.

Kenneth Low, Senior Audiologist | **York** | **Nominated by relative**

We were delighted with my husband's new hearing aids. This was made super easy because Kenneth took us through each stage of what to do, how to do it, and why we should. My husband had only had one hearing aid in the past so getting used to the new ones was more of a challenge. Technology has also moved on so there was more to learn. Even though we were the last appointment of a long day Kenneth did not rush any part of the appointment and explained everything in detail. We felt completely reassured by him.

A wonderful service by the audiology department in general too; from the first fitting of new moulds for ears to the final fitting. A week on and we are still delighted by the difference it has made, so a wholehearted thanks to Kenneth and the team.

Central Sterile Services Department | **Scarborough** | **Nominated by colleague**

Due to Bridlington main theatres working seven days a week, Scarborough Central Sterile Services department has gone above and beyond in keeping use in sterile equipment - with multiple priorities and the drivers making multiple trips - to ensure we have everything when they can. Thank you.

Rebecca Smith, Outpatient Services Administrator | **York** | **Nominated by colleague**

Rebecca (Bex) has been with our team for about 18 months and has made a significant impact since her arrival.

She is so happy and outgoing, eager to learn and willing to do any task. She is usually the first person to offer to help someone or jump on a task where we may be shorthanded, like the outpatient phone lines. Bex is very empathetic and friendly and excels at patient care, especially when on the main reception desk.

Her actions yesterday are an example of this - a lady came in to see her husband on the stroke ward, but she is afraid of lifts. So Bex took it upon herself to escort the lady up to the ward and then asked the ward to call her when the lady wanted to leave. She then proceeded to go back up to the ward and come back down in the lift with the lady. She went above and beyond her duties - something that she does daily showing how kind and caring she it.

Bex is a huge asset to our team and loved by everyone. She is an incredible example of the type of employee the NHS and this Trust needs, and well deserving of a Star Award.

Festus Ogunjimi, Speciality Doctor Emergency Medicine | **York** | **Nominated by patient**

Festus is the best doctor I have encountered since moving to the UK. He was caring and kind and made sure I understood what he was saying. Most importantly, he took the time to call me the day after he saw me in ED to follow up and inform me of the outcomes of referrals to other services, which no other healthcare practitioner has done for me before. In the difficult situation that the NHS is in, he deserves to be acknowledged. Thank you, Festus.

Megan York and Georgia Potter, Service Managers **York** **Nominated by colleague**

Georgia and Megan were coming back from a meeting in York Hospital when they saw a patient who was in visible pain and distress leaning against a wall in the corridor. They stopped to see if the patient was OK and if they could do anything to help. The patient had just been discharged from Ward 25 and was accompanied by their elderly parent. Georgia and Megan called the ward and spoke to the nurse in charge to see if they should come back to the ward to be reviewed. Given the patient's symptoms the ward advised they should go straight to ED.

Georgia and Megan helped the patient and their parent to get to ED by walking them the whole way. They also sourced a wheelchair for the patient. Once in ED they helped the patient check in at reception and took them to the relevant waiting area. The patient was soon admitted for treatment, and they were thankful for Megan and Georgia's help.

I found out about this by chance, and I thought it was worthy of a Star Award submission. They are both caring members of staff who go beyond in their day jobs to make sure our cancer patients are seen as soon as possible with the correct member of the clinical team.

Katie Matthes, Support Manager **York** **Nominated by patient**

I recently fell hard onto my rear end. I had a full hip replacement in October, and was concerned that I may have damaged the replacement joint and/or pelvis. I also have osteoporosis and a history of insufficiency fractures in my spine and pelvis. When the pain levels started to increase, I consulted with my GP. They said they would make an urgent x-ray referral, but that it could take a couple of weeks to be seen.

As I was so worried, I called the x-ray department that morning and got through to Katie, asking how long it would take to be seen once the referral arrived. However, the referral had not yet arrived, so Katie emailed my GP on my behalf. When it still had not come through by the afternoon, she called me again to update me before calling the surgery herself and asked for the referral to be sent through. She then called me back to say it had been received and made an immediate appointment for me.

I have since had the x-rays, and thankfully all appears to be fine, although I am awaiting final confirmation. Katie's actions helped ease my worries, and more importantly, kept me out of ED, which is what I was aiming to do. Thank you, Katie!

Dorcas John, Staff Nurse **Scarborough** **Nominated by colleague**

Dorcas is always happy and smiling and works hard. This nomination is to show that her hard work does not go unnoticed. On busy shifts, despite caring for her own patients, she also helps where she can without being asked; supporting her colleagues and ensuring patients receive the best care. Dorcas never complains about how hard the ward demands can be. She is a breath of fresh air!

Agnieszka Dyrala, Healthcare Assistant | **Scarborough** | **Nominated by colleague**

Agnes is a hard worker with the kindest heart. She is always on her feet and cannot do enough for her colleagues and patients alike. As a previous domestic, she goes above and beyond her HCA duties, ensuring the ward is tip top! It is exhausting just to see her work so hard. Well done, Agnes, for showing excellence every shift.

Muhammad Arif, Speciality Doctor Paediatrics | **Scarborough** | **Nominated by colleague**

Dr Arif is a well-respected colleague who shows kindness to all his patients with genuine care and compassion. He is loved by patients and staff alike. Dr Arif is prompt at seeing patients and always demonstrates a clear plan of care, never failing to communicate with the nursing team. What I love the most is his gratitude to the team for their input of care, making you feel valued in your work. He is many of the children's favourite doctor and without doubt the nurses too! I hope you know how much we appreciate you.

Jax Meehan, Clerical Officer | **York** | **Nominated by patient**

Jax was wonderful when I called the Audiology department. She was helpful, polite, and lovely and she answered all my queries. Jax also went beyond that to advise me on a matter that was related to the call but not what the call was about. A lovely lady!

Consultant Radiologists **York** **Nominated by colleague**

The Radiology department at the Trust has an exceptional reputation for registrar training in the region, as well as receiving consistently positive feedback for the individual consultants in the department who support registrar training during their rotational placements.

The most recent feedback from the registrars who have just completed their training placement with us has again been positive with all survey responses rated as good or excellent. Because of the excellent reputation for training and the positive team culture the registrars report experiencing when working with us, we have successfully managed to recruit several prior registrars as consultant radiologists once they have completed their training. The competition to secure consultant radiologist employment at the Trust has meant we have retained a high-quality radiology service which ultimately benefits our patient population.

I am nominating the Consultant Radiologist team as a whole, not only for the work that goes into organising and support the trainees who come to our department, but also to acknowledge that despite the ever-increasing pressure on the team, that they manage to still provide an excellent experience for our consultants of the future. Feedback from the recent registrars who have worked in the department includes:

- The Monday, Thursday, and Friday teaching has been brilliant! I have learnt a lot, and it is a positive of York.
- The teaching at York, both regular scheduled and extra sessions leading up to exams, has been one of the highlights.
- Great one-to-one teaching with Victoria, with time to go through scans and expand on learning. During MSK I spent the most time with Aaron, Samir, and John, all of whom were encouraging and patient during procedures and happy to make time during the week to talk through my reports.
- Dr Lightfoot has been wonderful in supporting the registrars. He has been supportive during exam results, no matter what the outcome was, and in liaising with car parking and security when one of us had an incident after work.
- Thanks very much indeed for the amazing placement.
- Great placement overall and hope to be back!
- It has been brilliant!

Committee Report

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

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

ALERT
IPC – MSSA line infections remain a concern on Ward 31. Rapid work to address is underway
ASSURE
IPC – CG meetings continue to be key part of improvement work across Trust **Clinical Policies –** Committee noted continued improvement in this matter

ADVISE
Maternity – Committee approved Section 31 submission. Committee discussed staffing shortfall that extends to neonatal team as well as midwifery. Committee advised that efficiency work lead by Chief Nurse was advancing and could potentially allow funding of up to 20 midwifery posts if approved following QIA and consultation processes. Committee discussed potentially high proportion of emergency LSCS (particularly at SGH) and will receive more detailed update at future meeting. Service risks discussed and Committee requested additional clarity on those that are safety risks vs those that are risks to delivery of improvement **UEC –** Committee noted improvement in ambulance handover due to improvement screening of conveyancing and modification to ways of working in ED to provide increased focus on this area **Sepsis Report –** Committee received assurance that many metrics around identification in ED were improving but that time to be seen by doctor remained unacceptably long. Chief Nurse advised that work was on-going to look at PGD as mechanism to reduce risk. Committee also requested to be updated on sepsis identification for in-patients **CQC –** Committee received update on work relating to full inspection and recent focussed visit **Nurse Staffing –** Committee received report noting high priority attached to supernumerary role of nurse managers
RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Surgery CG – Outlying Medical Patients: Committee received an update on this risk. Surgical juniors continue to provide first tier medical cover which is key safety mitigation. However, this results in medical team input being attenuated with typically 2-3 weekly review from senior medical team. Consideration being given to reducing surgical bed-base to provide single area to accommodate outlying medical patients but concern remains about senior medical capacity

Virtual Fracture Clinics: Concern, particularly at SGH, that booking procedures may risk some patients not receiving appropriate follow-up. COO to investigate urgently and provide update

ENT: Concern that safety-netting of referrals may not be sufficiently robust. MD to investigate and provide update

Complaints: Metrics in relation to both number of complaints and timeliness around responses remain a concern. Committee advised that Chief Nurse had scheduled a Trust-wide Rapid Improvement Event

IPC: Committee received strong assurance that CG-level IPC meetings are positively impacting improvement work. Concerns around estate on Ward 16

Major Trauma – Committee received Inspection Report. Positive progress noted along with some continuing and some new concerns. Principal issues – Weekend theatre access, Co-ordinator role and rehabilitation provision. Committee to receive and discuss Trust response and action plan at future meeting

Learning from Deaths – Mental Capacity Act training remains a concern

Committee Report

Report from:	**Resources Committee**
Date of meeting:	**18/03/2025**
Chair:	**Jim Dillon**

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

ALERT
▪ February Emergency Care Standard position was 66.2% against a target of 69.8% ▪ Average Ambulance handover time in February had reduced to 35 minutes and 36 seconds. Although it is above the target of 32 minutes and 38 seconds this is a significant improvement with Scarborough averaging 28 minutes. ▪ Type 1 attendances comparatively low but type 3 attendances increased by 1,000 ▪ 12 hour trolley waits remain high at 433 ▪ Financial outturn position unconfirmed due to uncertainty over ICB support to cover projected deficit. ▪ Staff survey results very disappointing with continuing deterioration in most measures. Innovative and robust action plan required based on changing leadership behaviours. ▪ Participation levels in survey reduced and poor compared to other trusts. ▪ Staff absence levels remain high; a focussed improvement plan requested.
ASSURE
▪ £72m Capital budget on track to be spent for 24/25 ▪ Pay dispute in relation to the grading of Health Care Workers resolved and agreed ▪ 62 day wait for Cancer first treatment was 70.6%. Above target and highest percentage in 5 months ▪ Committee noted the reducing number of complaints across the trust.

ADVISE
▪ £2.9m funding expected to support net zero schemes including replacing steam pipe in Scarborough ▪ W45 Ambulance Handover initiative introduced to assist challenges in A&E ▪ Consultant ED Audit identifies issues of "Over Medicalised" treatment of arrivals at A&E and recommending presence of Senior Decision Makers at the front door. ▪ Concerns over the condition and reliability of CT equipment across sites. Introduction of diagnostic centres should improve situation. ▪ Committee noted the completion of the six monthly Nurse Safe Standard Review and expressed support for its recommendations.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
No new significant risks identified

Audit Committee: Items Escalated to the Board

The Audit Committee met on 4 March 2025.

The meeting was quorate. In accordance with the plan for an Executive to attend each meeting by rotation, Karen Stone attended in order to provide assurance in relation to limited assurance internal audit reports for which she is sponsor, BAF risks under her responsibility and any outstanding actions resulting from internal audits.

Prior to the formal meeting, the Non-Executive Director members of the Committee held a private meeting with Internal Audit. There was nothing new of concern they wished to draw to our attention and everything is on track for the end of the year. I had also had an email exchange with External Audit, who confirmed there was nothing they wished to raise.

The Committee wishes to draw the following matters to the attention of the Board.

Items for Assurance

Internal Audit

Internal Audit are on track with their plans and envisage being able to complete all their work by the year-end.

We approved the Internal Audit Plan and Counter Fraud Plan for 2025/26, noting that the total days had decreased from 660 days to 652 days. We acknowledged that this 8 day reduction was less than the 50 days requested by the Chair of the Board and supported the view that it was important to prepare a plan based on organisational priorities and the need to bring about organisational learning and improvement.

As part of our review of the Counter Fraud Plan, we noted the new legislation coming into effect on 1 September 2025, requiring the organisation to prevent fraud and introducing a new offence of failing to do so. The Counter Fraud team is working through the implications of this for our organisation.

We conducted our annual review of internal audit and there were no issues of concern. We noted that Audit Yorkshire had received a clean bill of health from the External Quality Assessment conducted by CIPFA in the autumn of 2024. This confirmed that they complied fully with the Public Sector Internal Audit Standards.

External Audit

We reviewed the External Audit Strategy Memorandum for the forthcoming audit. After careful consideration and having received assurance from the Director of Finance that this represented value for money, we approved an audit fee of £125k,

an increase of £30k on last year. This increase is comprised of two elements: the additional work associated with the revised ISA 600 on group accounts and the alignment of the fee with the market for NHS external audits.

Item for Consideration and Action by the Board

Cover Sheets

We noted the relatively recent change, whereby cover sheets simply refer to EDI and sustainability and very rarely include a summary of the key points of the paper, as they used to do. We were concerned by this and request that this summary be re-instated.

Broader Use of Internal Audit

We wondered whether we could in future use Internal Audit, given their independence, to monitor the implementation and success of any staff engagement plans.

Jenny McAleese
Chair of the Audit Committee
March 2025

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

TRUST PRIORITIES REPORT

March 2025

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NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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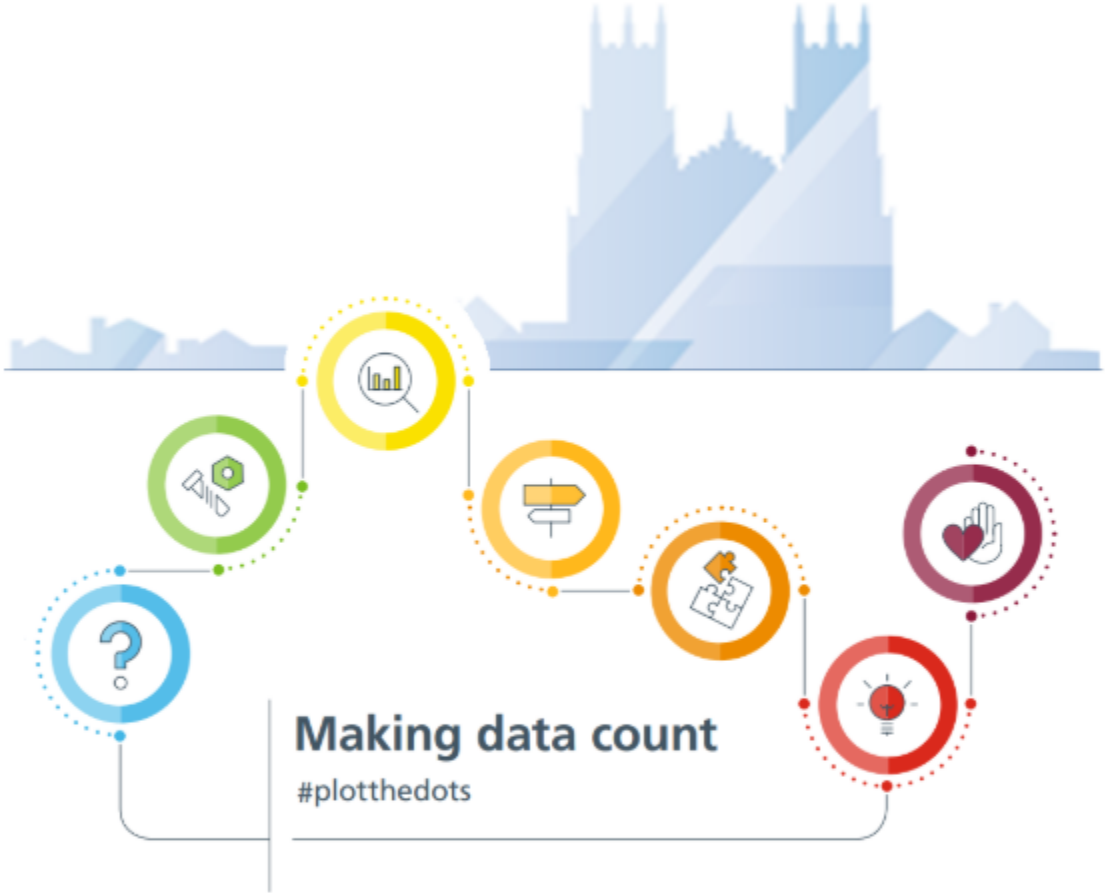


Executive Summary

Priority Metrics

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Ambulance average handover time (number of minutes)	2025-02			35	33	50
ED - Median Time to Initial Assessment (Minutes)	2025-02			4		18
ED - Emergency Care Standard (Trust level)	2025-02			66.2%	69.8%	78%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-02			16.4%		7.5%
ED - 12 hour trolley waits	2025-02			433		0
Cancer - Faster Diagnosis Standard	2025-01			62.2%	71%	77%
Cancer - 62 Day First Definitive Treatment Standard	2025-01			70.6%	62.1%	70%
RTT - Total Waiting List	2025-02			44325	44957	44663
RTT - Waits over 65 weeks for Incomplete Pathways	2025-02			50	0	0

Executive Summary:

The February 2025 Emergency Care Standard (ECS) position was 66.2%, against the monthly target of 69.8%.

Average ambulance handover time in February 2025 reduced significantly to 35 minutes 36 seconds. The target was 32 mins 58 seconds. Scarborough ED handover average was 28 minutes, showing real improvement. 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 January 2025 saw a deterioration in the 28-day Faster Diagnosis standard (FDS) to 62.2% (compared to 72.3% in December 2024) failing to achieve the monthly improvement trajectory of 71%. Unvalidated performance for February 2025 shows some improvement.

62 Day waits for first treatment January 2025 performance was 70.6% an improvement on the 66.4% seen in December 2024, the monthly trajectory of 62.1% 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 February 2025, the Trust had Fifty 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, 44,325 against the trajectory of 44,957.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

March 2025

Headlines:

The February 2025 Emergency Care Standard (ECS) position was 66.2%, against the monthly target of 69.8%.

Average ambulance handover time in February 2025 reduced significantly to 35 minutes 36 seconds. The target was 32 mins 58 seconds. Scarborough ED handover average was 28 minutes, showing real improvement. 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.

Factors impacting performance:

- The number of Type 3 attendances increased by approximately 1,000 patients in February and held a strong performance of over 95%.
- W45 ambulance handover went live on 5th March 2025.
- Activity at both acute hospital shows higher average in February and March 2025 (MTD) compared to January. In March 2025, up to 10th March MTD, York Hospital received daily average of 272 attendances, some days maximum of 320 attendances per day.
- We continue to have workforce challenges, particularly nursing and doctors. The York Minor Injuries service, for example, has sickness absence levels of ~30% and therefore relies on bank shifts to operate.
- There are continued challenges with our local community health and social care capacity.

Actions:

Please see following pages for details.

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 > 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) * ED - Proportion of Ambulance handovers within 15 mins * ED - Proportion of Ambulance handovers waiting > 30 mins * ED - Proportion of Ambulance handovers waiting > 45 mins
SPECIAL CAUSE CONCERN			* ED - Emergency Care Standard (Trust level)

Acute Flow (1)
Scorecard

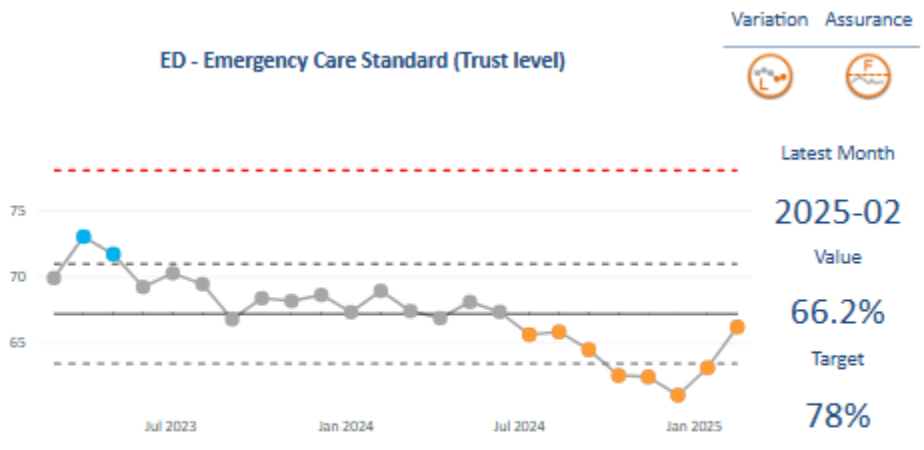
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-02	H	F	71%		66%
ED - Proportion of all attendances seen by a Doctor within 60 mins	2025-02		F	28.7%		55%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-02		F	16.4%		7.5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2025-02			1561		
ED - 12 hour trolley waits	2025-02		F	433		0
ED - Emergency Care Attendances	2025-02	L	?	16359	16084	17807
ED - Emergency Care Standard (Trust level)	2025-02	L	F	66.2%	69.8%	78%
ED - A&E attendances - Type 1	2025-02		?	9502	9416	10423
ED - Emergency Care Standard (Type 1 level)	2025-02		F	43.8%	51.9%	66%
ED - A&E Attendances - Types 2 & 3	2025-02	L	?	6857	6668	7384
ED - Median Time to Initial Assessment (Minutes)	2025-02	L	P	4		18
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-02	H		46.7%		
Proportion of SDEC attendances transferred from ED	2025-02			63.1%		
Proportion of SDEC attendances transferred from GP	2025-02			26.9%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-02			50.2%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-02		P	13.8%		20%

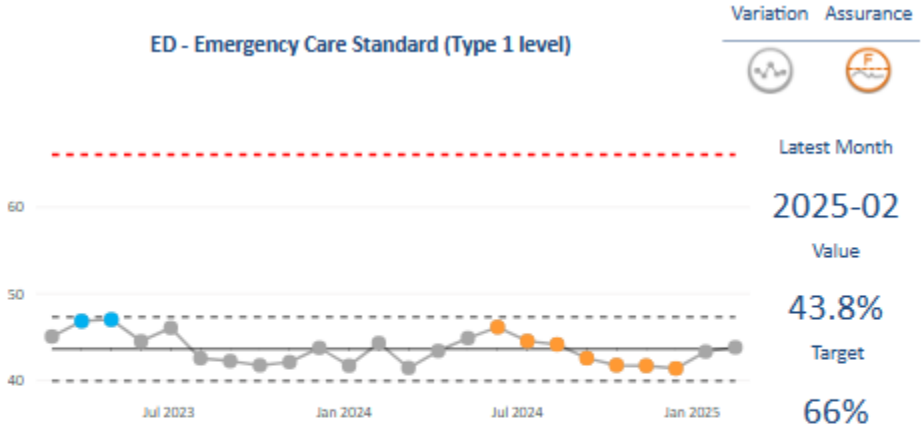
Executive Owner: Claire Hansen

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 **3.1**.



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 **0.5**.

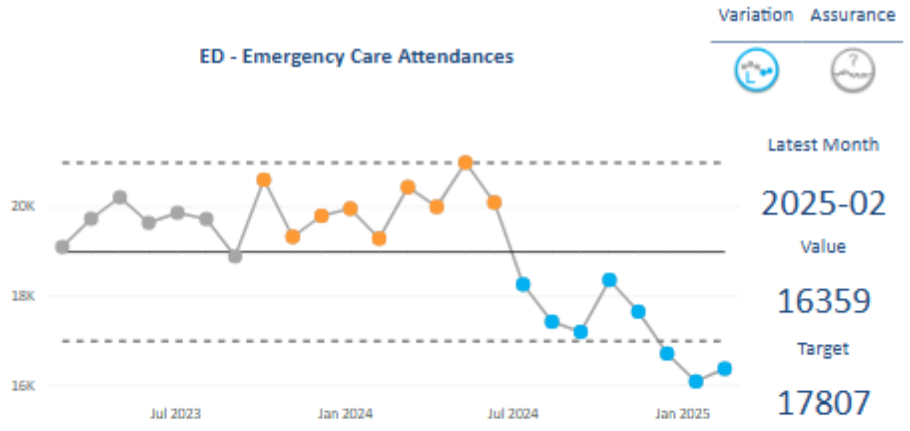
Rationale: To monitor waiting times in Emergency Departments and Urgent Treatment Centres. **Target: SPC1:** NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025. **SPC2:** Modelling showed that to achieve 78% as a Trust Type 1 performance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

Actions:

- The findings of an audit completed by an ED Consultant in January 2025 have been shared with the Scarborough ED Consultant team and Clinical Navigators through a series of sessions. Though the audit related to Scarborough attendances, the results will also be shared with the York team in March 2025.
- The findings suggest that many patients coming to our Emergency Departments may be 'over-medicalised' with unnecessary diagnostics being carried out. This may cause delays at the front door but could also be delaying some inpatient diagnostics required for discharge decisions.
- One way to change this practice would be to ensure there is a senior decision maker at the front door working alongside the streaming team; there is an affordability challenge with this approach. The Medicine Care Group is conducting a workforce review and considering options for a future workforce model to best support the changing demand arriving at our Emergency Departments.
- The principles of an Emergency Department Ambulatory Care service are being established at both sites, despite current challenges and changes to physical estates. This service is designed to support patients who do not require ED Majors but who are likely to require more than a slot with the Minor illness GP. This service principles are in line with the Optimal Care Service; feedback about the name of the service has been taken into account.

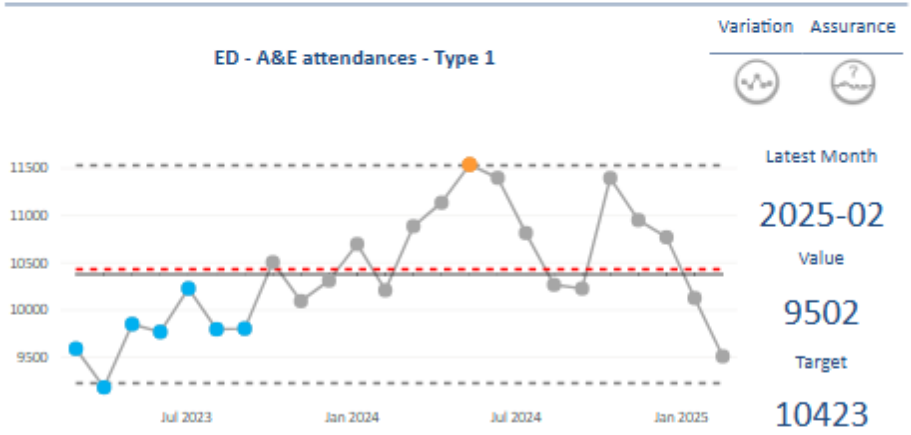
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

The latest months value has **deteriorated** from the previous month, with a difference of **285.0**.



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 **617.0**.

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:

Type 1 attendances in February 2025 remained low which is likely to have contributed to the improvements in ECS% and 12hr performance.

The Community UEC Improvement Group continues to meet monthly. It brings together partners from across the system to understand and maximise the use of pathways which could reduce attendances to our Emergency Departments.

Two pathways in particular could be contributing to the reduction in attendances:

North Yorkshire and York Coordination Hub (YAS-led)

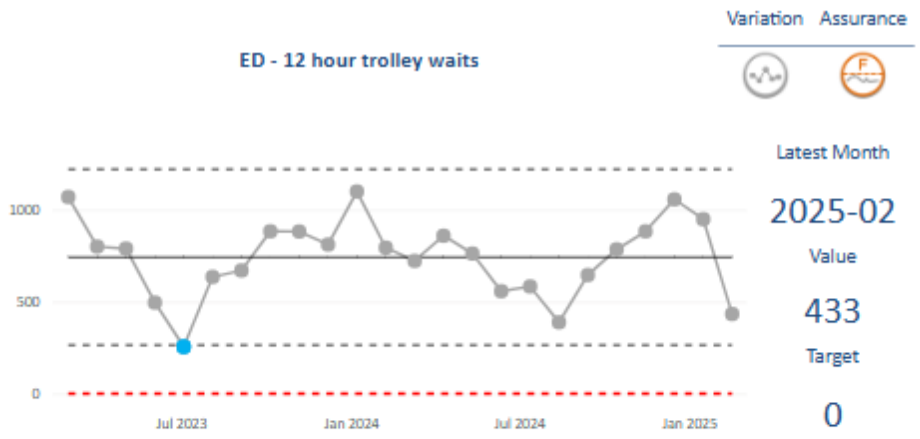
- The Hub team, led by YAS, takes calls from crews and gives advice about appropriate alternatives to conveying a patient to the Emergency Department.
- Since going live in November 2024 the Hub has taken over 700 calls. 66% of those calls have resulted in an avoided dispatch or conveyance.
- The model has demonstrated benefits to multidisciplinary team collaboration but is costly due to GP expenses.
- We are awaiting a decision as to whether the pilot will be extended; currently it runs to the end of March 2025.

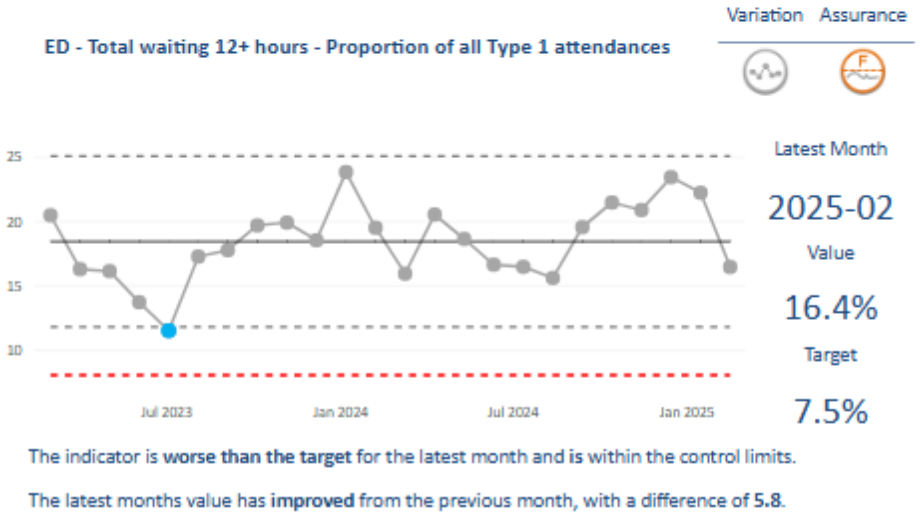
Frailty Crisis Hub (Nimbuscare-led)

- The team are finding that number of conveyances it is possible to avoid is capped at around 300 per month, due to lack of capacity in York Community Teams. A business case is being drawn up for expansion of the service.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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.

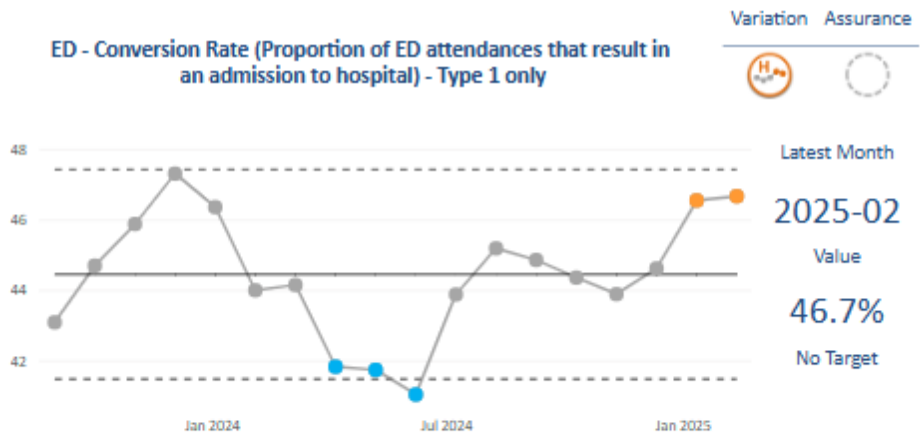
Actions:

- A new Acute Model of Care is being developed, to ensure clarity on moving patients quickly and appropriately through the best urgent and/or emergency pathway for their needs. This includes the Emergency Department and the Integrated Assessment Unit.

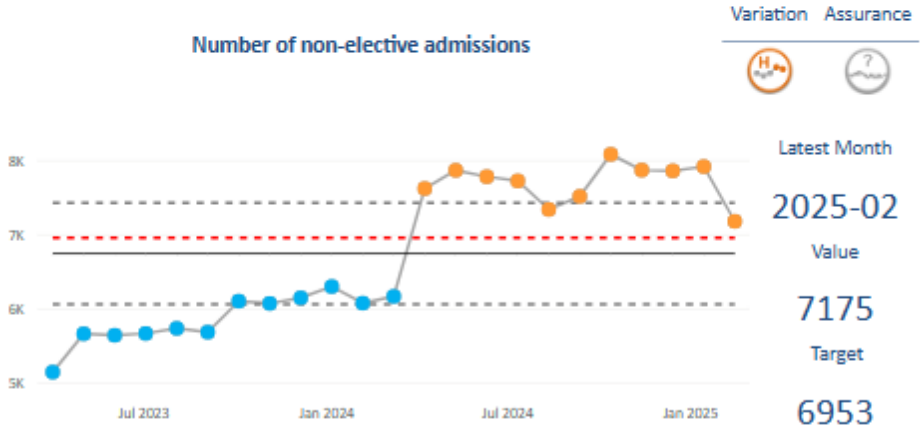
- The recently updated Continuous Flow standard operating procedure continues to be implemented, and the new Temporary Escalation Spaces (TES) SOP has started. These SOPs have impact of timeliness of the flow out of the Emergency Departments and help address the exit block. These policies are linked to two core triggers of a) ambulance delay more than 45 minutes and b) any patient waiting more than 10 hours following a Decision To Admit (DTA).

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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



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 **738.0**.

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 proportion of Type 1 patients being admitted to hospital increased slightly in February 2025 compared to previous months; it should be noted that these admissions include transfers to any assessment and/or same day emergency care (SDEC) area, not only downstream wards.
- Work needs to be undertaken looking into criteria for admission, and this must be clinically led. The admission criteria will be considered as part of the development of the wider model of care.

Acute Flow (2)
Scorecard

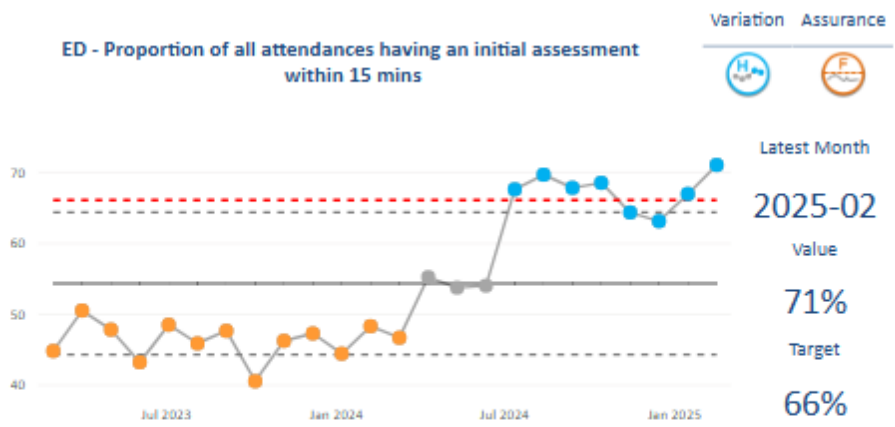
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-02	H		46.7%		
Number of SDEC attendances	2025-02			2221		
Proportion of SDEC attendances transferred from ED	2025-02			63.1%		
Proportion of SDEC attendances transferred from GP	2025-02			26.9%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-02			50.2%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-02		P	13.8%		20%
Number of RAFA attendances (York Only)	2025-02			122		
Number of attendances at SAU (York & Scarborough)	2025-02			744		
ED - Proportion of Ambulance handovers within 15 mins	2025-02		F	32.7%		65%
ED - Proportion of Ambulance handovers waiting > 30 mins	2025-02		F	33%		5%
ED - Proportion of Ambulance handovers waiting > 45 mins	2025-02		F	19.9%		10%
ED - Proportion of Ambulance handovers waiting > 240 mins	2025-02		?	0.9%		0%
ED - Number of ambulance arrivals	2025-02			4074		
ED - Ambulance average handover time (number of minutes)	2025-02		?	35	33	50

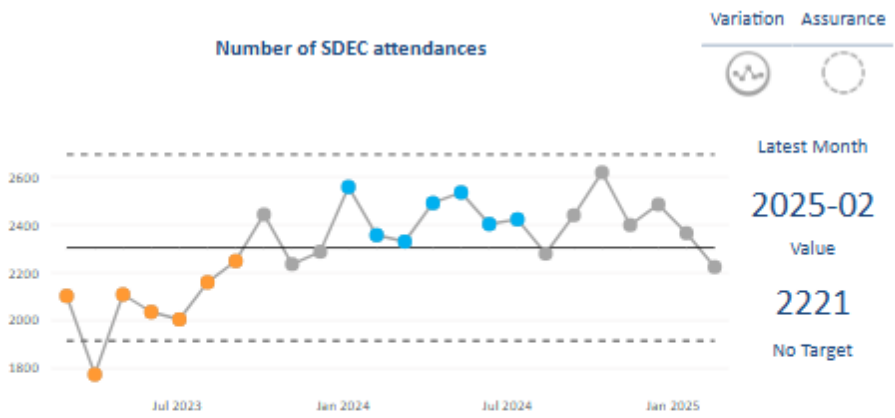
Executive Owner: Claire Hansen

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 **4.1**.



The latest months value has **deteriorated** from the previous month, with a difference of **141.0**.

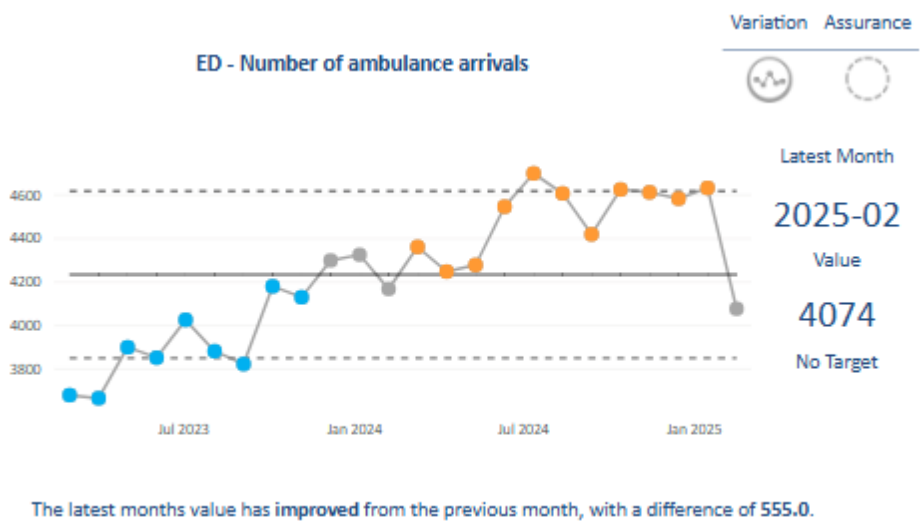
Rationale: SPC1: To monitor waiting times in A&E. Patients should be assessed promptly by within 15 minutes of arrival based on chief complaint or suspected diagnosis and acuity. **SPC2:** SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.
Target: SPC1: 66% assessed within 15 mins. **SPC2:** No target.

Actions:

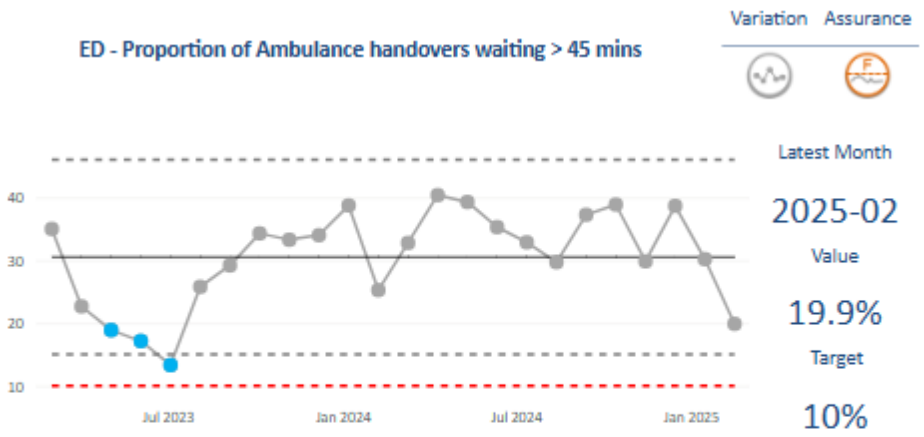
- The proportion of patients having an initial assessment within 15 mins increased markedly at the York site on the day the Optimal Care Service standard operating procedure came into effect (3rd July 2024). The position has remained positive since that point.
- The total number of patients attending our SDECs has decreased slightly. Medical SDEC capacity continues to be impacted by a lack of Acute Physicians.
- There is work underway to develop alternative pathways for some of the 'inappropriate' attendances at our SDEC wards, for example elective follow-up or 'bringback' patients. There might therefore continue to be a short-term decrease in the number of patients attending SDEC, in readiness for the new clinical model which will ultimately support more same-day outcomes and reduce average lengths of stay.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **555.0**.



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 **10.3**.

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.

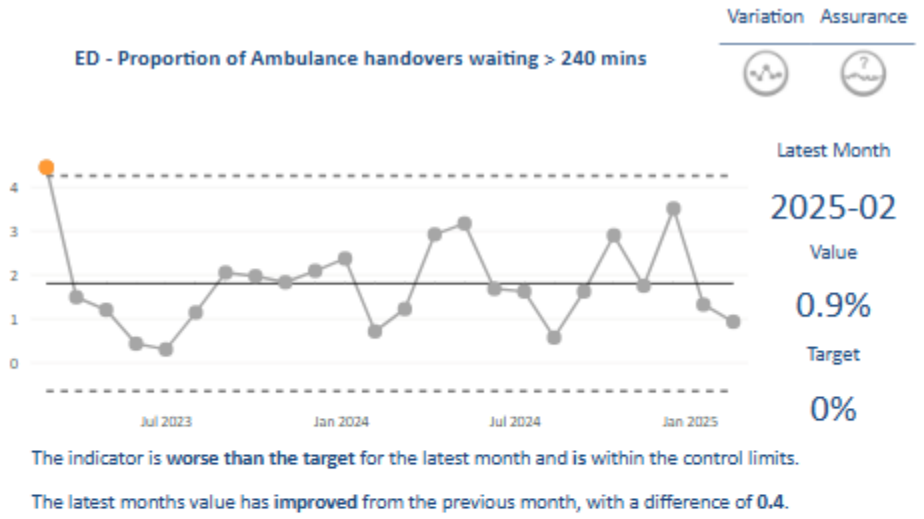
Actions:

The number of ambulance arrivals decreased in February 2025 by ~10%, in line with there being ~10% fewer days in February than January.

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.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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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:

- The proportion of ambulance handovers over 4 hours reduced to below 1%.
- This will in part be due to continued use of ambulance handover nurses at both Emergency Departments.
- There has also been a focus on ambulance handovers in preparation for the launch of “withdraw at 45” (W45) on 5th March 2025.

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			
COMMON CAUSE / NATURAL VARIATION		* Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside * 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

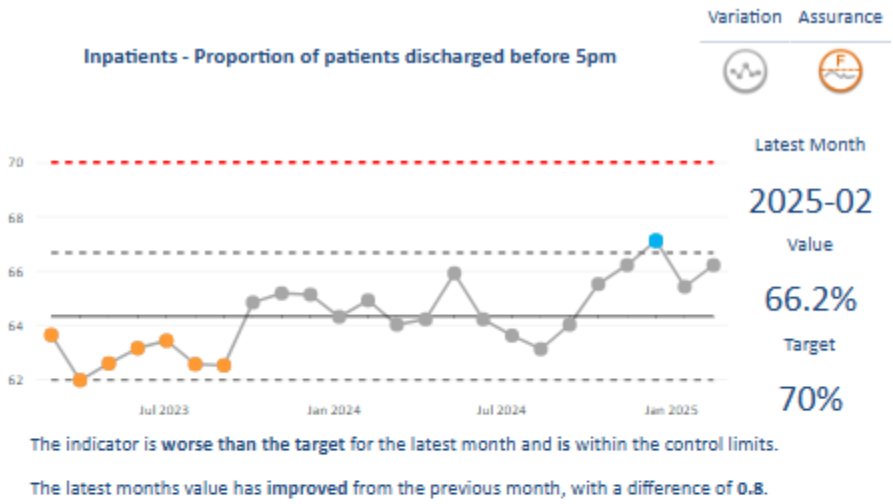
York and Scarborough Teaching Hospitals NHS Foundation Trust

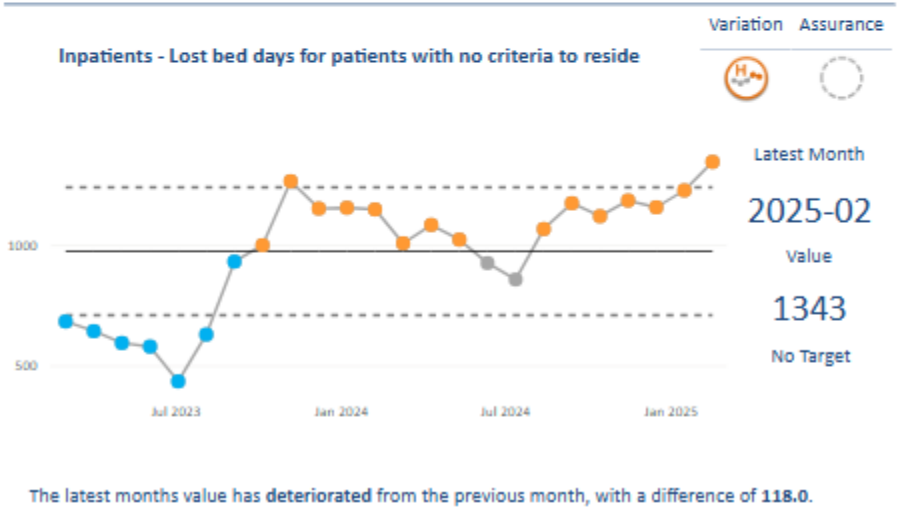
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2025-02		F	79.6%		90%
Patients with Senior Review completed at 23:59	2025-02			48.3%		
Inpatients - Proportion of patients discharged before 5pm	2025-02		F	66.2%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2025-02	H		1343		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2025-02		?	17.9%	17.5%	15.1%
Number of non-elective admissions	2025-02	H	?	7175	6309	6953
Number of zero day length of stay non-elective admitted patients	2025-02		?	2293	1876	2073
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2025-02		F	130	100	96
Overnight general and acute beds open	2025-02		?	889	838	838
Of those overnight general and acute beds open, proportion occupied	2025-02		?	92.5%		92%
Community bed occupancy/availability	2025-02		?	90.5%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

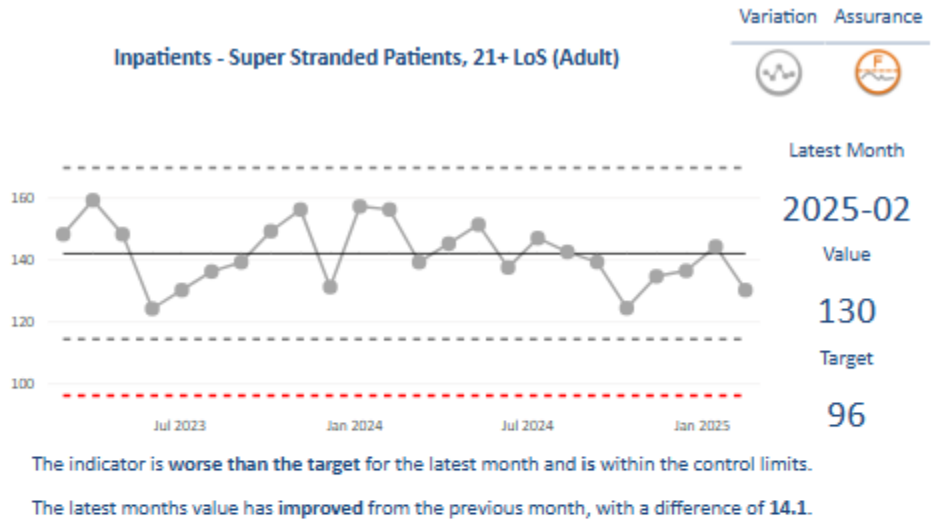
Actions:

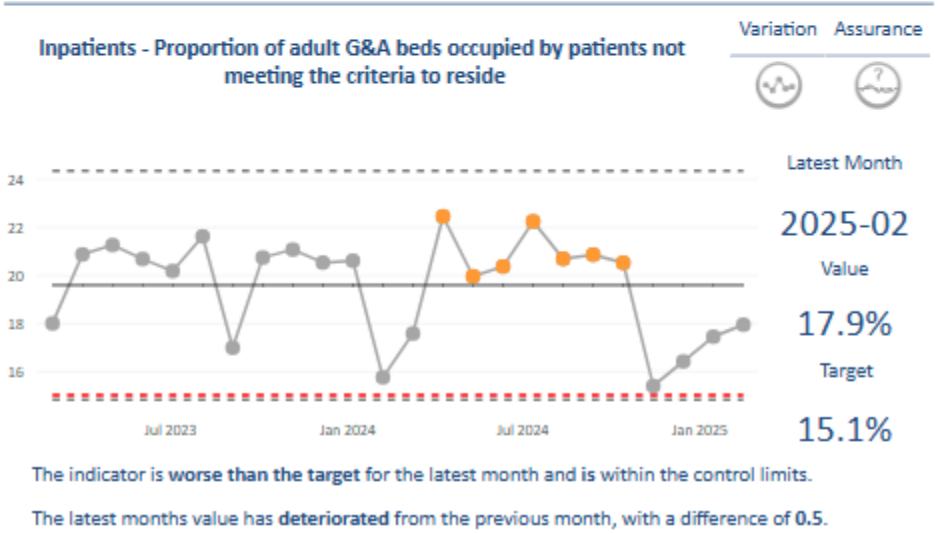
- The Discharge Sprint team has been working with eight wards throughout February to support with effective board rounds. As part of the Sprint work they have been encouraging a focus on the timeliness of discharges. The team has this data at ward level and are monitoring changes; a full review will be carried out in April 2025 to determine next steps.

- Lost bed days for patients with no criteria to reside has been increasing since July 2024 despite a significant drop since then in the proportion of patients not meeting the criteria to reside. The lost bed days figure is cumulative so delays to discharging patients to a more appropriate care setting will translate to a continued increase in this figure.

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).

Actions:

- The number and proportion of super-stranded patients recovered slightly in February 2025. To support further reductions, the Medicine Care Group plans to develop consistent Long Length of Stay reviews. The team is limited by clinical capacity to lead these given the number of priority actions underway.
- During the week to 2nd March 2025 the average percentage of super-stranded occupancy had fallen again to 14.9% against a North East and Yorkshire average of 19.3%. In the same week, the average percentage of patients with no criteria to reside fell again to 13.1%.
- Both City of York and North Yorkshire local authorities are establishing Discharge to Assess (D2A) models for Pathway 1 patients.

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

The Cancer performance figures for January 2025 saw a dip in the 28-day Faster Diagnosis standard (FDS) to 62.2% (compared to 72.3% in December). Provisional February position shows an improvement in FDS back to December position of 71%.

62 Day waits for first treatment in January 2025 was 70.6%, an improvement on December 2024 performance (66.4%), above national target and the 2nd highest percentage in 5 months. 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. Draft trajectories have been submitted as part of the 2025/26 planning process, with national targets to achieve 80% FDS and 75% 62-day performance by March 2026.

Factors impacting performance:

- January 2025 saw 2,894 total referrals across all cancer sites in the trust, the highest volume since July 2024. There was an average of 93 referrals per calendar day, compared to 88 average per calendar day in December 24. Seasonal variation, coupled with 3 bank holidays and patient-initiated delays in December, are contributing factors impacting FDS performance and breached pathways in January.
- The following cancer sites exceeded 75% FDS in January 25: Breast, Haematology, None Site Specific and Skin pathways. Skin 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 January: Breast, Haematology and Skin. Gynaecology, Lung, Upper GI and Urology achieved above their internal trajectories
- 31-day treatment standard was 98.3% overall. 294 treatments were delivered in January, in comparison to 270 treatments delivered in December. Urology had the highest volume of treatments delivered (68) and achieved 100%. Skin delivered 62 treatments and Breast delivered 47 treatments, both also achieving 100%.
- At the end of January, the proportion of patients waiting over 104+ days equates to 2% of the PTL size, at 41 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 Urology position also continues to improve, in January 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	
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	* Cancer - Faster Diagnosis Standard * Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result
SPECIAL CAUSE CONCERN			

CANCER
Scorecard

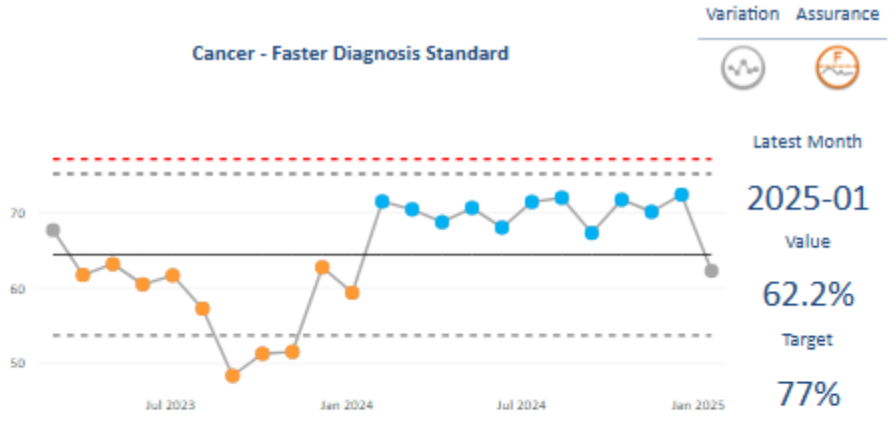
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

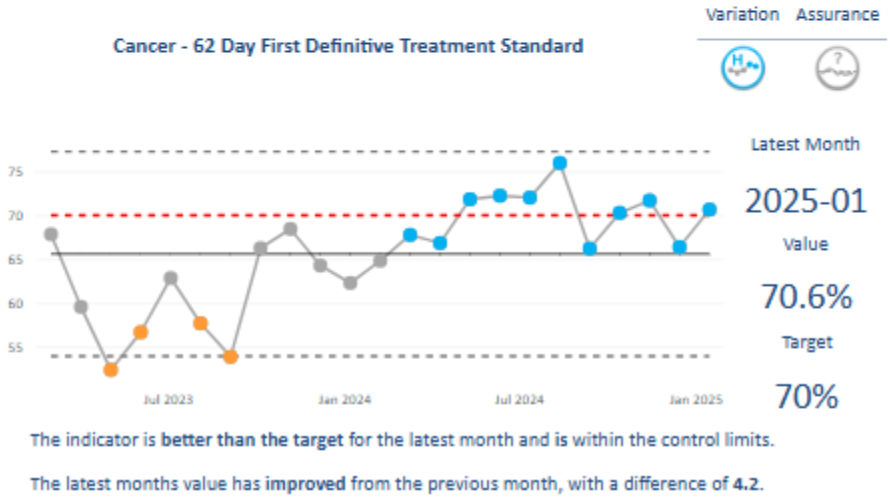
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard	2025-01		F	62.2%	71%	77%
Cancer - 62 Day First Definitive Treatment Standard	2025-01	H	?	70.6%	62.1%	70%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2025-02		?	162	143	143
Proportion of patients waiting 63 or more days after referral from cancer PTL	2025-02		?	7.4%		12%
Cancer 31 day wait from diagnosis to first treatment	2025-01		?	98.6%		96%
Total Cancer PTL size	2025-02	L		2112		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2025-02		F	74.8%		80%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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:

- Planning for 2025-26 underway with national cancer planning pack released early February and draft improvement trajectories at tumor site and cumulative trust level submitted, compliant with national targets of 80% FDS and 75% 62-day standard by March 2026. 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.

- 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 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. Provisional FDS position in February suggests highest FDS performance month ever in Urology.

- 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. An update will be provided at Trust March Cancer Board, including FiT referrals and percentage of colonoscopies performed without Fit/Fit <10. Gynaecology session took place and actions being worked through at pace to increase hysteroscopy capacity. Urology reviewing actions from improvement plan and progressing options around a STT model for a cohort of haematuria patients.

Headlines:

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

At the end of February 2025, the Trust had fifty 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, 44,325 against the trajectory of 44,957.
- 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 53.6% at the end of February 2025 compared to 53.9% at the end of January 2025. 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 were over trajectory for RTT52 weeks; 1,181 against the February 2025 trajectory of 1,018. 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.
- All of the above metrics were impacted by ongoing validation work on the Outpatient PTL, resulting in circa 2,000 additional RTT clocks being opened in February. There are no 65week performance risks identified in this work to date.
- Delivery of the 2024/25 elective recovery plan. Initial analysis shows that at the end of February 2025 the Trust is ahead of the 2024/25 activity plan with a provisional performance of 124% of the Weighted Value Trust Activity Plan submitted to NHSE. From a financial point of view this equates to a provisional performance of 119% 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

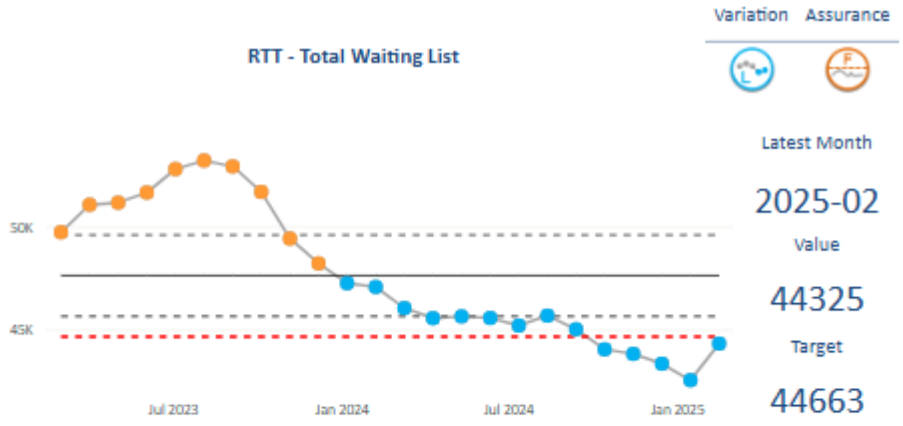
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

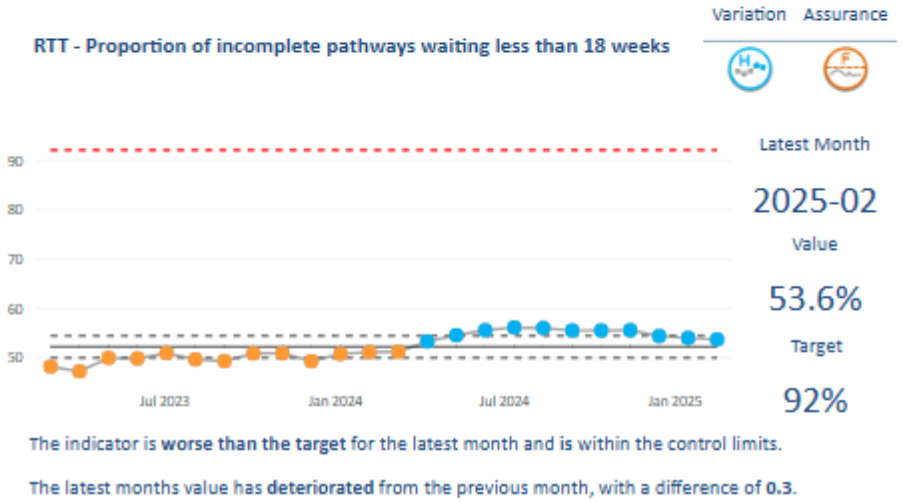
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List	2025-02			44325	44957	44663
RTT - Waits over 78 weeks for incomplete pathways	2025-02			0	0	0
RTT - Waits over 65 weeks for Incomplete Pathways	2025-02			50	0	0
RTT - Waits over 52 weeks for Incomplete Pathways	2025-02			1181	1018	923
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-02			53.6%		92%
RTT - Mean Week Waiting Time - Incomplete Pathways	2025-02			18.8		
Proportion of BAME pathways on RTT PTL (S056a)	2025-02			1.8%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2025-02			12.1%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2025-02			66.4%		

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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.

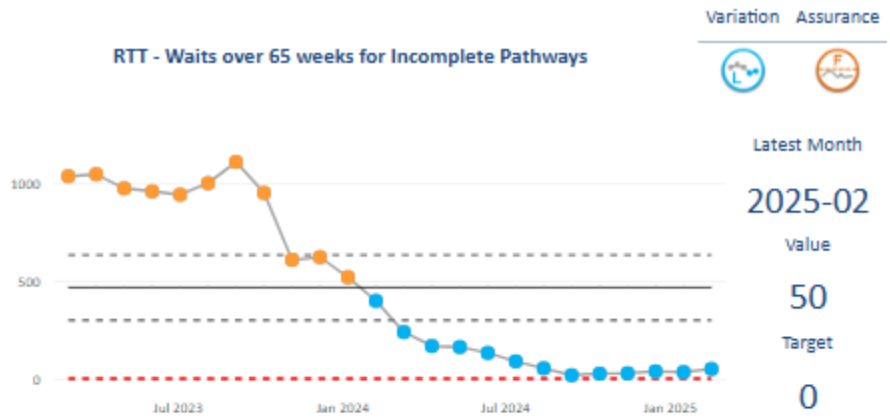
- The Trust is part of cohort 2 of the national Further Faster (FF) Programme, several specialties perform well against the key metrics including the did not attend (DNA) rate, pre-referral triage and advice and guidance. The Trust has been seen a 70.6% improvement since July 23 (baseline month) against 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%.

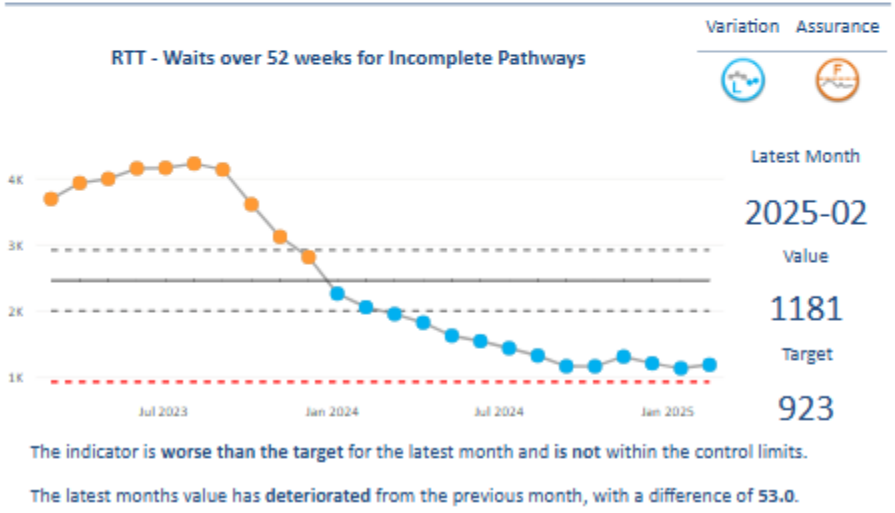
- 2024/25 Elective Recovery plan continues with the below workstreams. The 2025/26 plan is being developed with a greater focus on productivity and efficiency.

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

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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 and February 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 February 2025, the Trust was 163 behind the trajectory (1,181 against 1,018). The Total waiting List Position was impacted by the ongoing data quality work on the Outpatient PTL which led to circa 2,000 RTT clocks being opened in February.
- Mutual aid and independent sector capacity for Neurology identified. Insourcing clinics began in February 2025 providing 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%.

Health Inequalities

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile

At end of: **February 2025**

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	19	5201	12.13%	8.88%
2	19	6093	14.21%	13.59%
3	19	8915	20.79%	20.94%
4	19	9406	21.93%	20.68%
5	19	13275	30.95%	35.90%
Unknown	17	1435		
Total	**19**	**44325**		

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: **February 2025**

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	19	29102	98.22%	94.34%
Black, Black British, Caribbean or African	18	78	0.26%	0.94%
Mixed or multiple ethnic groups	19	148	0.50%	1.26%
Asian or Asian British	20	211	0.71%	2.97%
Other ethnic group	18	89	0.30%	0.49%
Unknown	19	11760		
Not Stated	19	2937		
Total	**19**	**44325**		

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 - DNA rates * Outpatients: 1st Attendances (Activity vs Plan)	
COMMON CAUSE / NATURAL VARIATION	* Outpatient procedures * Proportion of elective admissions which are day case	* 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)	2025-02		F	20.7%		25%
Outpatients - DNA rates	2025-02	L	?	4.2%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2025-02	H	?	18334	17732	19723
Outpatients: Follow Up Attendances (Activity vs Plan)	2025-02		?	42762	41229	45738
Outpatient procedures	2025-02		P	13894	7103	7884
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2025-02	H	F	26828		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2025-02		F	3.8%	4.9%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2025-02	L	F	24.8%		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*	2025-02		?	9		0
Day Cases (based on Activity v Plan)	2025-02		?	7234	6330	7037
Electives (based on Activity v Plan)	2025-02		?	650	523	576
Proportion of elective admissions which are day case	2025-02		P	91.8%		85%

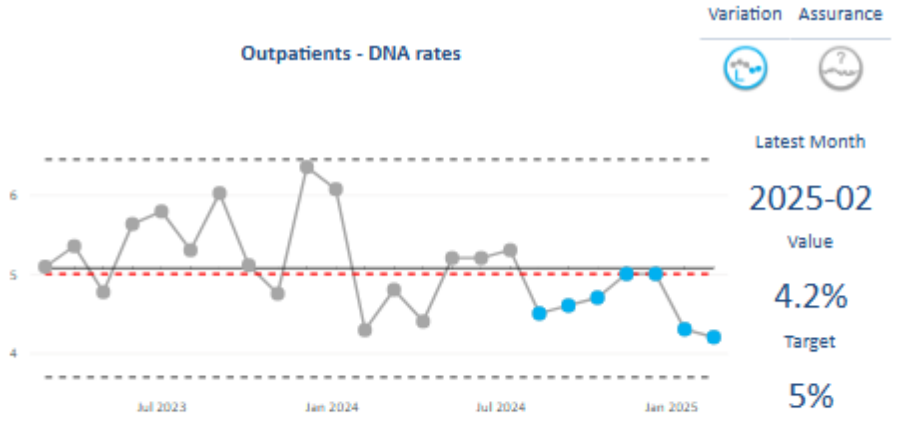
KPIs – Operational Activity and Performance

Outpatients (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

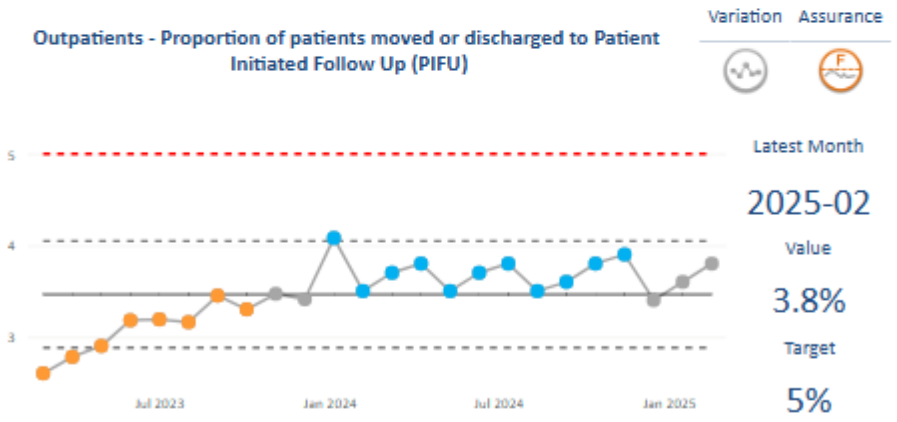
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

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



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 which stand at 4.2% in February 2025, the lowest rate in over 2 years.

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. Significant improvements have been seen in the surgery and cancer, specialist and clinical support services care group. Further work planned for the medicine and family health care groups.
- The Trust delivered the NHSE planning priority of 46% of first and outpatient procedures as a proportion of all outpatient activity in February 2025, with 51%. Year to date the Trust has achieved performance of 53%.
- The medicine care group has an improvement plan to address the waiting times for patients awaiting rapid access chest pain clinic. Improvement seen in February 2025.

Headlines:
The February 2025 Diagnostic target position for patients waiting less than six weeks at month end was 73.5%, against the trajectory of 86.5%. The Trust saw the following modalities achieve their trajectories at month end:

- Flexi-Sigmoidoscopy
- Echo-cardiography

Factors impacting performance:

- Performance has begun to see a recovery following the seasonal decline in performance in December and January due to patient choice and reduced capacity over the Christmas period.
- CT performance is being largely driven by cardiac CT backlog. Equipment issues with breakdown of CT1 and CT3 in January impacted ability to deliver activity.
- MRI has seen a reduction in performance due to increased fast track and RTT >52 week wait escalations, staffing gaps, a reduction in the capacity Nuffield can support with and an increase in GA/acute demand which takes up more scanner capacity. Image quality provided by CDC mobiles limits cohort of studies which can be scanned.
- NOUS (non-obstetric ultrasound) backlog due to specialist nature (MSK) – difficulty securing an MSK locum to support with backlog reduction so far, but discussions commenced with a locum MSK sonographer.
- Reporting demand continues to outstrip capacity. Reliance on in-house radiologist insourcing and outsourcing to external providers.
- Workforce challenges continue within Cardiology for healthcare scientists.
- Gastroenterology consultant workforce challenges at Scarborough impacting ability to deliver planned lists. Locum has been recruited to cover acute and elective endoscopy. The York team provide cross site cover as required.
- Nurse staffing at York has also been behind plan due to a mix of vacancies and sickness meaning rate of recovery at York has slowed.

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 - Sleep studies * 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 - DEXA Scan * Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography * 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 - Urodynamics
SPECIAL CAUSE CONCERN			* Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology

DIAGNOSTICS – National Target: 95%

Scorecard

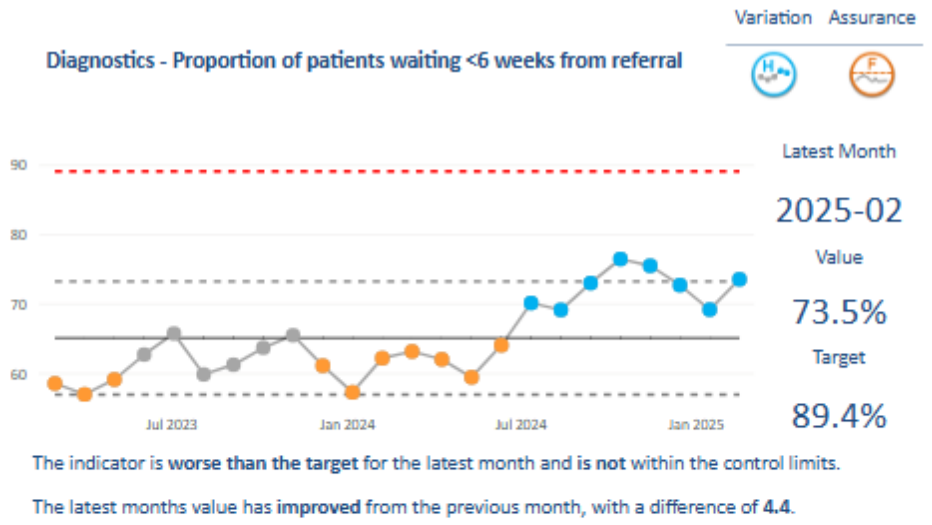
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-02	H	F	73.5%	86.5%	89.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2025-02	H	F	75.3%	82.7%	85%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2025-02		F	70.8%	83.4%	85%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2025-02		F	72.6%	93.5%	95%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2025-02		?	77.8%	92.4%	95.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2025-02	H	F	74.9%	89.9%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2025-02	L	F	44.8%	94.2%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2025-02	H	F	94.3%	90.6%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2025-02		?	97.6%	95.2%	95.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2025-02	H	?	86.8%	95.6%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2025-02		F	43.9%	63.5%	70.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2025-02	H	F	83.2%	85.9%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2025-02	H	?	83.9%	53%	52.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2025-02		?	76.7%	93.1%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2025-02		?	80.8%	83.2%	84.8%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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Rationale: Maximise diagnostic activity focused on patients of highest clinical priority.
Target: Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%.

Actions:

Endoscopy:

- Gastroenterology have recruited to the East Coast and the new consultant is due to start in April.
- 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.
- 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, anticipated to be in place 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.
- Recovery plan agreed with Dexa radiographer principal to reduce backlog of Dexa imaging. Field safety notice still in place but only impacts on a small cohort of patients. Dexa radiographers asked to protect scan capacity.
- CT – independent sector, mobiles and WLIs have reduced the backlog of non cardiac CT waiters on both sites. UEC CT scanner due to open end of April at Scarborough with the new static CT scanner opening at Scarborough CDC in June. These new scanners support more efficient scanning than the existing CT1 in use for elective CT on the East Coast. Work completed with independent sector mobile provider to offer contrast imaging at Bridlington site which supports backlog reduction whilst awaiting the CDC opening.
- Locum advertisements submitted to medical staffing to try to get increased medical cover for MSK USS to clear the backlog. Increased in MSK USS lists planned for April once works completed on second USS room at Askham Bar. MSK sonographer training being supported to take on soft tissue ultrasound from MSK backlog
- Insourced reporting trial via cancer alliance funding has reduced reporting time for patients on a cancer pathway on average by 2 days.

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)

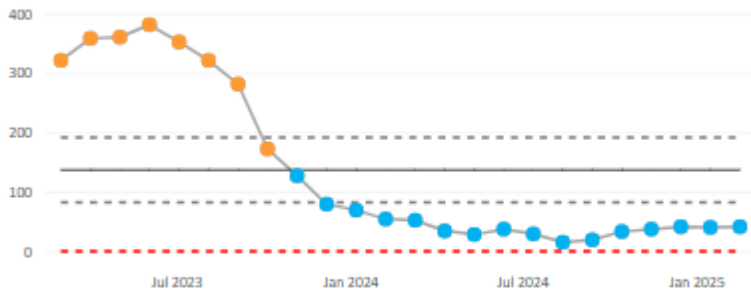
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2025-02			4		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2025-02			81%	95%	95%
Children & Young Persons: RTT - Total Waiting List	2025-02			3566		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-02			59.3%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2025-02			41	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



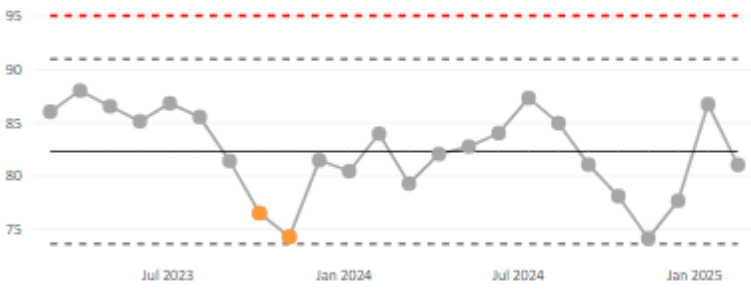
Latest Month
2025-02
Value
41
Target
0

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

The latest months value has **deteriorated** from the previous month, with a difference of **1.0**.

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

Variation Assurance



Latest Month
2025-02
Value
81%
Target
95%

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

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

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 41 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 deteriorated from 86.7% in January 2025 to 81% in February.

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 ran significant volumes of 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

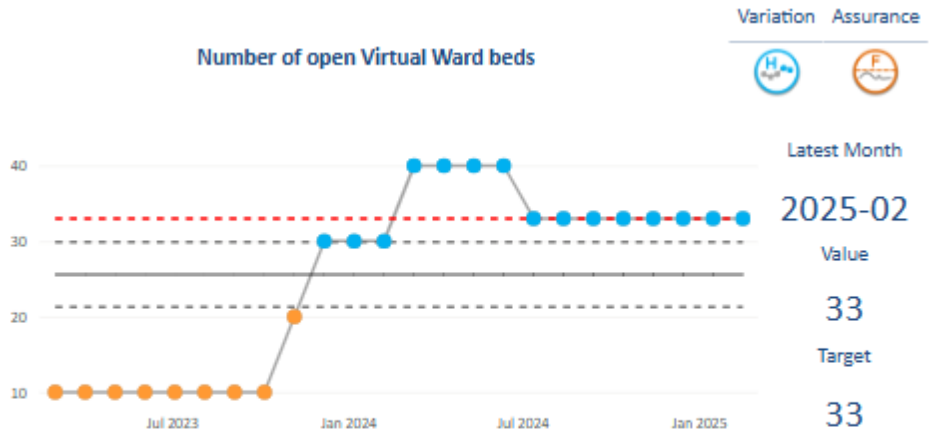
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-02	H	F	33		33
Proportion of Virtual Ward beds occupied	2025-02		?	60.6%		80%
Community Response Team (CRT) Referrals	2025-02	H		494		
Total Urgent Community Response (UCR) referrals	2025-02	H		472		
2-hour Urgent Community Response (UCR) care Referrals	2025-02	H		131		
2-hour Urgent Community Response (UCR) Compliancy %	2025-02		P	84.7%		70%
Number of Adults (18+ years) on community waiting lists per system	2025-02			813		
Number of CYP (0-17 years) on community waiting lists per system	2025-02	L		1911		
Number of District Nursing Contacts	2025-02			19782		
Number of Selby CRT Contacts	2025-02			2032		
Number of York CRT Contacts	2025-02	L		3628		
Referrals to District Nursing Team	2025-02			2122		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2025-02	L	P	708	1056	1056

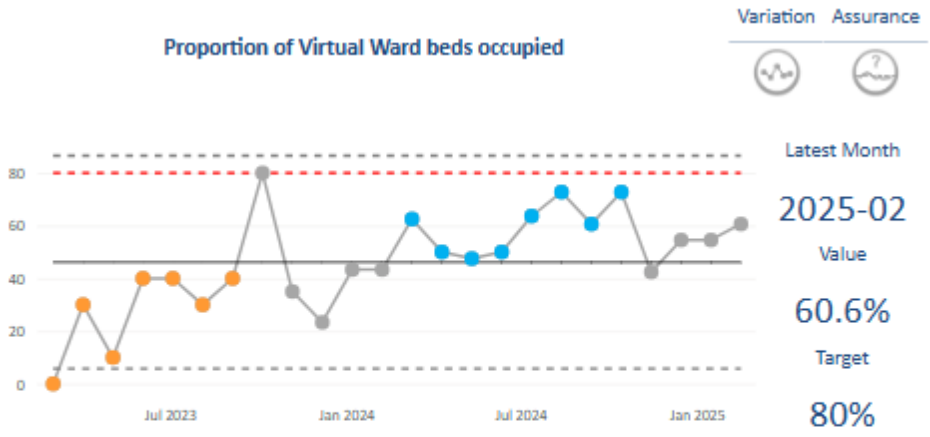
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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**.



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 **6.0**.

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.

The ambition for the virtual ward utilisation rate is 80%; at the most recent snapshot occupancy was 60.6%.

- **Frailty Virtual Ward (FVW):** The team was unsuccessful in the recruitment of a second trust grade medic and so are going back to recruitment and hoping to expand in Q2.
- GIRFT recently undertook a review of the frailty pathway and their report has been received. The key recommendation is spreading the core FVW team to cover 7 days (currently the weekends is a shared care model with CRT) which it is hoped can be enabled through the recruitment of the second trust grade. Other workforce options are being considered. This will then provide a resilient model to spread to cover 7 days in continued partnership with CRT.
- IV antibiotic pathway development also recommended by GIRFT. Rachel Davidson is leading the conversation with Microbiology team. Skills development for nursing staff underway.
- Humber's Frailty Virtual Ward which supports Scarborough patients has had occupancy rates of over 80%, at times reaching 100% since the new year.

- **Heart Failure (HFVW):** The next phase of the in-reach model at York ED is to use charitable funds to appoint a 0.8WTE Band 7 nurse to expand the service. Recruitment activities are underway.
- A follow up meeting with the GIRFT virtual ward team has been scheduled.

- **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. A meeting is being set up to learn from the vascular team about the benefits (and any disbenefits) experienced through this approach with the hope of other specialties becoming interested in the model.

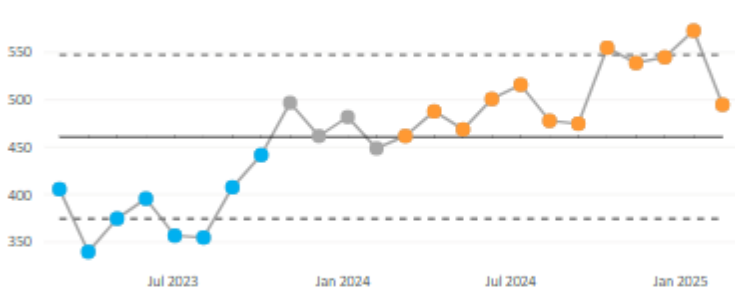
- **Cystic Fibrosis (CFVW):** Some patients benefit from staying at home during a period of being acutely unwell, and the system is set up to allow this model of care and oversight for up to three patients at a time. There is not 'spare' capacity, the pre-existing team work in a different way to support appropriate patients, and numbers will remain low due to the niche criteria.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

Community Response Team (CRT) Referrals

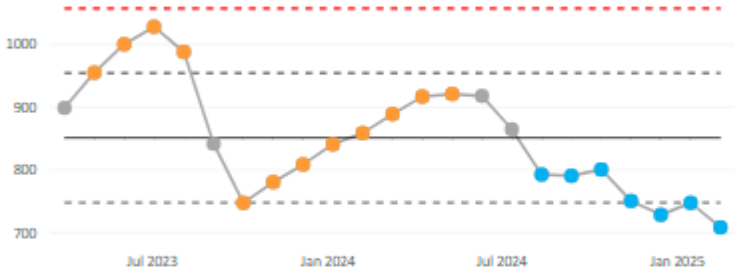


Latest Month
2025-02
Value
494
No Target

The latest months value has **improved** from the previous month, with a difference of **78.0**.

Variation Assurance

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



Latest Month
2025-02
Value
708
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 **improved** from the previous month, with a difference of **39.0**.

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. Recruitment following business case approval has been successful.
- **SPC2:** Plan for OT service in place to deliver improvement from January 2025. The 'let's make sense together' initiative commenced in February 2025.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

March 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)

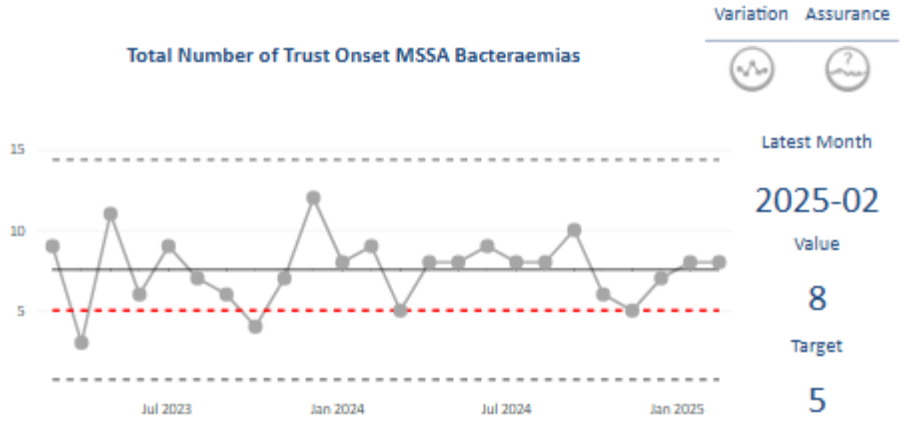
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-02			8	4	5
Total Number of Trust Onset MRSA Bacteraemias	2025-02			1		0
Total Number of Trust Onset C. difficile Infections	2025-02			9	9	10
Total Number of Trust Onset E. coli Bacteraemias	2025-02			16	11	13
Total Number of Trust Onset Klebsiella Bacteraemias	2025-02			6	4	4
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2025-02			1		2
Pressure Ulcers per thousand Bed Days	2025-02			3.5		
Patient Falls per thousand Bed Days	2025-02			6.4		8.7
Medication incidents per thousand bed days	2025-02			4.8		

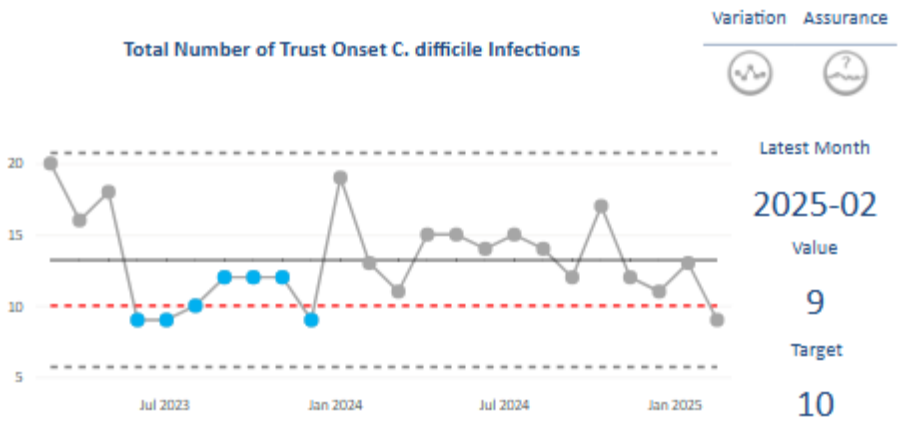
Executive Owner: Dawn Parkes

Operational Lead: Sue Peckitt



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 **improved** from the previous month, with a difference of **4.0**.

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

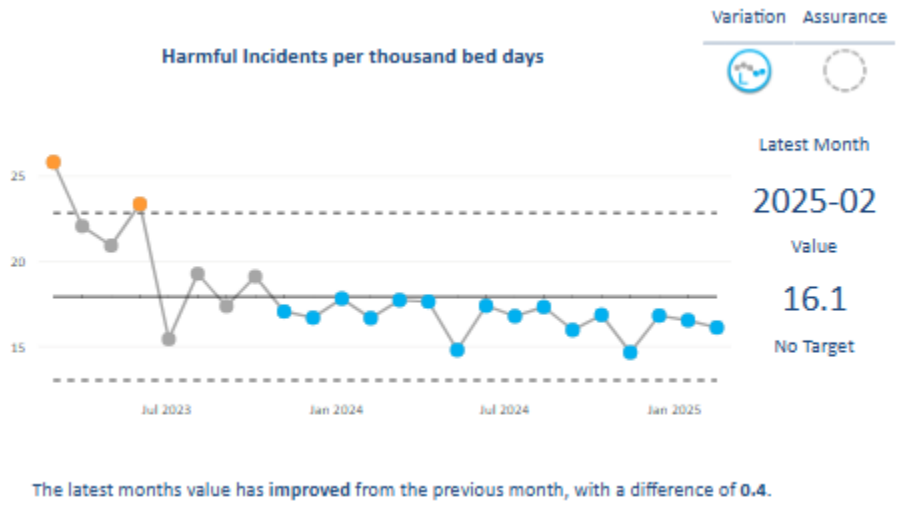
Quality & Safety
Scorecard (2)

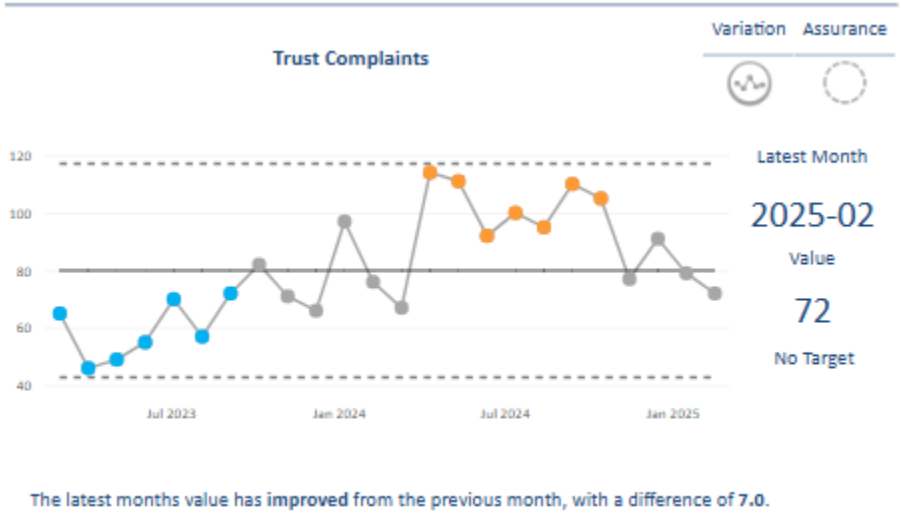
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2025-02			50.5		
Harmful Incidents per thousand bed days	2025-02			16.1		
Total Number of Never Events Reported	2025-02			0		0
In-Hospital Deaths	2025-02			200		
Quarterly SHMI	2024-09			96.1		100
Monthly SHMI	2024-10			92.4		100
Quarterly HSMR	2024-09			113		100
Monthly HSMR	2024-11			124.2		100
Trust Complaints	2025-02			72		
Antepartum Stillbirths	2025-01			0		
Intrapartum Stillbirths	2025-01			0		
Early neonatal deaths (0-7 days)	2025-01			2		
PPH > 1.5L as % of all women - York	2025-01			5.2%		
PPH > 1.5L as % of all women - Scarborough	2025-01			3%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2025-01			61.1%		

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





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:

Harmful Incidents per 1000 bed days:

The SPD chart demonstrates that there is no special cause reported. The number of incidents has remained below the mean for 12 months.

On this basis we now need to recalculate the control limits to understand where further standardisation and improvement needs to be made.

Throughout the winter period acuity and dependency increased however the number of reported incidents (All incidents) has remained stable. We have not seen an increase in the level of harmful incidents as a proportion of all incidents.

Factors impacting performance:

The number of new complaints remains high with a slight reduction 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:

In line with our 2025/26 priorities and national guidance, we have pledged to reduce current ambulance handover times. Together with the Yorkshire Ambulance Service, we are launching the "Withdraw at 45" (W45) initiative from March 2025, at which time the maximum handover time should be 80 minutes.

Work is underway to relieve the pressures in ED, to improve patient flow and therefore improve patient experience. This is complimented by the Discharge Sprint which also looks to ensure there is effective communication with patients, carers and families. Baseline data through a patient survey has been undertaken against which improvements will be monitored. We anticipate this should help reduce complaints.

To support Investigating Officers in managing and responding to complaints, we have refined our complaint management training so that with effect from Q1 2025/26 complaints training will be delivered through the training offered by the Parliamentary and Health Service Ombudsman and we are commissioning complaints letter writing skills training with an external provider.

In response to the theme of staff attitude being a theme of complaints, we are planning customer service skills training for both clinical and administrative staff. This will be delivered in Q1 2025/26.

To support improvements in communications with patients and carers three wards have implemented bedside handovers, resulting in enhanced communication and improved patient experience. This is being evaluated with the intent to extend it to other wards across the Trust in the forthcoming months.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

March 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 * Anaesthetic cover on L/W - Scarborough
SPECIAL CAUSE CONCERN		* SCBU no of babies affected - Scarborough	* Planned homebirths - Scarborough * Homebirth service suspended - Scarborough

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 * Cold babies - Scarborough * Preterm birth rate <37 weeks - Scarborough * Preterm birth rate <34 weeks - Scarborough * Preterm birth rate <28 weeks - Scarborough	
SPECIAL CAUSE CONCERN			

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	2025-01			44.4%		57%	Target
Assisted Vaginal Births - Scarborough	2025-01			9.3%		12.4%	Target
C/S Births - Scarborough	2025-01			45.4%		41.7%	Baseline
Elective caesarean - Scarborough	2025-01			16.7%		18.1%	Baseline
Emergency caesarean - Scarborough	2025-01			28.7%		23.6%	Baseline
Induction of labour - Scarborough	2025-01			49.5%		44.2%	Baseline
HDU on L/W - Scarborough	2024-12			1		5	Target
BBA - Scarborough	2025-01			1		2	Target
HSIB cases - Scarborough	2025-01			0		0	Target
Neonatal Death - Scarborough	2025-01			0		0	Target
Antepartum Stillbirth - Scarborough	2025-01			0		0	Target
Intrapartum Stillbirths - Scarborough	2025-01		P	0		0	Target
Cold babies - Scarborough	2025-01			0		1	Target
Preterm birth rate <37 weeks - Scarborough	2025-01			5.6%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2025-01			2.8%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2025-01			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	
COMMON CAUSE / NATURAL VARIATION	* 3rd/4th Degree Tear - normal births - Scarborough * 3rd/4th Degree Tear - assisted birth - Scarborough	* Low birthweight rate at term (2.2kg) - Scarborough * Breastfeeding rate at discharge - 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	* Carbon monoxide monitoring at 36 weeks - Scarborough
SPECIAL CAUSE CONCERN			

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	2025-01			0%		0%	Target
Breastfeeding Initiation rate - Scarborough	2025-01	H		81.5%		75%	Target
Breastfeeding rate at discharge - Scarborough	2025-01			60.4%		65%	Target
Smoking at booking - Scarborough	2025-01			8.8%		6%	Target
Smoking at 36 weeks - Scarborough	2025-01			6.5%		6%	Target
Smoking at time of delivery - Scarborough	2025-01			6.7%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2025-01			97.3%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2025-01		F	78%		95%	Target
SI's - Scarborough	2023-10			1		0	Target
PPH > 1.5L as % of all women - Scarborough	2025-01			3%		2.1%	Baseline
Shoulder Dystocia - Scarborough	2025-01			1		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2025-01		P	1%		2.8%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2025-01		P	0%		6.1%	Target
Informal Complaints - Scarborough	2025-01			0		0	Target
Formal Complaints - Scarborough	2025-01			0		0	Target

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	2025-01		P	113		169	Target
Bookings <10 weeks - Scarborough	2025-01		F	65.5%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2025-01		?	2.7%		10%	Target
Births - Scarborough	2025-01		?	108		113	Target
No. of women delivered - Scarborough	2025-01		?	105		112	Target
Planned homebirths - Scarborough	2025-01	L	F	0%		2.1%	Target
Homebirth service suspended - Scarborough	2025-01	H	F	24		3	Target
Women affected by suspension - Scarborough	2025-01		?	0		0	Target
Community midwife called in to unit - Scarborough	2025-01	L	P	0		3	Target
Maternity Unit Closure - Scarborough	2025-01		?	2		0	Target
SCBU at capacity - Scarborough	2025-01		?	4		0.7	Baseline
SCBU at capacity of intensive care cots - Scarborough	2025-01		?	11		4.6	Baseline
SCBU no of babies affected - Scarborough	2025-01	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2025-01		?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2024-12		?	95.1%		100%	Target
Anaesthetic cover on L/W - Scarborough	2025-01		F	5		10	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		* Homebirth service suspended - York * 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 * 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	2025-01			310		295	Target
Bookings <10 weeks - York	2025-01			71%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2025-01		P	3.5%		10%	Target
Births - York	2025-01			233		245	Target
No. of women delivered - York	2025-01			229		242	Target
Planned homebirths - York	2025-01			1.3%		2.1%	Target
Homebirth service suspended - York	2025-01	L		4		3	Target
Women affected by suspension - York	2025-01			0		0	Target
Community midwife called in to unit - York	2025-01			0		3	Target
Maternity Unit Closure - York	2025-01			0		0	Target
SCBU at capacity - York	2025-01	L		0		0.2	Baseline
SCBU at capacity of intensive care cots - York	2025-01			28		21.9	Baseline
SCBU no of babies affected - York	2025-01	L		0		0	Target
1 to 1 care in Labour - York	2025-01			100%		100%	Target
L/W Co-ordinator supernumerary % - York	2024-12			100%		100%	Target
Anaesthetic cover on L/W - York	2025-01		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 * C/S 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			

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	2025-01			55.8%		57%	Target
Assisted Vaginal Births - York	2025-01			9.9%		12.4%	Target
C/S Births - York	2025-01			33.9%		35.5%	Baseline
Elective caesarean - York	2025-01			14.2%		14.6%	Baseline
Emergency caesarean - York	2025-01			19.7%		20.8%	Baseline
Induction of labour - York	2025-01			42.4%		45.2%	Baseline
HDU on L/W - York	2023-10			8		5	Target
BBA - York	2025-01			2		2	Target
HSIB cases - York	2025-01			0		0	Target
Neonatal Death - York	2025-01			2		0	Target
Antepartum Stillbirth - York	2025-01			0		0	Target
Intrapartum Stillbirths - York	2025-01		P	0		0	Target
Cold babies - York	2025-01			0		1	Target
Preterm birth rate <37 weeks - York	2025-01			6%		6%	Target
Preterm birth rate <34 weeks - York	2025-01			3%		2%	Target
Preterm birth rate <28 weeks - York	2025-01			0.9%		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	2025-01			0%		0%	Target
Breastfeeding Initiation rate - York	2025-01	H	P	88.8%		75%	Target
Breastfeeding rate at discharge - York	2025-01			69.4%		65%	Target
Smoking at booking - York	2025-01			3.9%		6%	Target
Smoking at 36 weeks - York	2025-01			3.6%		6%	Target
Smoking at time of delivery - York	2025-01			5.2%		6%	Target
Carbon monoxide monitoring at booking - York	2025-01			91%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2025-01	H	F	74.4%		95%	Target
SI's - York	2023-10			2		0	Target
PPH > 1.5L as % of all women - York	2025-01			5.2%		4.3%	Baseline
Shoulder Dystocia - York	2025-01			2		2	Target
3rd/4th Degree Tear - normal births - York	2025-01			2.2%		2.8%	Target
3rd/4th Degree Tear - assisted birth - York	2025-01		P	0.9%		6.1%	Target
Informal Complaints - York	2025-01			2		0	Target
Formal Complaints - York	2025-01			5		0	Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

March 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		* Monthly sickness absence * Overall vacancy rate * 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			

Workforce
Scorecard (1)

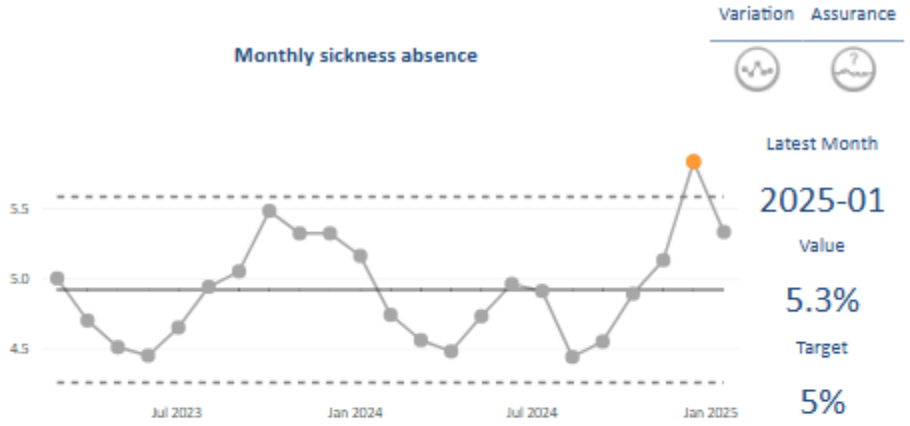
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2025-01			5.3%		5%
Annual absence rate	2025-01			4.9%	4.7%	4.7%
12 month rolling turnover rate Trust (FTE)	2025-02			8.6%		10%
Overall vacancy rate	2025-02			8.8%		6%
HCSW vacancy rate	2025-02			7.9%		5%
Midwifery vacancy rate	2025-02			0.5%		0%
Medical and dental vacancy rate	2025-02			5.8%		6%
Registered Nursing vacancy rate	2025-02			6.3%		5%
AHP vacancy rate	2025-02			7.1%	8.5%	8.5%
Total Agency Whole Time Equivalent Filled	2025-01			130.3		151
Total Bank Whole Time Equivalent Filled	2025-01			646.2		557
OVERALL: Percentage of rosters approved six weeks before start date	2025-01			52.2%		100%
NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent	2025-01			6508.9	0	0
NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)	2025-01			31%	22%	22%

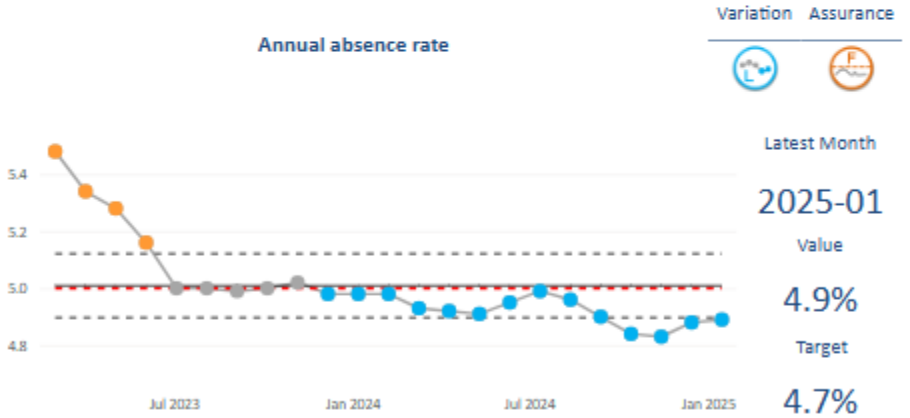
Executive Owner: Polly McMeekin

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 **improved** from the previous month, with a difference of **0.5**.



The indicator is **worse than 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**.

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

Factors impacting performance and actions:

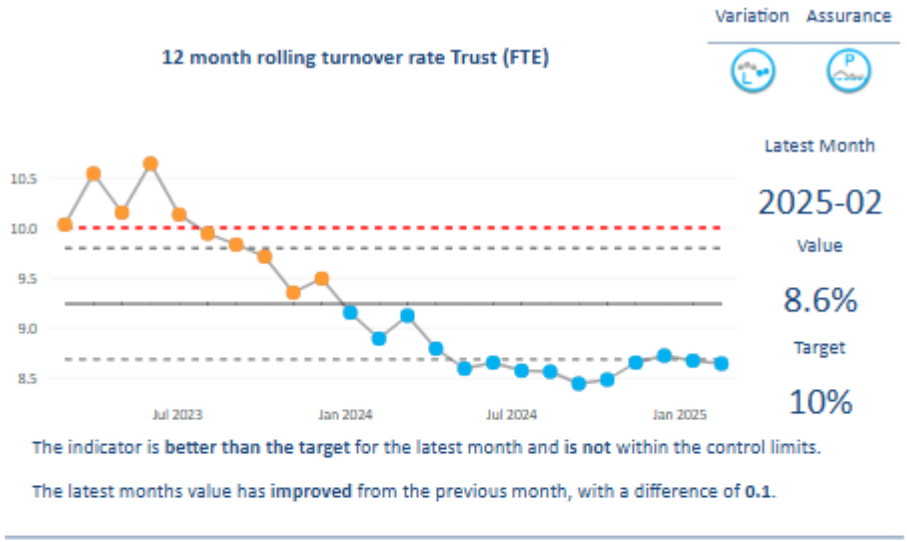
This table below shows a detailed breakdown of reasons for absence in January. It includes the level of WTE lost to each reason and the percentage contribution to total absences. Total absences were reduced by 52 WTE from December.

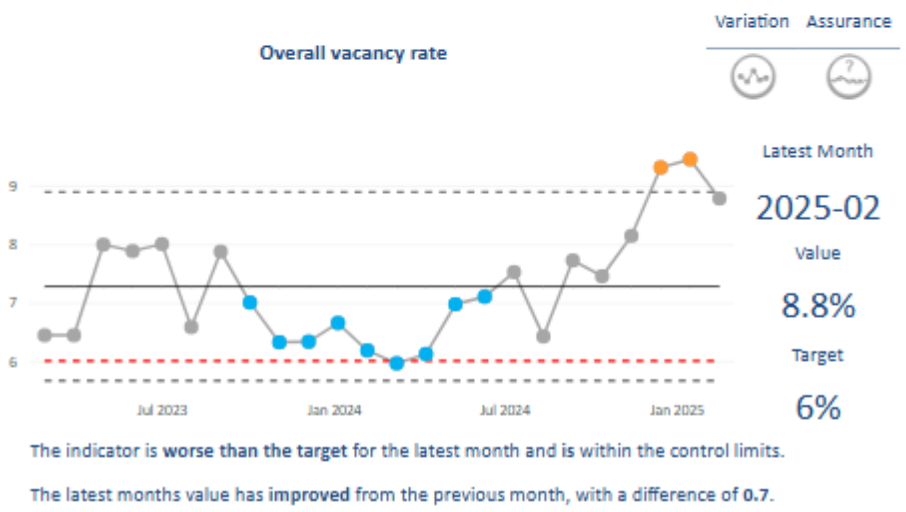
Absence Reason	WTE Lost	%
Anxiety/stress/depression/other psychiatric illnesses	102.09	20.8
Cold, Cough, Flu - Influenza	87.20	17.8
Other (12 reasons each accounting for <=2% of absences)	49.22	10.0
Known causes not classified on ESR	48.30	9.8
Other musculoskeletal problems	44.17	9.0
Gastrointestinal problems	43.38	8.8
Injury, fracture	23.60	4.8
Back Problems	18.93	3.9
Pregnancy related disorders	17.44	3.6
Chest & respiratory problems	16.72	3.4
Headache / migraine	15.42	3.1
Benign and malignant tumours, cancers	12.98	2.6
Genitourinary & gynaecological disorders	11.48	2.3

Anxiety and stress and cold and 'flu remain the two largest causes of staff absence. The 12 causes grouped under the heading "other" includes heart, cardiac and circulatory problems (11.23 WTE), ear, nose, throat (5.75 WTE) and eye problems (4.12 WTE).

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

The embargo on the 2024 Staff Survey results was lifted on 13 March 2025. The Trust's results are available to view alongside the results of other providers in England at www.nhsstaffsurveys.com. The Trust is now working to refresh its Staff Survey action plans.

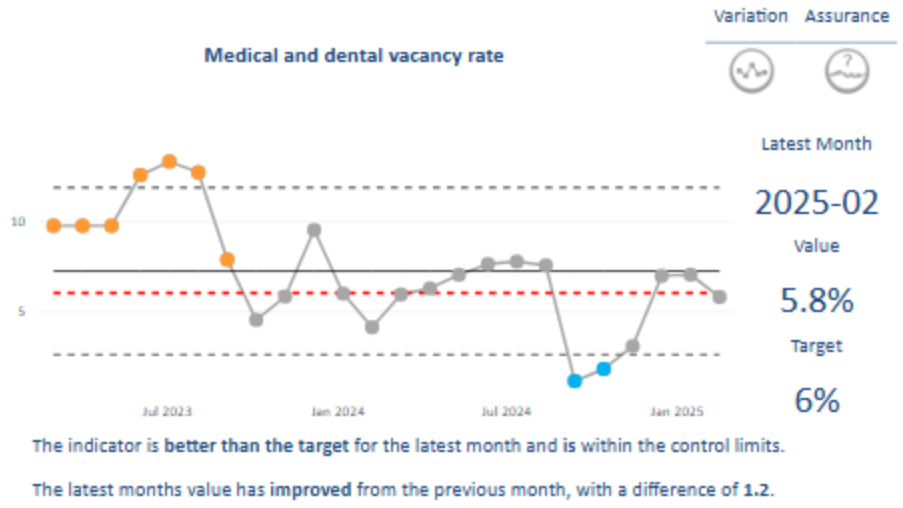
The Trust has received confirmation it has been successful in obtaining funding to support the NHS Stay and Thrive programme. Stay and Thrive targets support to internationally educated colleagues to improve their experiences of work. The funding will be used to facilitate a conference for those interested in developing their careers in the Trust and NHS.

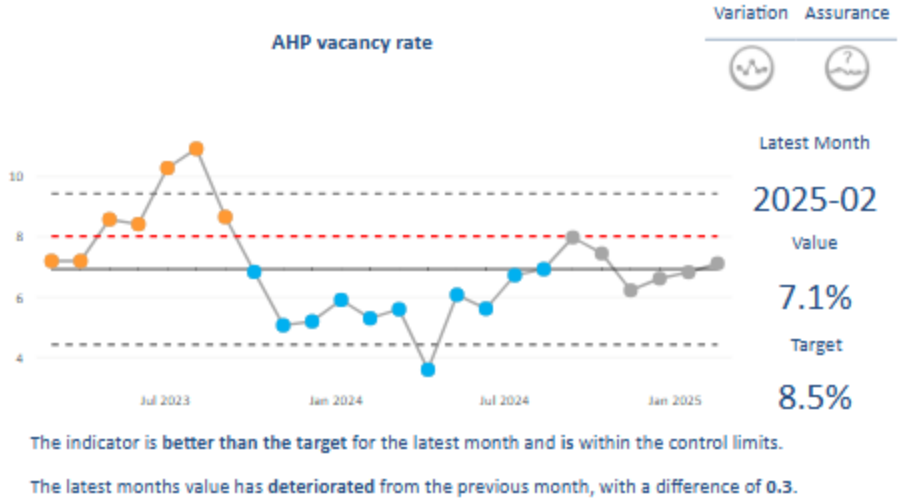
Recruitment restrictions remain in place through the enhanced vacancy control process. At the end of January 2025, the Trust was 1.5% (147 WTE) above its 2024-25 planned workforce size. There was a marked rise in Bank usage from December (55 WTE) linked to winter pressures.

The Trust is in the process of completing its annual plan for 2025-26. The plan aims for a small reduction in workforce size across the year. Growth in substantive staffing (linked primarily to the development of Community Diagnostic Centres and increased activity rates in hospitals) will be exceeded by reductions in temporary workforce (Bank and agency) usage. The push-down on temporary staffing is partly predicated on reducing absence rates from 4.8% to 4.3% and assumes the current low rate of staff turnover is maintained.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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 February, the Trust welcomed seven new medical staff into posts, including one substantive Consultant in Anaesthetics.

In addition, 14 offers of employment in medical posts were made, including seven permanent Consultant posts within Acute Medicine, Dermatology, Anaesthetics, Paediatrics and Trauma and Orthopaedics.

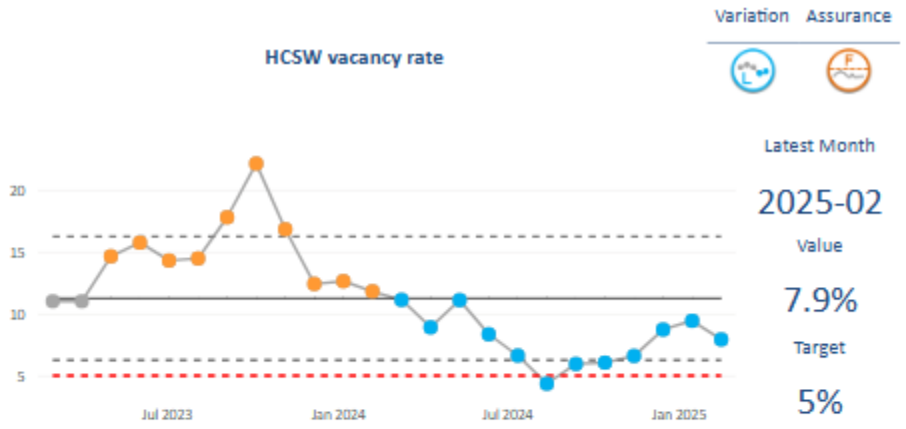
The Trust also welcomed nine internationally educated nurses (the final cohort for 2024-25). This group are the first to be recruited by the organisation after completing the bridging course from the colleges in Kerala, India.

The government has begun to offer automatic settled status to individuals with EU pre-settled status who meet specified criteria. This is welcome news for our EU staff who wish to remain indefinitely within the UK.

The government has also given warning that the cost of an employer's Certificate of Sponsorship will be raised to £525. This is both for new applications and employees who require visa extensions. The cost is currently £239. The increase will be implemented as soon as accompanying legislation has been passed.

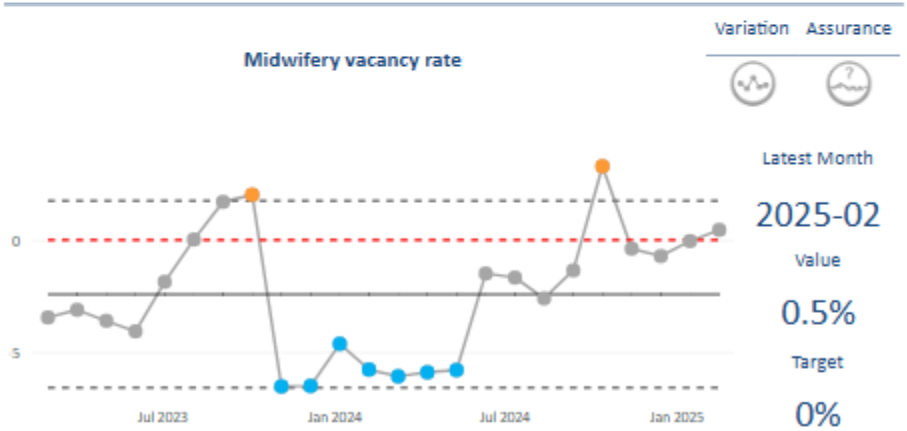
Executive Owner: Polly McMeekin

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 **improved** from the previous month, with a difference of **1.5**.



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 **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 41 WTE HCSWs within the recruitment pipeline, with 23 WTE currently undertaking pre-employment checks. 18 WTE HCSWs are booked onto upcoming Academy programmes.

The Trust is ready to embark on a programme to complete a review of HCSWs' job banding. Recent consultations conducted by UNISON, Royal College of Nursing and Unite the Union resulted in staff accepting a proposal from the Trust to adopt new job descriptions and, where appropriate, provide remuneration for work previously undertaken above the level of roles at Band 2. The outcome follows 12-months of partnership working between the Trust and unions to ensure the workforce is aligned to national job profiles.

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 between January and February have stayed the same with the headcount being 60 and the WTE 55.

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								
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
Jan-25	2599.84	143.44	128.03	333.00	61.53	176.50	74.80	-20.17
HCA								
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
Jan-25	1277.11	121.98	62.43	319.80	135.39	240.80	0.00	56.39
M&D								
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
Jan-25	1106.04	65.44	52.10	160.31	42.77	81.10	56.43	19.99

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.

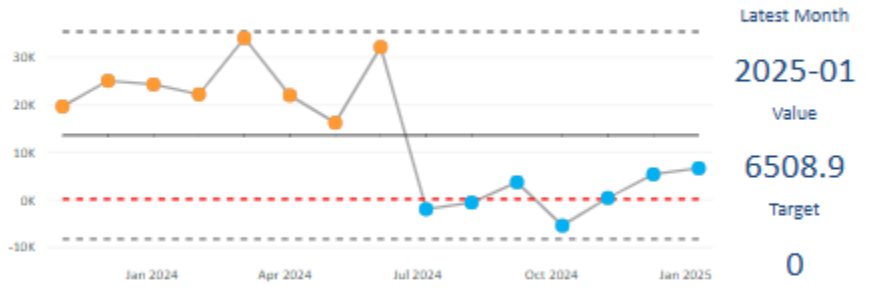
The Trust has relaunched the Medical Temporary Staffing Review Group with representation from the Medical Director's Team, Clinical Directors, Care Group Management, Finance Management and HR teams specialising in medical recruitment and medical bank and agency use. The initial focus of the group is 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. 767 shifts were worked in February which is an increase from the previous month, when 746 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



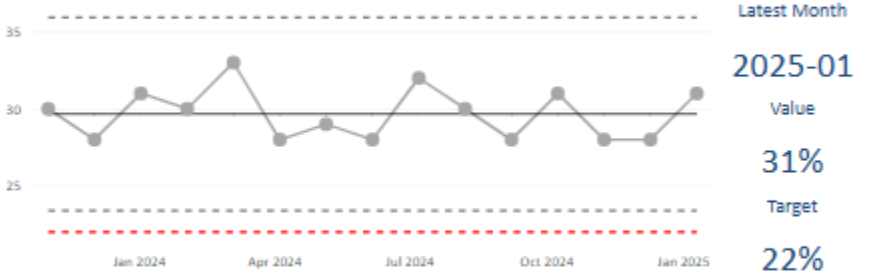
Latest Month
2025-01
Value
6508.9
Target
0

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 **1264.7.**

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

Variation Assurance



Latest Month
2025-01
Value
31%
Target
22%

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 **3.0.**

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 of the NHS England Level of Attainment Standards for eRostering within nursing in-patient ward areas. Work is now underway to replicate this 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 96% of rosters were published on time, with 53% of rosters for non-IPUs, an improvement 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	24%	14	28.51%
Non-IPU's	0%	0	46.78%	51	27.77%
AHPs	0%	0	91.4%	43	27.40%

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	98%
Additional Clinical Services	87%	Healthcare Scientists	32%
Sci and Technical	59%	Medical and Dental	43%
Admin and Clerical	47%	Estates and Ancillary	4%

Workforce
Scorecard (2)

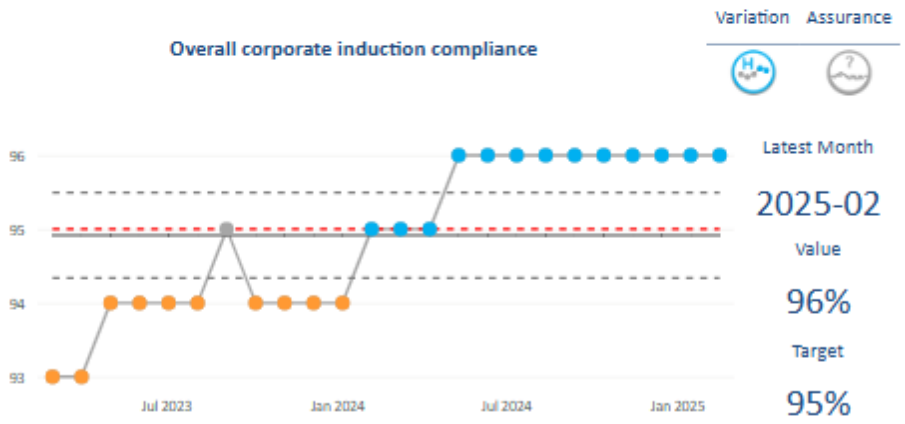
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-02			87%		87%
Overall corporate induction compliance	2025-02			96%		95%
A4C staff stat/mand training compliance	2025-02			89%		87%
A4C staff corporate induction compliance	2025-02			96%		95%
Medical & dental staff stat/mand training compliance	2025-02			74%		87%
Medical & dental staff corporate induction compliance	2025-02			95%		95%
Appraisal Activity	2024-12			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)	2025-01			35.3%		
Percentage recommending the Trust as a place to receive treatment (quarterly - data taken from PULSE, Staff Survey data omitted for Q3)	2025-01			32.7%		

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.

In February, the Government announced the first of several planned changes to the apprenticeship regime. The initial changes will see Level 2 Maths and English, which are currently a mandatory inclusion in apprenticeships for those who have not previously achieved a pass in both subjects, become optional for apprentices aged 19+. In addition, the minimum duration of an apprenticeship will be reduced from 12-months to eight-months effective from 1 August.

Further announcements are expected in the coming weeks to extend use of Apprenticeship Levy funds to a wider range of development programmes and direct more funding to entry-level apprenticeships.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

DIGITAL AND INFORMATION SERVICES

March 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

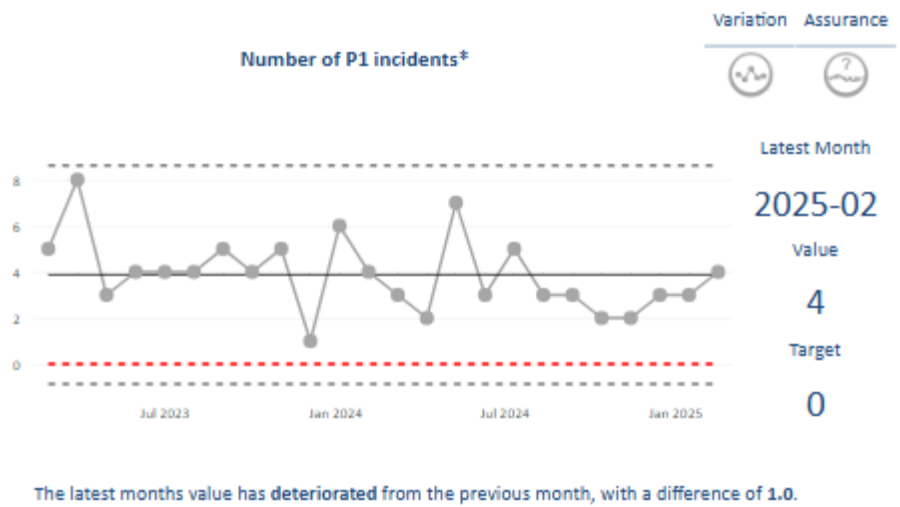
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

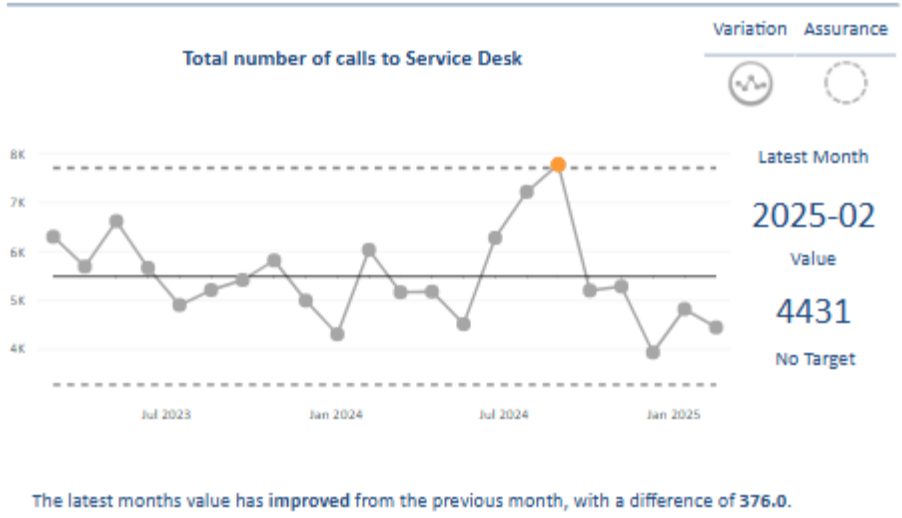
Executive Owner: James Hawkins **Operational Lead:** Steve Lawrie/Rebecca Bradley

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2025-02			4		0
Total number of calls to Service Desk	2025-02			4431		
Total number of calls abandoned	2025-02			1333		
Number of information security incidents reported and investigated	2025-02			31		
Number of patient Subject Access Requests (SAR) received (monthly)	2025-02			262		
Number of patient Subject Access Requests (SAR) completed (monthly)	2025-02			225		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2025-02	L	P	64%		80%
Number of FOIs and EIRs received (monthly)	2025-02			79		
Number of FOIs and EIRs completed (monthly)	2025-02			71		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2025-02	H		99%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy





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

Target: 0 P1 Incidents

Factors impacting performance:

4x P1 incidents occurred.

1. 5/2 CPD unexpected partial disruption to new user connections during planned update that should not have caused impact. Duration approx. 30 minutes.
2. 12/2 Wifi/wired network disruption at Selby Hospital when services failed over to secondary/backup configuration. Some users encountered issues.
3. 17/2 Ricoh printing unavailable for approx. 20 minutes.
4. 20/2 wifi network performance issues. Root cause traced to configuration issues and changes regressed. Duration approx. 1 hour.

Actions:

Telephone call performance has been impacted during January and February by a range of factors.

The telephone queue provides information on both the caller's place in the queue, and also a "message of the day" for any high-impact incidents, along with encouraging staff to use the online IT Self Service route for non-urgent support.

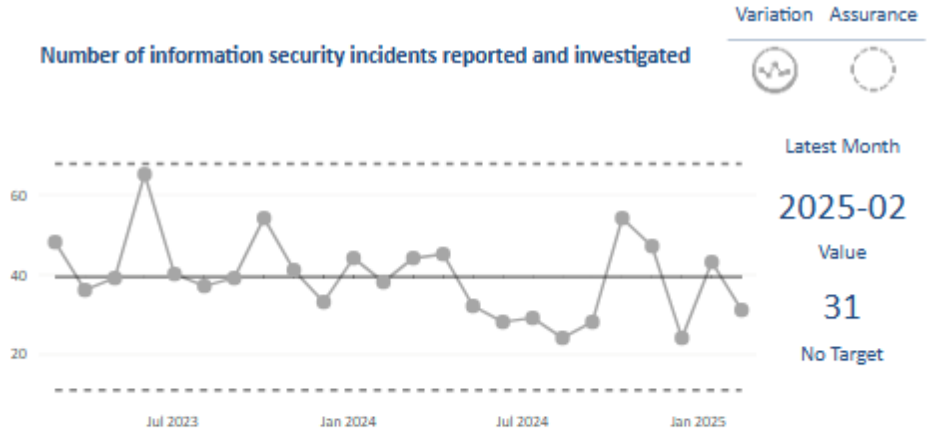
Staff waiting on hold may choose to hang up after hearing the recorded messages if their issue is not urgent and then call later, or may choose to use the IT Self Service route to support instead.

We have recently recruited 6 new team members (total team size 10), requiring training before they can provide effective telephone support. The 4 experienced colleagues have spent time mentoring new team members, resulting in less time on ticket resolutions.

We will continue to promote the use of IT Self Service as a route to support for non-urgent faults and service requests. This can provide access 24/7 to knowledge articles and request forms that help capture all the relevant details to enable IT support services to be delivered efficiently and effectively.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley



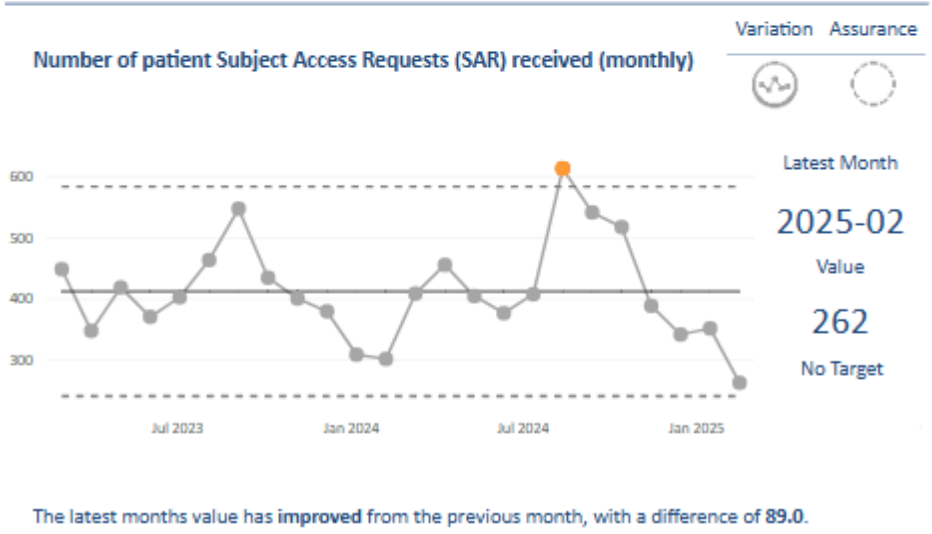
Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

Factors impacting performance:

There has been a decrease in incidents during February. The Trust saw the number of incidents due to emails being sent to the wrong recipient in other NHS Trusts increase during this time.

Actions: Trends will be communicated to staff and root cause analysis will be completed on all incident investigations.



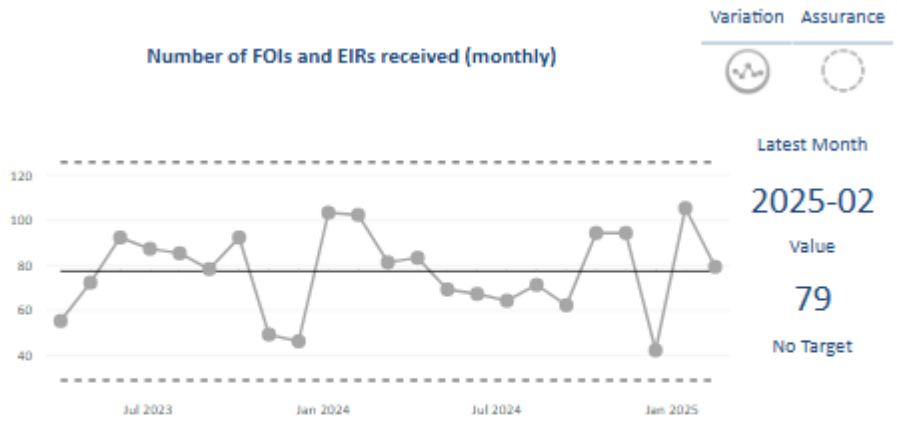
Rationale: Monitoring of Subject Access Requests received to ensure the Trust is managing its statutory obligations under the UK GDPR.

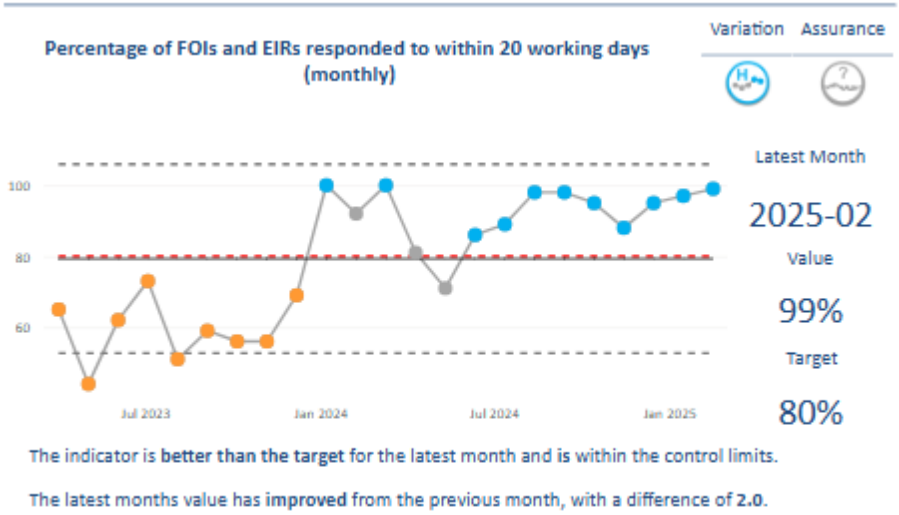
Number of Subject Access Requests submitted by patients

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 which are no longer included in this count.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley





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

The number of FoIs the Trust received in February reduced to just above average.

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

March 2025

Summary Dashboard and Income & Expenditure

Finance (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£11.2m	-£11.7m	↓	Deteriorating
Core CIP Delivery Variance to Plan (£20.0m Target)	£2.8m	£1.5m	↓	Deteriorating
Corporate CIP Delivery Variance to Plan (£33.3m Target)	-£14.2m	-£18.5m	↓	Deteriorating
Variance to Agency Cap	£1.9m Below	£2.2m Below	↑	Improving
Month End Cash Position	£11.2m adverse to plan	£11.2m adverse to plan	-	No change
Capital Programme Variance to Plan	£7.8m behind plan	£8.9m behind plan	↓	Deteriorating

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	745,780	680,670	703,466	22,796
Other Income	70,895	65,085	72,593	7,508
Total Income	816,675	745,755	776,058	30,303
Pay Expenditure	-522,997	-481,340	-507,827	-26,487
Drugs	-68,812	-63,116	-70,819	-7,702
Supplies & Services	-86,932	-79,538	-85,582	-6,043
Other Expenditure	-166,053	-132,445	-119,831	12,614
Outstanding CIP	23,174	17,039	0	-17,039
Total Expenditure	-821,620	-739,400	-784,058	-44,658
Operating Surplus/(Deficit)	-4,945	6,355	-8,000	-14,354
Other Finance Costs	-12,225	-11,211	-8,590	2,621
Surplus/(Deficit)	-17,169	-4,857	-16,590	-11,733
NHSE Normalisation Adj	17169	400	359	-41
Adjusted Surplus/(Deficit)	0	-4,457	-16,231	-11,774

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 £16.2m against a planned deficit of £4.4m for January (Month 11).

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 formally forecast an £18m deficit. This position had been agreed with NHSE at that time. Since this agreement, NHSE has confirmed that £18m cash-backed deficit support will be paid in March (M12) providing the Trust with a breakeven forecast position.

There continues to be risk in the position linked to additional ERF as the Trust has delivered ERF over the initial nominal ceiling.

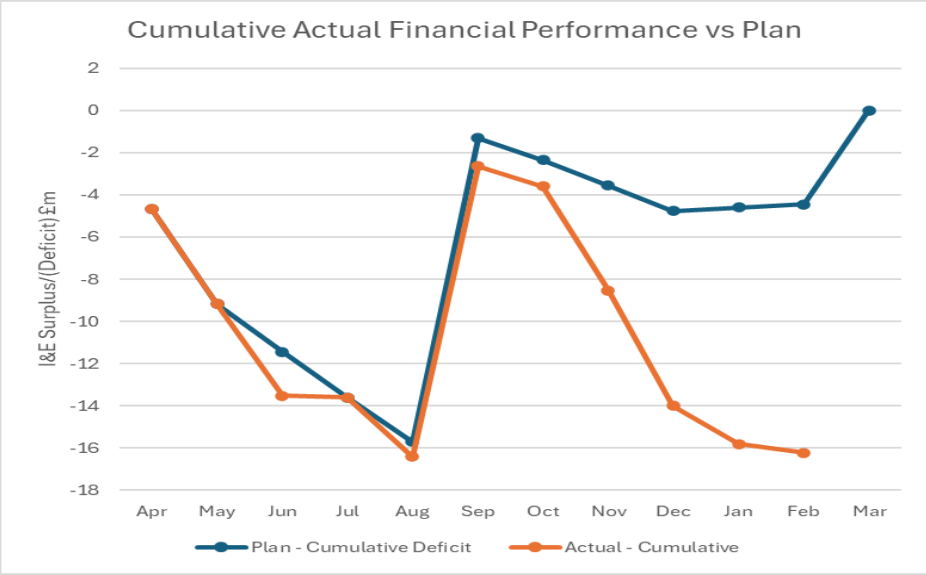
Key Subjective Variances: Trust
Finance (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	2,686	ERF overperformance & pay award funding	No mitigation or action required.
ICB Income	20,131	ERF overperformance & pay award funding	No mitigation or action required.
Employee Expenses	(26,487)	Agency, bank and WLI spending is ahead of plan to cover medical vacancies and deliver increased elective activity.	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	(7,702)	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	(6,043)	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	(17,039)	The Core Programme is £1.5m ahead of plan and the Corporate Programme £18.5m behind plan at M11	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.

Cumulative Actual Financial Performance vs Plan

Finance (3)



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 M11 with an actual deficit of £16.2m.

Forecast			
	Adjusted Surplus/(deficit)		
Scenario	Plan £'000	Forecast £'000	Variance £'000
Likely Case	0	0	0
Best Case	0	0	0
Worst Case	0	-21,475	-21,475

Likely Case
In M10 the Trust submitted a likely forecast with a deficit of £18m. The ICB have now confirmed that this deficit is supported through a further cash allocation therefore moving the forecast to a breakeven position. Details with regards to the assumptions and risks are included in a subsequent slide. This position has now been formally reported.

Best Case
The best case forecast at M11 reflects the likely case and now includes the confirmed deficit funding, reducing the forecast £18m deficit to balance.

Worst Case
The worst case forecast is a deficit of £21.4m against the balanced plan. This forecast, assumes the gap in CIP delivery will not be managed and the high risk and medium risk plans will not be delivered.

Actual V's Forecast				
	Adjusted Surplus/(deficit)			
Scenario	FOT £'000	Forecast YTD M10 £'000	Actual YTD M10 £'000	Variance
Likely Case	-18,000	-16,400	-16,231	169

The actual YTD M11 deficit (£16.4m) tracks just under the most likely forecast outturn of £18m prepared in M10. During February, the ICB confirmed £18m deficit support funding, brings our forecast outturn at M11 to a balanced position. Assumptions and risks are detailed below:

Likely Case
The table opposite demonstrates the component parts of the breakeven outturn.

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;

The income to support the High-Cost drug pressure previously assumed at £5.6m as agreed with the ICB is included at £4.3m giving an adverse movement of £1.3m, in addition, the A&G income to be received is £1.7m lower than assumed to date (£4.9m vs £6.7m) these have been offset in the forecast with the mitigations previously identified re discretionary expenditure and enhanced vacancy control.

Unidentified and high risk CIP have deteriorated from £12.2m to £14.3m, this is offset by ERF over recovery of £3m and 'other' £8.6m

M11	
2024/25 Forecast	£m
Unidentified CIP / High Risk Plans	-14.3
Pay Award pressure	-1.6
Pass through drugs (net of ICB provisions)	-13.5
B2-3 re banding	-2.2
ERF Over recovery (net of expenditure)	3.1
Technical Review	1.9
Deficit support funding	18.0
Other	8.6
Cease Medical Agency	0.1
Discretionary Expenditure Control	0.5
Enhanced Vacancy Control	0.3
ICB High Cost Drug Income	-1.3
Advice & Guidance	-1.7
Further Care group / Directorate mitigations	2.1
2024/25 FOT	**0.0**

Cumulative Actual Financial Performance vs Plan

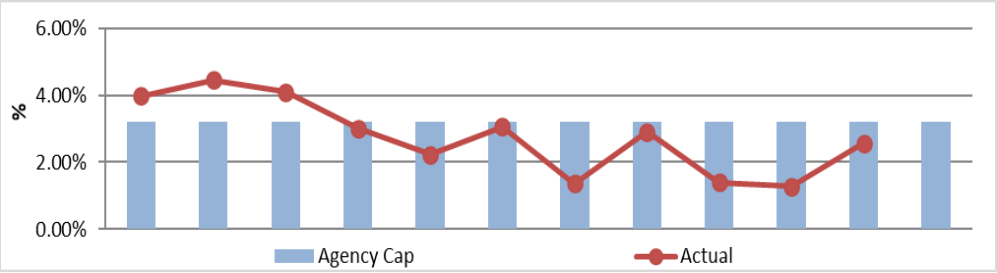
Finance (5)

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	217,376	193,909	198,116	-4,207	199,202	1,086	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	84,244	76,468	79,754	-3,286	77,350	-2,404	£1.7m relates to the premium cost of covering medical vacancies, £0.8m Community Nursing overspend, £0.6m Midwifery overspend, £0.6m non-pay underspend, £0.2m overachieved CIP.
Medicine	189,897	173,694	185,980	-12,286	174,473	-11,506	£7.9m relates to the premium cost of covering medical vacancies, £3.7m drug overspend.
Surgery	158,066	144,704	148,601	-3,897	145,095	-3,506	Overspend mainly relates to Resident Doctors pay costs over budget - £2.1m (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	649,583	588,774	612,450	-23,676	596,121	-16,330	

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	217,376	216,869	-13	216,856	520	Forecast deterioration largely due to profile of CIP target,however increased drug expenditure, outsourcing and winter flu testing all contributing to deterioration.
Family Health Care Group	84,244	87,261	0	87,261	-3,018	£1.9m relates to the premium cost of covering medical vacancies, £0.9m Community Nursing overspend, £0.7m Midwifery overspend, £0.5m non-pay underspend.
Medicine	189,897	202,755	-39	202,716	-12,819	£8.5m relates to the premium cost of covering medical vacancies, £4.0m drug overspend and £1.1m CIP planning gap.
Surgery	158,066	162,281	-51	162,230	-4,164	£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	649,583	669,167	-103	669,063	-19,480	

Agency, Workforce, Elective Recovery Fund
Finance (6)



Agency Controls

The Trust's has an agency cap of 3.2% of its overall pay spend in its plan. YTD M11 agency spend is 2.7% of overall pay spend, £13.8m against a plan of £16m.

	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,586.40	2,453.25	133.15	131,055	129,749	1,307
Scientific, Therapeutic and Technical	1,301.58	1,234.56	67.02	65,284	63,946	1,338
Support To Clinical Staff	1,904.31	1,717.00	187.31	59,147	60,217	-1,070
Medical and Dental	1,103.85	1041.23	62.62	134,503	148,276	-13,773
Non-Medical - Non-Clinical	3,257.85	2,842.83	415.02	108,170	103,556	4,614
Reserves				-18,783	0	-18,783
Other				1,964	2,083	-120
TOTAL	10,153.99	9,288.87	865.12	481,340	507,827	-26,487

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 11 Phase (Av %)	Activity to Month 11 Actual	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	104.00%	£130,123,659	£118,945,993	£146,691,569	£27,745,576	128.3%
West Yorkshire	103.00%	£1,365,316	£1,248,035	£1,480,019	£231,984	122.1%
Cumbria and North East	115.00%	£172,009	£157,233	£224,680	£67,447	164.3%
South Yorkshire	121.00%	£149,829	£136,958	£153,914	£16,956	136.0%
Other ICBs - LVA / NCA	-				*£0*	-
All ICBs	***104.02%***	***£131,810,813***	***£120,488,219***	***£148,550,182***	***£28,061,962***	***128.2%***
NHSE Specialist Commissioning	113.38%	£4,652,252	£4,252,622	£3,836,783	-£415,838	102.3%
Other NHSE	104.13%	£296,661	£271,178	£247,684	-£23,493	95.1%
All Commissioners Total	**104.31%**	**£136,759,725**	**£125,012,019**	**£152,634,649**	**£27,622,631**	**127.4%**

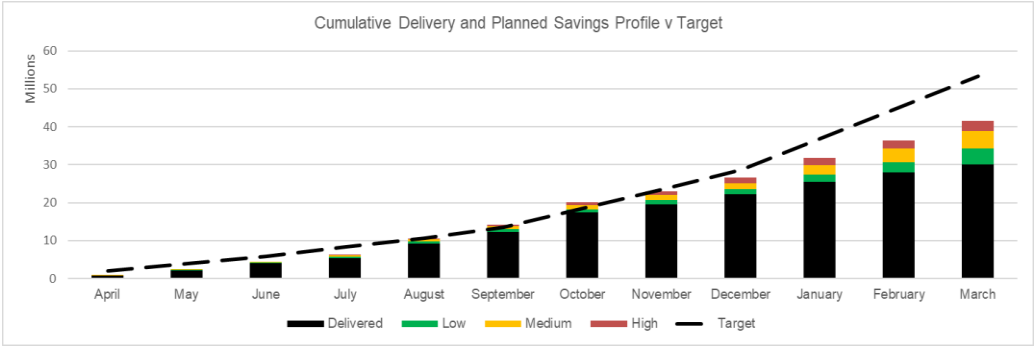
Elective Recovery Fund

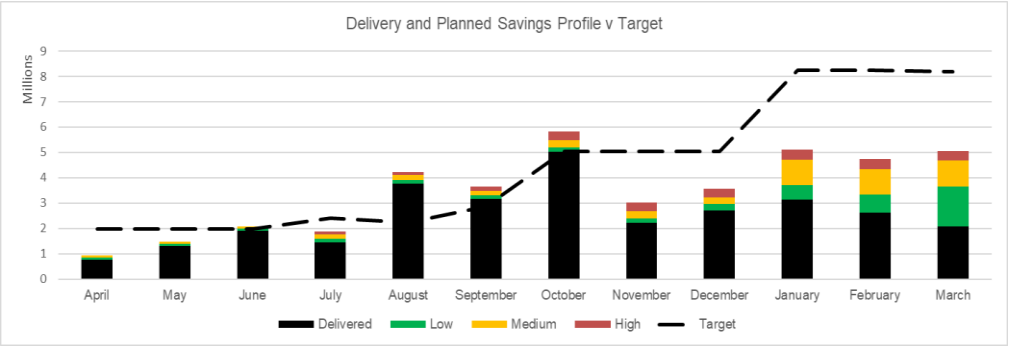
To give an early indication of ERF performance, we have developed an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity. Activity remains significantly up against the ERF Baseline target and following the backdated submission of some coding and counting corrections up to month 9, it potentially presents an overall £27.6m surplus for the period up to Month 11.

However, the updated FOT on ERF income now exceeds the HNY ICB financial ceiling threshold by over £4.2m, so it remains a risk that not all the ERF income will be received in 2024/25.

Cost Improvement Programme
Finance (7)

York and Scarborough Teaching Hospitals NHS Foundation Trust





2024/25 Cost Improvement Programme - February Position

	Full Year CIP Target	February 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	28,196	9,702	18,494	10,541	22,784	17,199	16,127	10,541	4,171	2,486
	33,326	**28,196**	**9,702**	**18,494**	**10,541**	**22,784**	**17,199**	**16,127**	**10,541**	**4,171**	**2,486**
Core Programme											
Medicine	4,152	3,513	2,567	946	2,734	1,417	3,291	861	3,291	0	0
Surgery	4,120	3,486	3,868	-382	4,139	-19	4,174	-54	4,174	0	0
CSCS	6,290	5,321	7,157	-1,836	7,562	-1,272	8,523	-2,234	8,221	215	87
Family Health	1,797	1,520	1,726	-206	1,833	-36	1,833	-36	1,833	0	0
CEO	104	88	37	50	41	63	41	63	41	0	0
Chief Nurses Team	207	175	150	25	161	47	161	47	161	0	0
Finance	382	324	230	93	235	147	235	147	235	0	0
Medical Governance	23	19	90	-71	98	-75	144	-121	144	0	0
Ops Management	233	197	212	-15	227	6	232	1	232	0	0
DIS	427	361	391	-30	427	0	478	-52	478	0	0
Workforce & OD	361	306	234	72	252	109	446	-84	252	194	0
YTHFM LLP	1,840	1,557	1,660	-103	1,843	-3	1,849	-9	1,849	0	0
Central	0	0	0	0	0	0	2,890	-2,890	2,873	18	0
	19,936	**16,868**	**18,323**	**-1,455**	**19,551**	**385**	**24,297**	**-4,361**	**23,784**	**426**	**87**
Total Programme	**53,262**	**45,064**	**28,025**	**17,039**	**30,092**	**23,170**	**41,496**	**11,766**	**34,325**	**4,598**	**2,573**

<u>Corporate Efficiency Programme</u>

The Corporate efficiency programme currently consists of 20 schemes which, following an initial risk assessment, give planned savings of £17.2m towards the £33.3m target.

In February £10.5m of the target was delivered in full year terms, £7.4m of which are recurrent savings, The YTD position shows delivery of £9.7m against target of £28.2m, £18.5m behind plan.

<u>Core Efficiency Programme</u>

The core efficiency programme currently has plans totaling £24.3m towards the required £20m target.

In February £19.6m of the target was delivered in full year terms £6.8m of which was recurrent. The YTD position shows delivery of £18.3m against target of £16.9m, £1.5m ahead plan.

Current Cash Position and Better Payment Practice Code (BPPC)

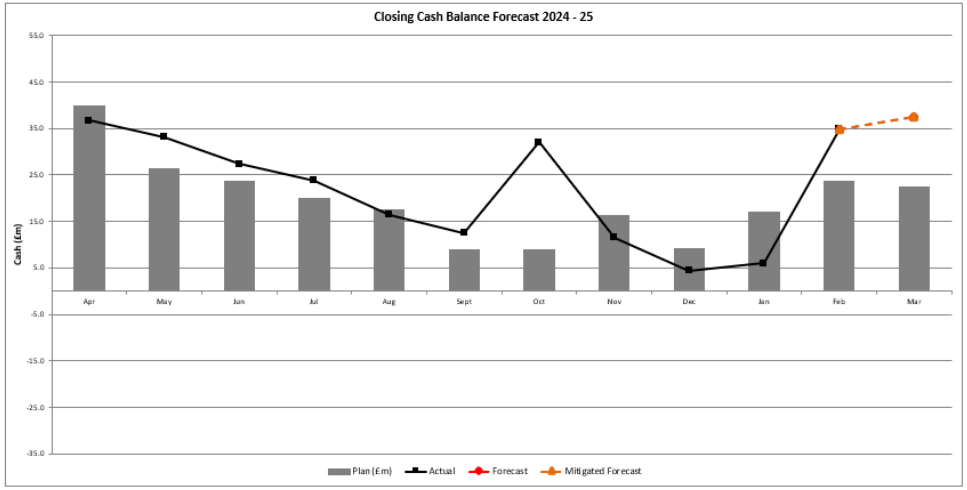
Finance (8)

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 February 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	34,869	



The cash forecast graph illustrates the cash position based on the actual cash balance at the end of February, at £34.9m against a plan balance of £23.6m.

February's balance includes PDC drawdowns of £22.3m in readiness for capital expenditure to be incurred in March with invoices becoming due in April/May.

All mitigating actions have been taken during the year; therefore, the actual forecast and mitigated forecast are the same. The current projected year end cash balance is £37.5m. This includes receipt of £18m additional income in March, recently confirmed.

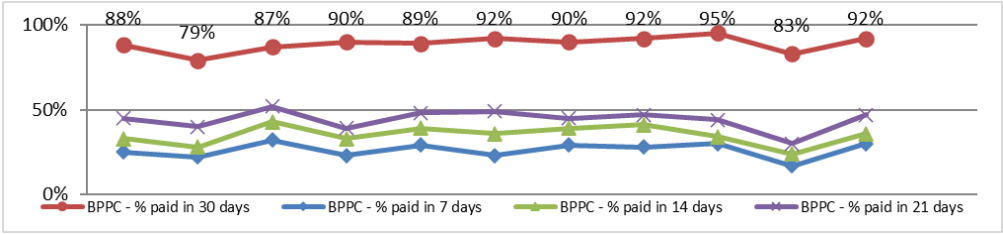
There has been no requirement for cash support during the year.

Cash will remain a focus during Q1 & Q2 of 2025/26 as planning work is finalised.

<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 February the Trust managed to pay 92% of its suppliers within 30 days.



Current and Forecast Capital Position

Finance (9)

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.

M11 Plan £000s	M11 Actual £000s	Variance to Plan £000s
43,029	34,088	(8,941)

The capital programme at month 11 is behind plan by £8.9m. 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 several high value leases due to complete in March and therefore we expect the leasing allocation to return to plan by year end.

Forecast Outturn

The forecast has increased by £2.7m from the M10 reported position. This is due to the announcement of national PDC funding for the Diagnostics Lung Screening Programme (£1.8m), additional NEEF funding for battery storage energy scheme (£475k), additional Diagnostics Digital Capability Programme (£428k) and Cyber Security (£34k).

We continue to mitigate unfunded pressures mainly through reprofiling expenditure on the EPR scheme to 25/26.

The current total capital forecast is £71.9m. £0.95m is funded via the charity, therefore the net CDEL impact to the DH group is £70.9m, outlined in the capital forecast table.

Throughout February, we have worked with capital colleagues on the timing of expenditure on schemes such as VIU/PACU/HT, ACTIF & RAAC to seek assurance on project progression. These schemes are key to obtaining a balanced capital position and utilising funding envelopes. This work will continue throughout March to inform the year end position and 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	41,811
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	**71,930**
Less Charitable Funded Schemes	(950)
Total Capital Forecast (Net CDEL)	**70,980**

System Summary – Note: M10 System position

Finance (10)

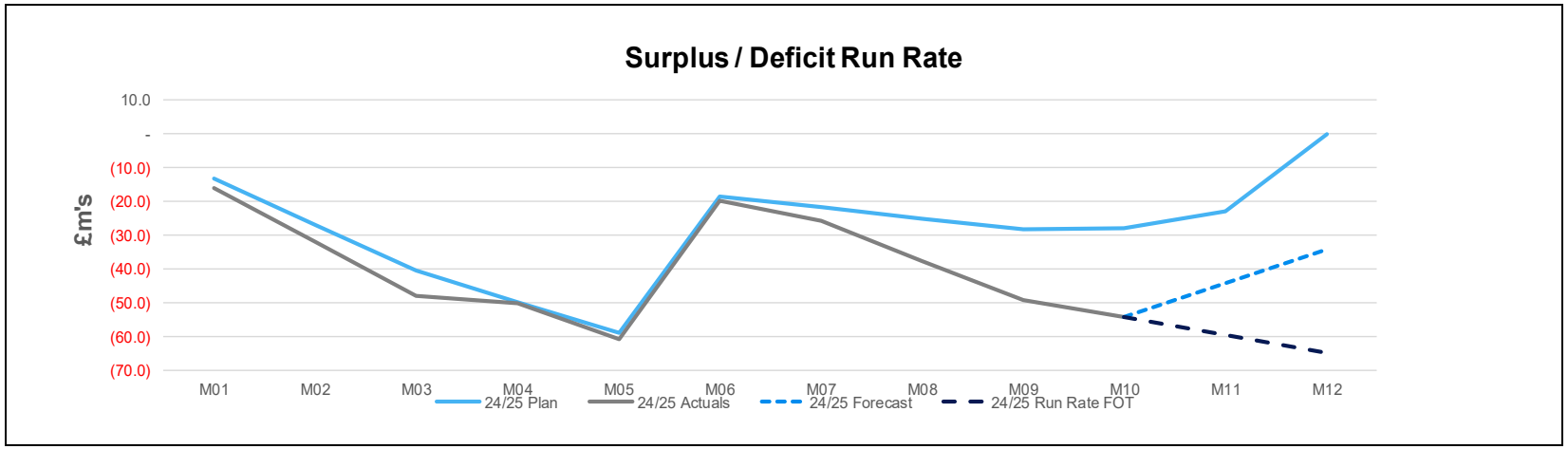
Year to Date

- ICB £268k adverse variance to plan
- Providers £26.2m adverse variance against plan
- ICS Actual YTD deficit £54.5m (£28m plan)

Forecast Outturn

- ICB Breakeven
- Providers: Harrogate Trust £16.4m deficit, York & Scarborough £18m deficit, all other providers reporting breakeven.
- Revised ICS deficit of £34.4m is an allowable deficit agreed by NHSE.
- ***M9 extrapolated (straight line) indicates circa £66m deficit.***

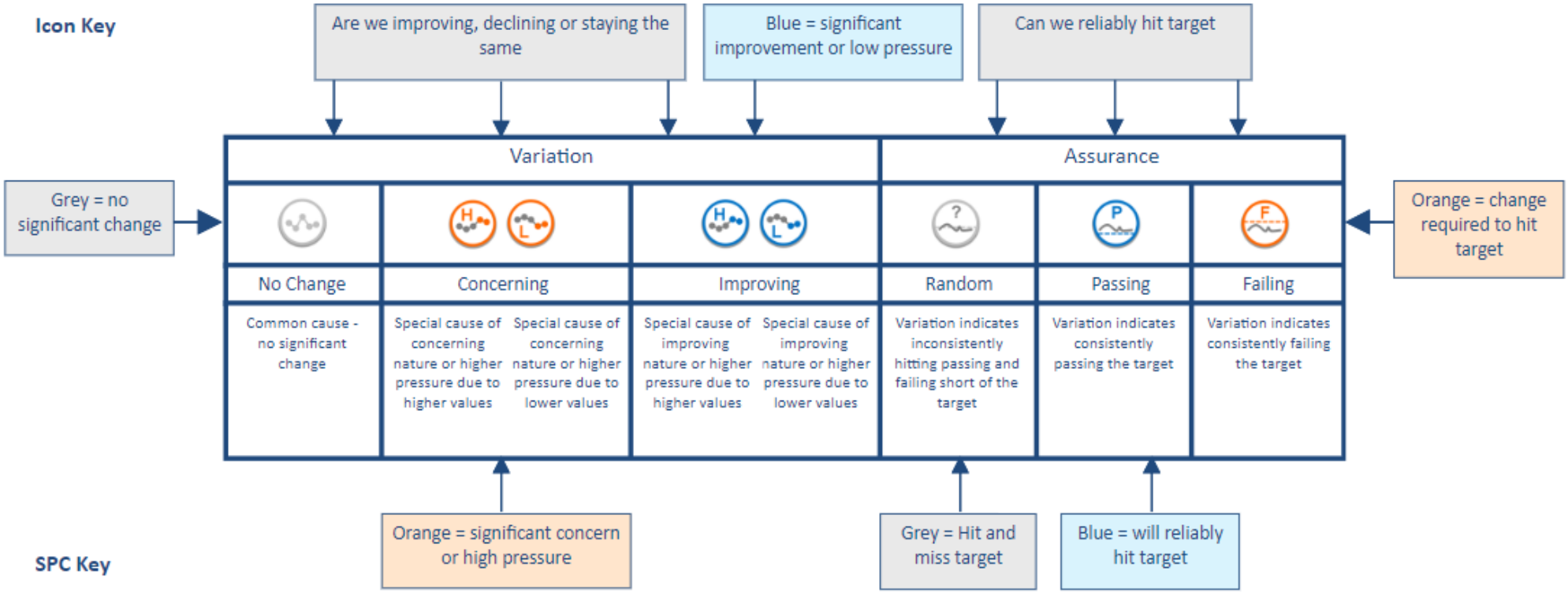
Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD	Actual YTD	Variance YTD		Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£000	£000	£000	%	£000	£000	£000	%
Humber And North Yorkshire ICB	0	(268)	(268)	(0.0%)	(0)	0	0	0.0%
Harrogate And District NHS Foundation Trust	(3,103)	(15,508)	(12,405)	(4.1%)	-	(16,400)	(16,400)	(4.5%)
Hull University Teaching Hospitals NHS Trust	(12,633)	(14,542)	(1,909)	(0.3%)	-	-	-	0.0%
Humber Teaching NHS Foundation Trust	(916)	(1,433)	(517)	(0.2%)	0	-	(0)	(0.0%)
Northern Lincolnshire And Goole NHS Foundation Trust	(6,768)	(6,884)	(116)	(0.0%)	-	-	-	0.0%
York And Scarborough Teaching Hospitals NHS Foundation Trust	(4,604)	(15,818)	(11,214)	(1.7%)	-	(18,000)	(18,000)	(2.3%)
ICS Total	(28,024)	(54,454)	(26,429)	(0.8%)	0	(34,400)	(34,400)	(0.8%)



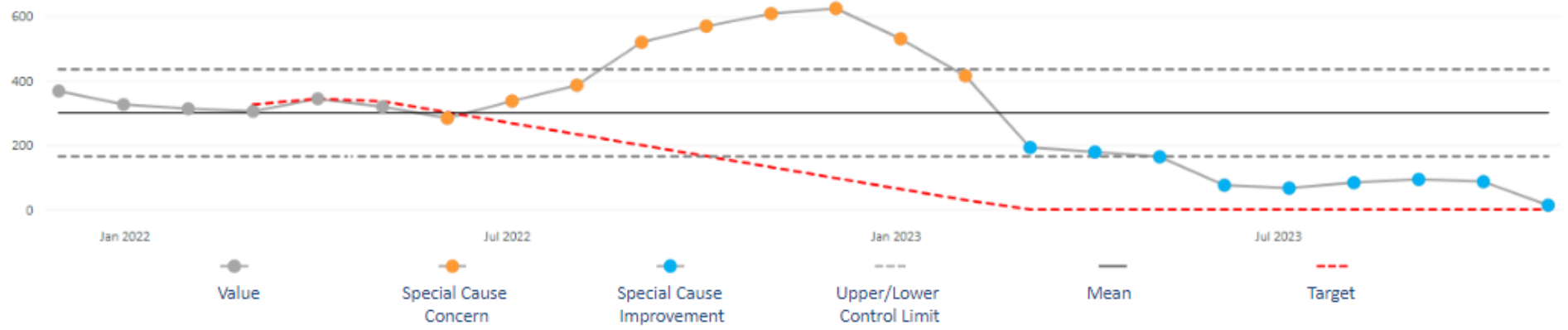
Keys

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 March 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 January 2025.

Recommendation:
The Board is asked to receive the updates from the maternity and neonatal service for January 2025 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	18/03/2025	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 January 2025.
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 January 2025.

Perinatal Deaths

In January 2025 there was sadly one antenatal stillbirth at 35 weeks gestation. There were two neonatal deaths from a multiple pregnancy (<22 weeks gestation). Following an immediate review there were no concerns highlighted with the care in either case therefore the cases will be reviewed using the National Perinatal Mortality Review Tool (PMRT).

The national MBRRACE-UK report for 2023 has been published.

- Trust stillbirth rate – 2.88/1000 births, this is within 5% mortality rate when compared with the group average

- Trust neonatal mortality rate – 0.91/1000 births, this is 5% to 15% lower mortality rate when compared with the group average.
- Trust perinatal mortality rate – 3.78/1000 births, this is within 5% mortality rate when compared with the group average.

Maternity and Newborn Safety Investigations (MNSI)

In the month of January there were no new cases that met the criteria for referral to MNSI. There remain three ongoing cases.

Patient Safety Incident Investigations (PSII)

In the month of January there were no new PSII declared. There remain three ongoing cases.

Moderate Harm Incidents and above

The postpartum haemorrhage (PPH) rate was 4.4% (15 cases). The data demonstrates there has been a reduction in the Trust rolling average over 12 months for PPH ≥1500mls from the national digital dashboard. 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 haemorrhage sprint audit commenced in January 2025, and this is the second consecutive month of the audit. In January, there were 15 cases, and the audit identified that 14 of the 15 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 Section 31 Progress Update

Annex 2 provides the January 2025 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 January 2025.

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 Tees, Esk and Wear Valleys Foundation Trust (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 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 collaborative leads.

LMNS Assurance Visit

There was a Local Maternity and Neonatal System/ Integrated Care Board and Regional Midwifery Team assurance visit on the 12 February 2025. High level feedback recognised the improvements being made despite the ongoing capacity and resource challenge. The report has been received for factual accuracy. An overview of the findings will be included in the April Maternity and Neonatal Board paper.

Maternity Incentive Scheme

The Maternity Incentive Scheme report and action plan was presented at the Trust Board in January 2025 and the Local Maternity and Neonatal System undertook a review of the

evidence. The LMNS agreed with the Trust's self-declaration of compliance with 4 out of 10 safety actions. The Maternity Incentive Scheme declaration form was submitted to NHSR by 3 March 2025. An action plan for the Maternity Incentive Scheme has been developed and will be presented quarterly at Care Group Board, Maternity and Neonatal Safety Champions and Quality Committee.

Improvement and Transformation

The quality and safety framework has been refreshed and relaunched in January 2025. There is a refreshed agenda for the Maternity Directorate, Labour Ward Forum, Guideline and Audit Group. The Digital Authority Group was established in February 2025.

The fourth caesarean section list project is in phase one of the implementation. The additional list is staffed by bank staff in line with the timelines stipulated in the business case to recruit to substantive posts. From 11 March a weekly additional list has been scheduled on a Tuesday and staffed by bank shifts in line with the business case implementation plan.

There is a new scan machine available in Room 4 on the Antenatal Day Assessment Unit at York. This will be staffed by the midwife sonographers, Monday-Friday and alternate Saturdays 9-5. The alternate Saturday list will be done by sonographers. This will commence from 24 March 2025. The aim of these additional lists is to endeavour to allow for women attending triage to be scanned on the day if required and is for third trimester scans only.

The three Local Authorities have agreed to onboard on to the national smoke-free pregnancy incentive scheme and an options paper is in draft to agree the next steps for the service within the next financial year.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

- 87 out of the 230 milestone actions have been completed to date (2 completed in February)
- 11 milestone actions are at risk of becoming off track with the end date prior to 31/03/2025.
- 92 milestone actions are off track as the delivery date has passed and the action has not been completed (0 in February 2025).
- 11 milestone actions have mitigations in place for these to be completed during March 25 – May 25
- 39 milestone actions require a timeline extension as the staffing gap continues to impact upon delivery
- 24 milestone actions cannot progress due to funding constraints
- 18 actions need timelines resetting to National, LMNS or Trust wide projects (awaiting confirmation of timelines to amend these)
- 3 milestone actions are not scheduled to start yet based on the original start dates

Key Achievements in January 2025

- The options appraisal for consenting planned caesarean births in clinic has been drafted and discussions ongoing with consultants and trained midwives around when we provide advice and information on planned caesarean births.
- The CPD application form has been refreshed following staff feedback. The new form to be shared via the staff bulletin, unit meetings and key message posters developed monthly.

- All fixed term and secondment job descriptions were approved at Vacancy Control Panel on 3rd February 2025. Active recruitment has commenced to recruit to these positions permanently.
- The Maternity Incentive Scheme (MIS) check and challenge meeting with the LMNS took place on 4th February 2025. All evidence has been reviewed and signed off. The declaration form has been completed and submitted to NHS Resolution.
- Procurement of the All4Maternity 1 year license has commenced. The platform is a resource tool for maternity workers, student midwives, midwives, parents and families that contains a range of e-modules and academic articles. Staff on the Scarborough site have access to the platform from 26 February and staff on the York site have access from 7 March.
- The annual LMNS assurance visit was held at the York site on the 12 February. The continued improvement of services was recognised and celebrated and suggestions for further improvement were already captured within the Maternity & Neonatal Single Improvement Plan.
- A review of all priority 1 high level actions to support re-prioritisation of workload for 2025/26 has been completed.
- A full review of the evidence for completed milestone actions in 2024/25 so far was completed in February by the Programme Team. Out of 87 completed actions to date, 2 actions required being made off track due to changing scope and 6 actions required further evidence which will be gathered in March 2025.
- Three Local Authorities have agreed to onboard on to the national smoke-free pregnancy incentive scheme and an options paper is being drafted to agree the next steps for the service within the next financial year.
- Direct supply of Nicotine Replacement Treatment (NRT) is available in the outpatient areas and administered by the Tobacco Dependency Advisor team.
- A visit to Askham Grange prison to place in February ahead of the community midwives for equitable health starting in post, a pathway is being developed in partnership to meet the national service specification for maternity care of women in prison.

Risks

Safety

1. 45 guidelines are overdue, this is a reduction since 30 December 2024. There are now twice monthly guideline meetings in place to address the backlog and 6-monthly 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 a 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 are 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. A temporary Team Manager has been appointed but she has come from the Eating Disorders Team. TEWV have 224 women on the caseload with 32 of these having been rag rated at red due to risk, lack of contact and needing urgent assessment. They are not able to offer routine

assessments until June 2025. Urgent assessments are taking approximately 6 weeks. The LMNS have been appraised of the status and concern.

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

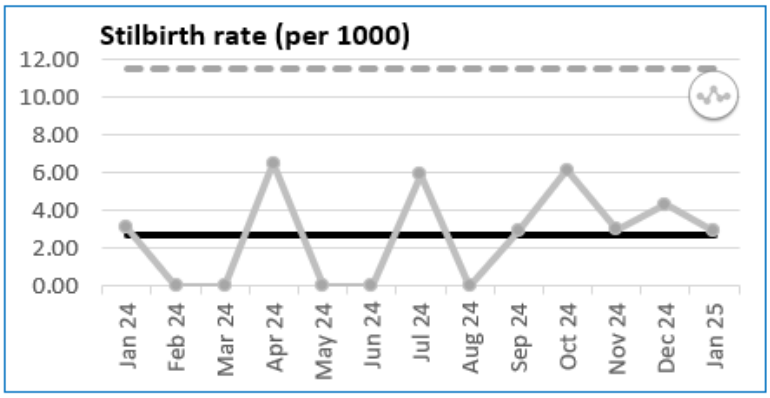
Date: 19th March 2025

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery January 2025

Dashboard

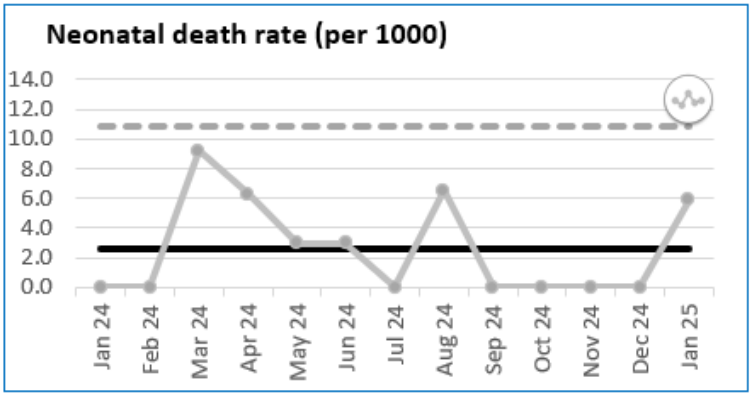
Latest month	01/01/25
Still birth rate/1000	**2.9**

No significant change



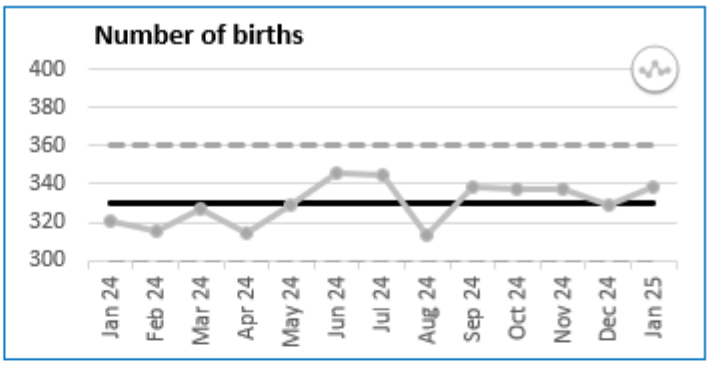
Latest month	01/01/25
Neonatal Death rate/1000	**5.9**

No significant change



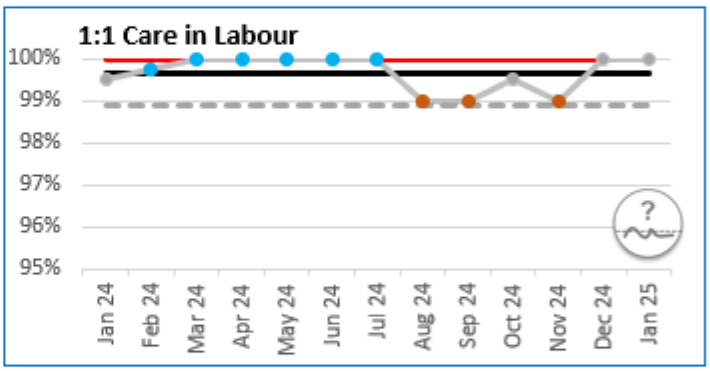
Latest month	01/01/25
Number of births	**338**

No significant change



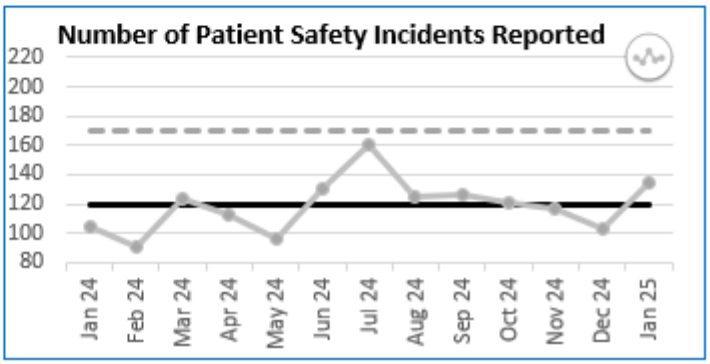
Latest month	01/01/25
1:1 Care in Labour	**100%**

No significant change



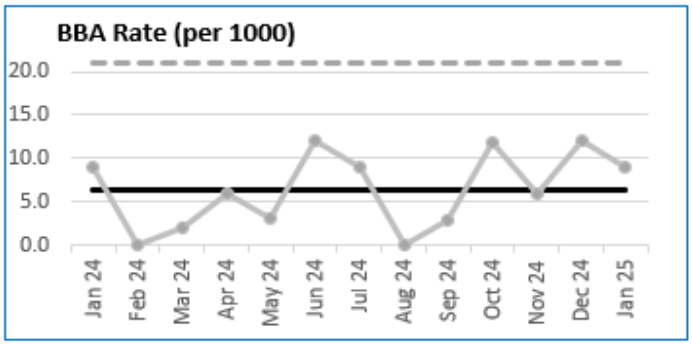
Latest month	01/01/25
Number of Patient Safety Incidents	**135**

No significant change



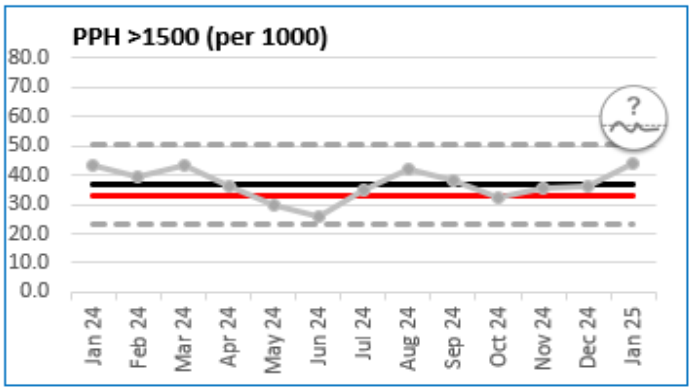
Latest month	01/01/25
BBA rate/1000	**9.0**

No significant change



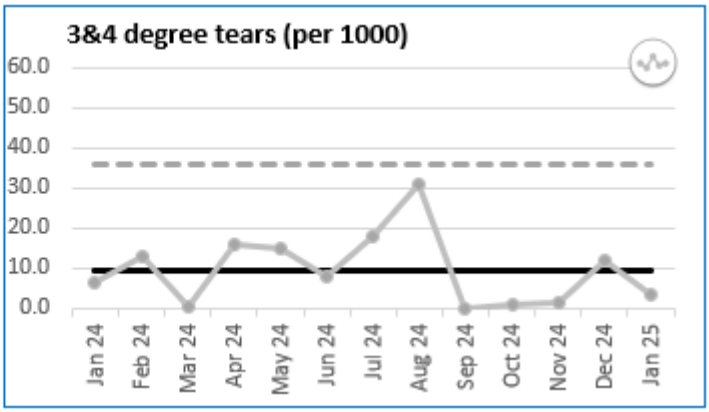
Latest month	01/01/25
PPH >1500 (per 1000)	**44.0**

No significant change



Latest month	01/01/25
3&4 degree tears (per 1000)	**3.2**

No significant change



Annex 2

Report to:	Quality Committee
Date of Meeting:	18 March 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 March 2025 monthly submission to the CQC which provides assurance on progress and impact on outcomes in January 2025.

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

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 January 2025 are outlined below.

Staff Group	York	Scarborough
Midwives	95% (175/185)	95% (74/77)
Consultants	100% (18/18)	70% (7/10)
Obstetric medical staff	67% (8/12)	100% (10/10)

The three Obstetric Consultants who were not complaint in January, one has completed their training in February 2025 and the other two are booked on in March 2025. Compliance will continue to be monitored at the Maternity Directorate, Quality Assurance Committee and Trust Board. A review of the process for booking Obstetricians onto the training is being undertaken to ensure training is completed within a 12-month period.

A.3 Risk Assessments and Care Plans

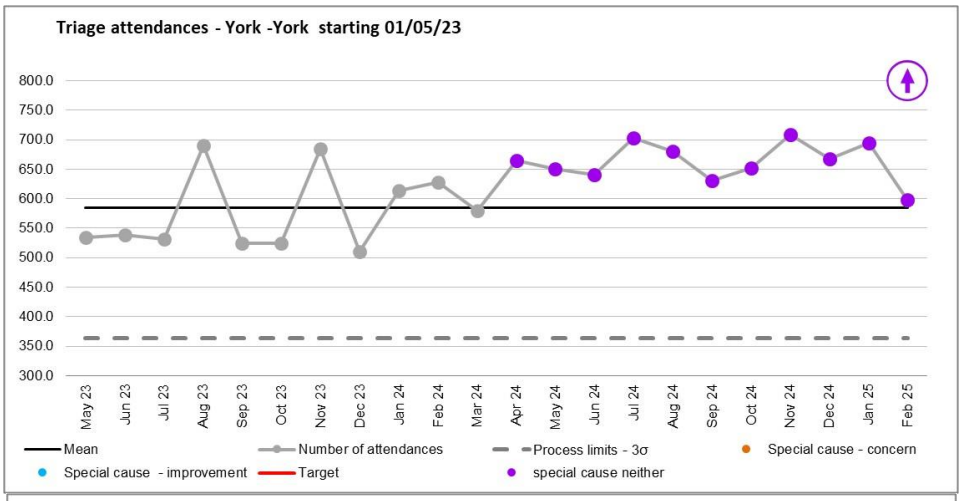
All antenatal risk assessments are recorded on BadgerNet. Table 1 highlights the antenatal risk assessment compliance.

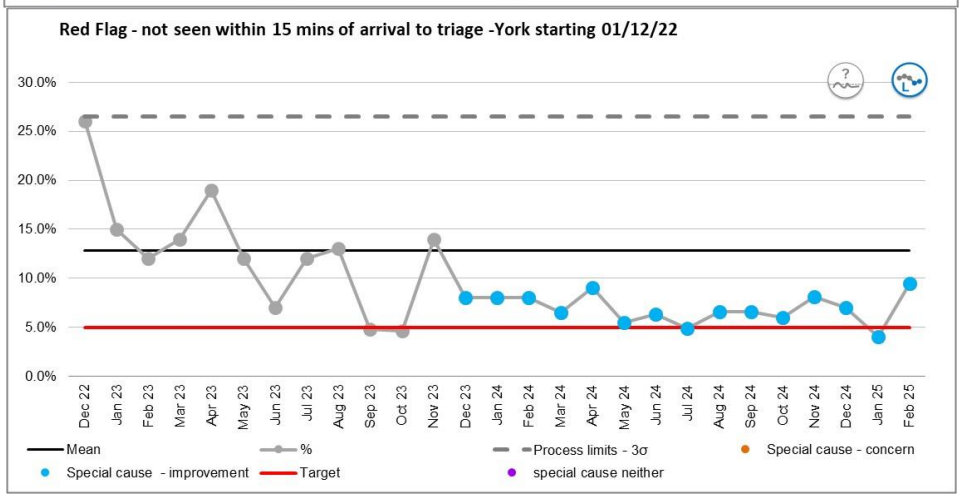
Month	Antenatal Risk Assessments
September 2024	98.5%
October 2024	98%
November 2024	98%
December 2024	98%
January 2025	99%

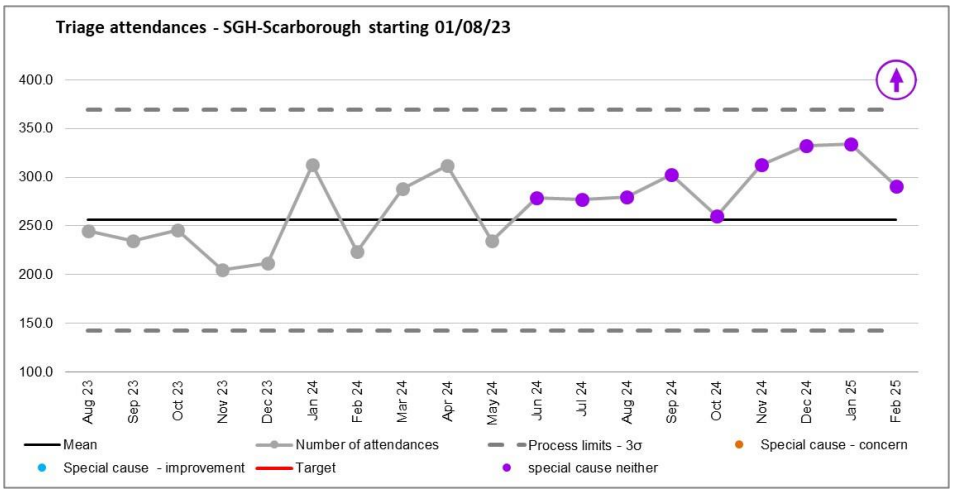
Quarter 3 audit for 2024/25 for intrapartum fetal monitoring highlighted:

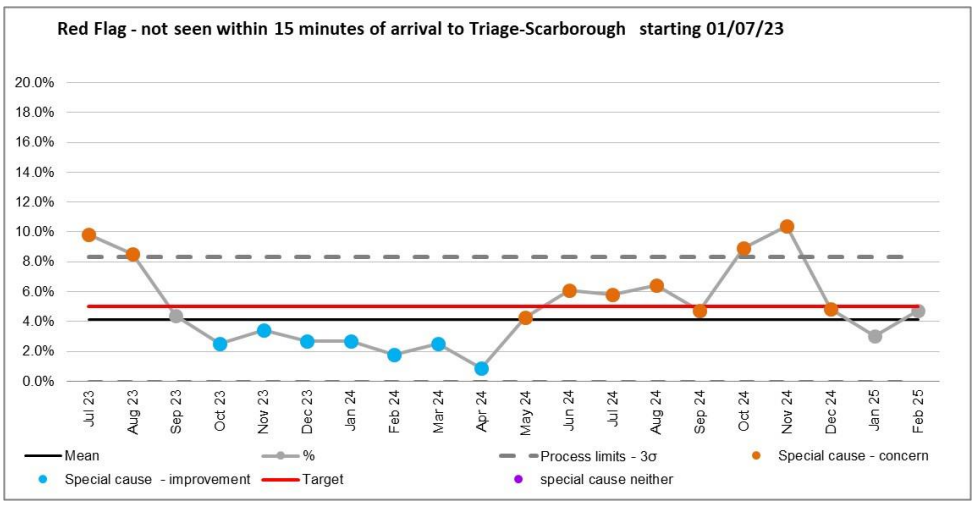
- 100% of intrapartum risk assessments were completed.

A.4 Assessment and Triage

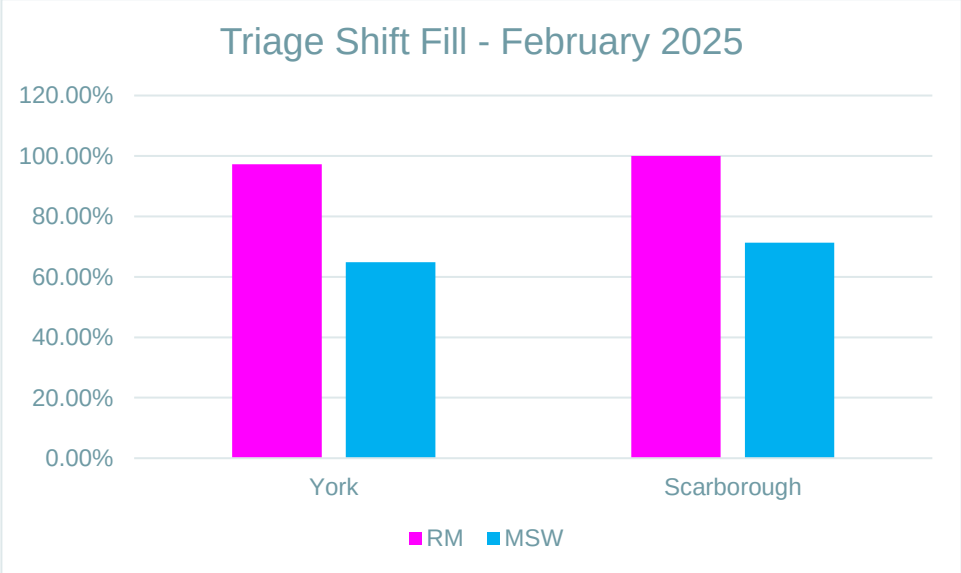








Staffing and skill mix remain a challenging across the Scarborough site which has resulted in Triage being undertaken on Labour Ward on 12 shifts throughout February 2025. Shift fill achieved 100% for Midwives on the Scarborough site, therefore relocation of service was due to Maternity Support Worker roster gaps. Expressions of interest has shown a potential increase in Triage staffing to approximately 4.8WTE. Confirmed numbers are awaited, with a roster impact in July 2025. Trained, dedicated agency Midwives continue to support triage on the Scarborough site and a review of the Maternity Support Workers resource will be reported in the next audit.



Birmingham Symptom Specific Obstetric Triage System (BSOTS) training is mandatory before shifts can be undertaken by Bank or Agency. A training year to end report will be provided for the next update.

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 meet the national reporting requirements for the Maternity Incentive Scheme and the Ockenden recommendations. There have been two quarterly

reports for the Perinatal Mortality Review Tool (PMRT) presented at Board and the Maternity claims scorecard has been presented at Quality Committee.

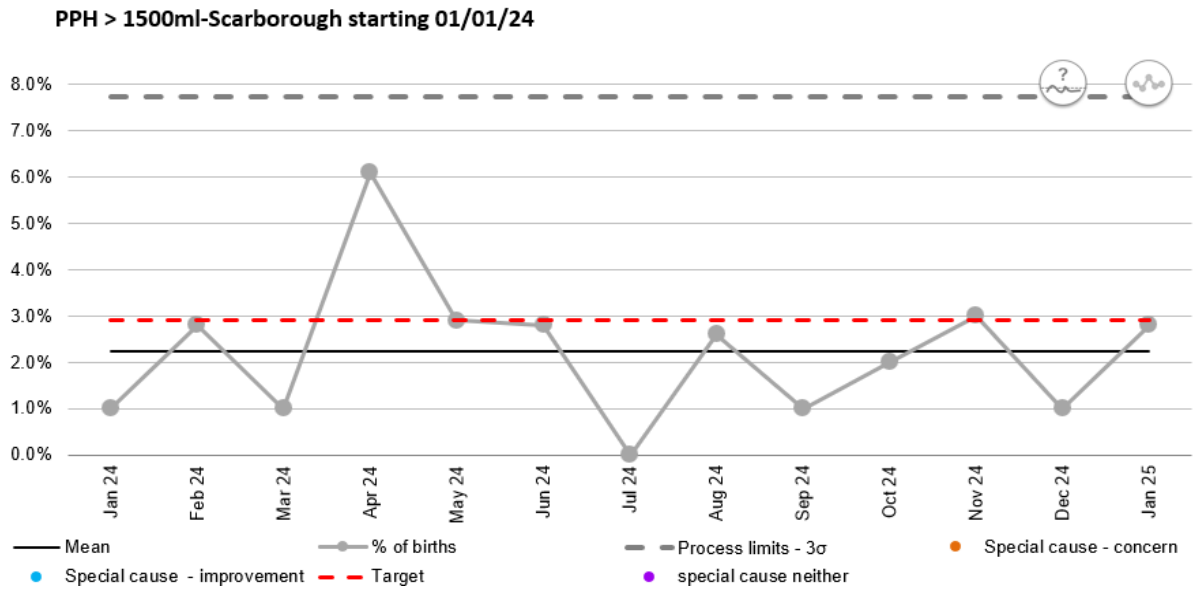
B.2 Postpartum Haemorrhage (PPH)

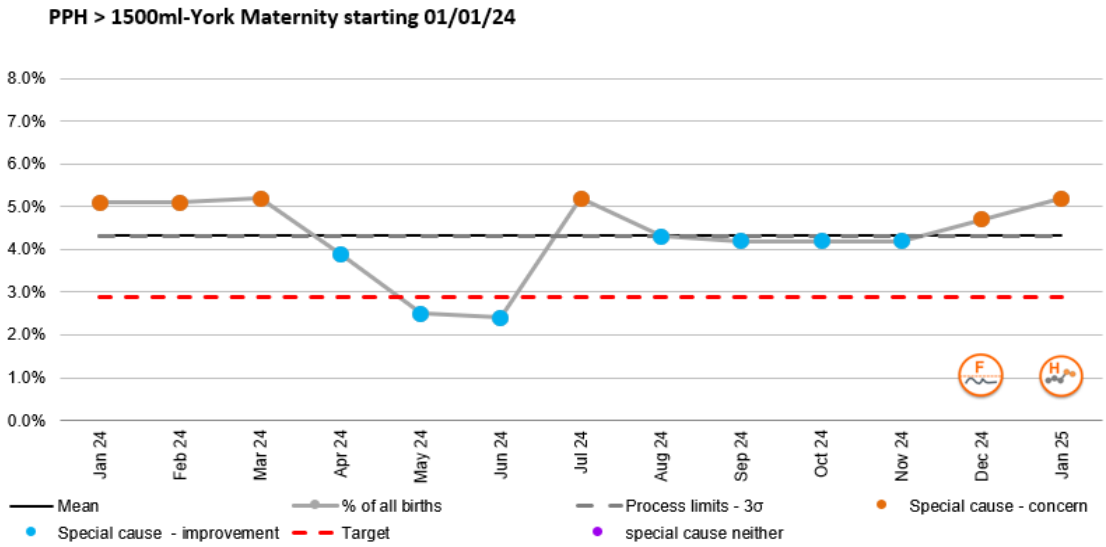
PPH over 1.5 litres

The reduction in the rate of postpartum haemorrhage (PPH) over 1500mls is a key priority for the maternity service. The PPH rate for January 2025 was 4.4% of all deliveries across both sites.

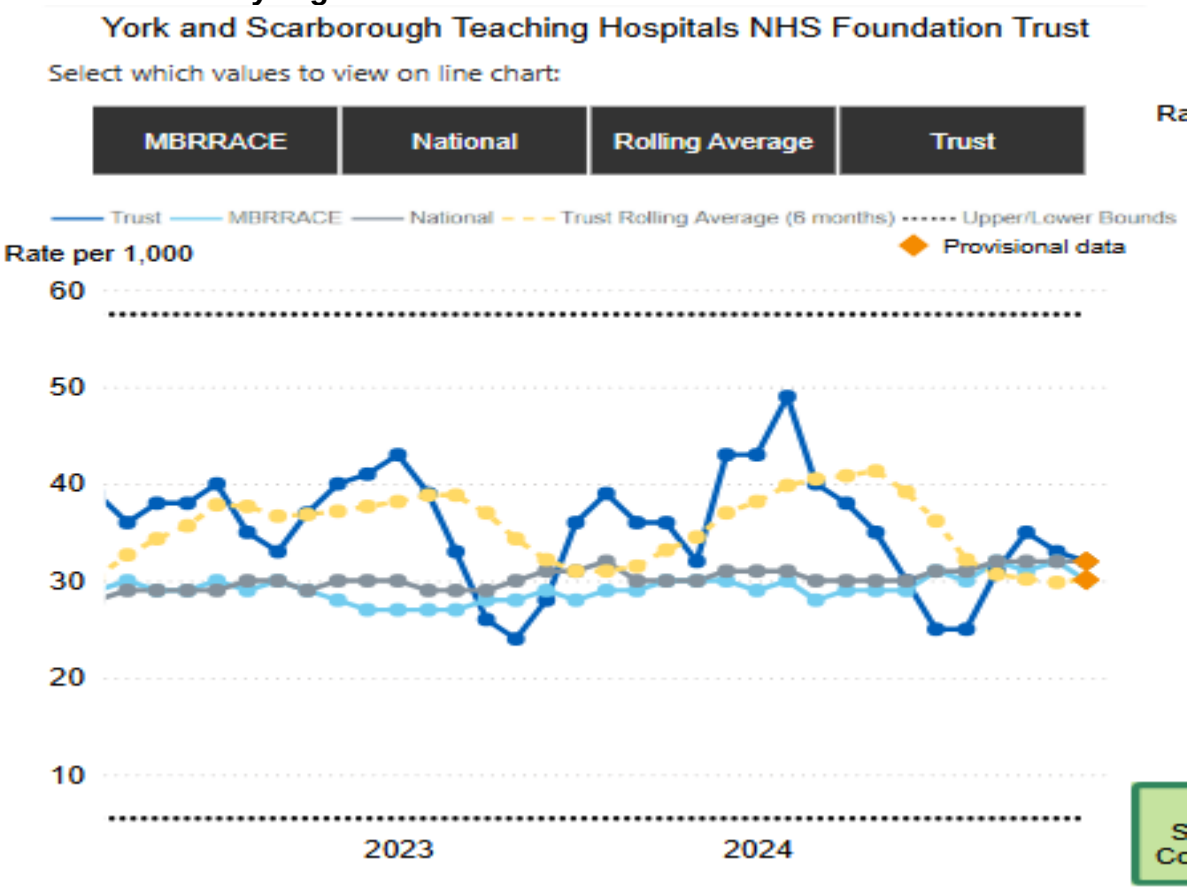
All PPHs are reviewed at the multidisciplinary Maternity Case Review meeting. The themes identified link to the ongoing improvement workstreams identified in the cluster review.

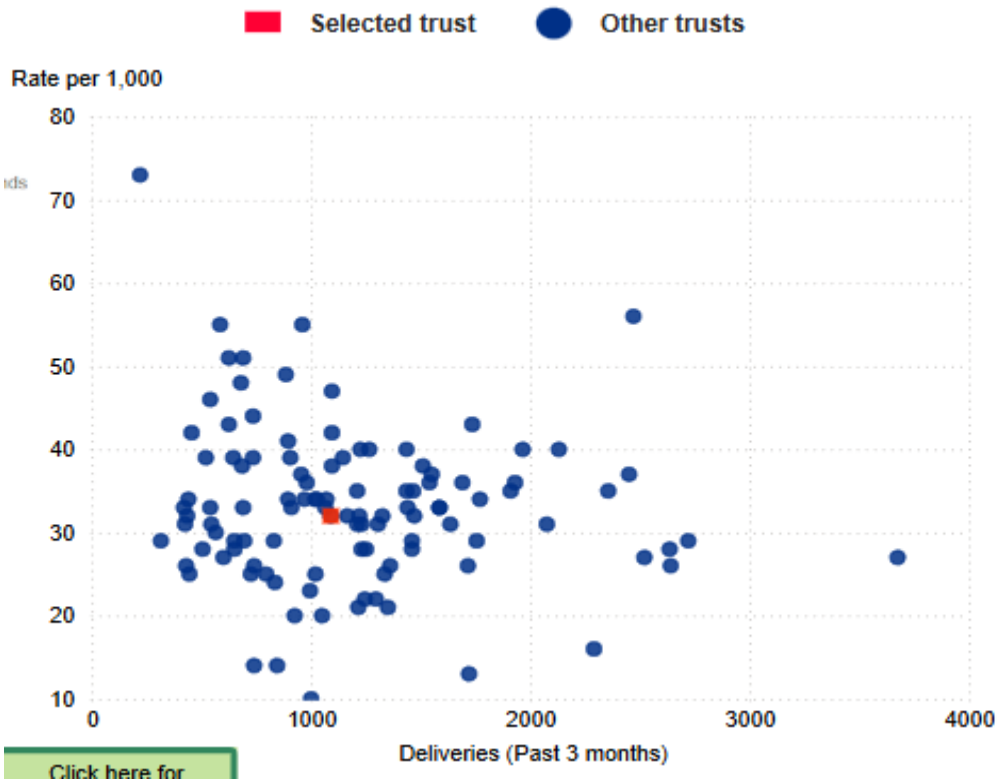
Blood Loss	Number in January 2024
1.5l – 1.9l	10
2l – 2.4l	3
> 2.5l	2





National Maternity Digital Dashboard





The national digital dashboard demonstrates an overall decline in the Trusts PPH rate over a 12-month period. The local SPC charts show common cause variation for Scarborough and York a special cause for concern. All the January 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 when reviewing the Trust rolling average for the 12 months on the national digital dashboard. A monthly PPH sprint audit commenced in January 2025. The monthly PPH sprint audit will be presented at the monthly labour ward forum and Maternity Directorate Group.

There is a thematic review of postpartum haemorrhages being undertaken by a Consultant Obstetrician.

Overview of the Monthly Sprint Audit

Standard	Results	Comments
FBC taken at 28 weeks	93% (14/15)	
Was Haemoglobin managed in accordance with guidance	93% (14/15)	
36-week PPH risk assessment completed	79% (11/14)	1 woman gave birth before 36 weeks.

PPH risk assessment completed on admission for birth	93% (14/15)	
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% (9/9)	
Postnatal oxytocin infusion should be used when there is moderate or high risk of postpartum haemorrhage	100% (15/15)	
PPH proforma fully completed	53% (7/15)	

14 out of the 15 women had multiple risk factors for PPH. Actions are in place to address areas of partial compliance.

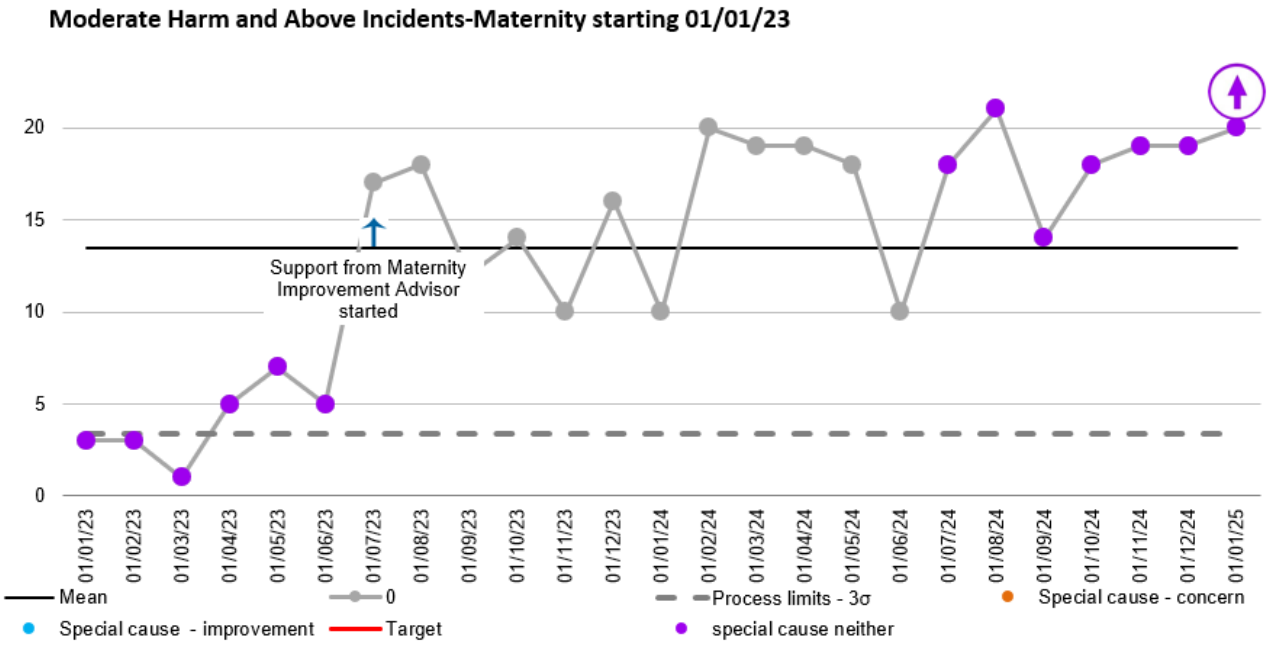
B.3 Incident Reporting

There were 20 moderate harm incidents reported in January 2025.

Datix ID	Incident Category	Outcome/Learning/Actions	Outcome
29615 29514 30885	Perineal Trauma	Ongoing audit of perineal trauma and the use of the OASI care bundle	Reviewed by the Quality and Patient Safety Midwife, all care was in accordance with guidance and onward referrals made
29970	Neonatal death	No immediate safety actions	To be reviewed using PMRT
29261	Antenatal stillbirth	No immediate safety actions identified	To be reviewed using PMRT

29508 29478 29735 29635 29938 29787 29933 30266	29240 30877 29509 29285 29306 30878	PPH ≥1500mls	PPH sprint audit started in January 2025	The PPH rate continues to be monitored through the Maternity Assurance Group. The Trust rolling average rate has reduced over 12 months.
30081		Ruptured uterus	Thematic review of a cluster over a 4-month period	Review is currently in progress

Incident grading is reviewed at the Maternity Services daily triage Monday to Friday to ensure it is accurate and in line with national guidance.



B.4 Management of Risks

B.4.1.1 Project Updates York

The maternity theatres at York have been refurbished and is 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.

Recruitment update - position from 1 February 2025:

- Fully recruited to at the Scarborough site.
- The vacancy rate on the York site is 1.46WTE. Active recruitment remains ongoing.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 March 2025
Subject:	Annual Inpatient Staffing Review
Director Sponsor:	Dawn Parkes, Chief Nurse
Author:	Emma George, Assistant Chief Nurse Anthony Moffat, Head of Nursing – Workforce & Education

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 paper summarises the nursing workforce review for adult and paediatric inpatient services, based on the quality metrics, professional judgement and staff required to meet the needs of patients. This review is consistent with the established requirements of the National Quality Board (NQB, 2016) and the NHS Improvement (NHSI 2018) Workforce Safeguards to ensure that Trust Boards are sighted on the assessed and recommended nurse staffing workforce required to care for inpatients.

Key points to highlight are:

- Completion of the required six-monthly nurse safe staffing review, with particular focus on the National Staffing Guidance for Acute Stroke services and the resource required.
- A proposal is made for the Ward Manager role to become full time (5 days) supervisory, as it is deemed vital to front line leadership and the delivery of high-quality care for patients across all Care Groups.
- Changes are required in children's services to level up the headroom and supervisory time to align with adult inpatient wards.
- A financial modelling paper will be submitted to Executive Committee April 2025 seeking opportunities of modelling the requirements of the safe nurse staffing review, considering long day allocations.

Recommendation:

To receive this Nurse Inpatient Staffing Inpatient Establishment review and accept the recommendations made following its completion.

To note the need for further nursing data assurance and analysis in regard to stroke rehabilitation nurse workforce model.

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
Resources Committee	18 March 2025	Noted.
Quality Committee	18 March 2025	Noted.
Executive Committee	19 March 2025	Noted.

Bi - Annual In-Patient Nurse Staffing Review March 2025

1. Introduction and Background

The purpose of this paper is to report on the outcomes of the review of the 6 monthly adult and paediatric ward nurse staffing establishments undertaken between September 2024 to January 2025. This 6 monthly review forms part of the Trust's approach to the systematic review of nurse staffing resources to ensure safe nurse staffing levels effectively meet quality of patient care needs and is a new process.

This paper focuses specifically on a review of nursing levels for the Trust's funded inpatient beds and does not include the nurse staffing required for additional bed capacity used in escalation spaces and areas such as maternity, critical care, outpatients, theatres, and the emergency departments that will be reviewed separately within a set calendar for these reviews to be undertaken in 2025.

The Trust board is accountable for safer nursing staffing levels consistent with the established requirements of the National Quality Board (NQB, 2016) and the NHS Improvement (NHSI 2018) and Workforce Safeguards. It is a NQB requirement that Trust Boards are formally sighted for safer nursing staffing levels and this is based on the assessed and recommended nurse staffing workforce required to care for inpatients.

Through the review process, Ward Managers, Matrons and Care Group Associate Chief Nurses are supported to review their workforce establishments and staffing models, taking account of measured and validated patient acuity and dependency (CHPPD), patient quality metrics and professional nursing judgement. The outcomes are considered and approved by the Senior Care Group Leadership Team. The process is detailed in Appendix 1. An assessment or re-setting of the nursing/midwifery establishment and skill mix, based on acuity and dependency data using an evidence-based toolkit must be reported to the Trust Board via internal Clinical Governance processes by ward or service twice a year.

It is critical that Trust Boards oversee workforce issues and grasp the detail of any risk to safe and high-quality care delivery. NQB highlighted that boards are accountable for ensuring their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing. While ultimate responsibility for safe staffing rests with the Chief Executive, boards are also responsible for proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care. NQB's guidance explicitly requires trusts to meet three expectations – deploying the right staff with the right skills at the right place and at the right time.

In direct response the Chief Nurse has established a formal approach to completing and presenting establishment reviews, continuing with a robust approach to assure the Board of the safety of nurse staffing and to make any recommendations to nursing establishment changes, that impact on quality care delivery and patient safety. This must be linked to professional judgement and patient outcomes. Any redesign or introduction of new roles, including but not limited to Nursing Associates, generic therapy focussed roles, would be considered a service change, and must have a full Quality Impact Assessment (QIA) and go through the Trust formal business case process.

As part of the safe staffing review, the Chief Nurse must confirm in a statement to the board that they are satisfied with the outcome of any assessment that staffing is safe, effective,

and sustainable. NHS provider boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources.

2. Current Position

The Trust currently has approximately 1000 general beds in use (including paediatrics); there are also at times additional beds open as temporary escalation spaces which equate when fully open to 60 additional temporary escalation spaces. The review of nursing and midwifery establishments is complex and any method of determining staffing levels has limitations. There is no one solution to determining safe staffing and therefore triangulation of methods is essential. Using a combined approach provides greater confidence in the decisions taken. The setting of establishments has been based on triangulation of:

1) Workload and patient information of acuity, dependency and activity using a validated Safer Nursing Care Tool.
2) Professional judgement.
3) Professional consultation and review of patient safety metrics.
4) Design and layout of ward

Safer Nursing Care Tool Audit (SNCT)

The safer nursing care tool provides organisational level metric to monitor impact on the quality of patient care and outcomes and gives a defined measure of patient acuity and dependency. It supports all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE/I 'Safe, sustainable and productive staffing' resources. Included are staffing multipliers to support professional judgement and it provides accurate data collection methodology. As an organisation we undertake this audit twice a year across all the adult inpatient wards, this has supported the decision making in this review. The SNCT is run in summer (June) and winter (February) to offer a rounded result of acuity and dependency due to seasonal changes. Ward Managers and their deputies are trained to input this data, and this is peer reviewed to ensure accuracy.

Patient acuity and dependency is also assessed and entered into the SafeCare Live module within Healthroster, twice a day using the evidence based Safer Nursing Care Tool. This calculates the care hours per patient day (CHPPD) required based on acuity and dependency needs to determine if the funded staffing levels meet the needs of the patients in our care and supports daily decision making regarding the deployment of staff. Whilst we monitor this data 24/7, 12 months a year, for the purpose of this review, as per national guidance, we use the twice-yearly audit to determine the staffing levels required.

The required CHPPD is determined by the level of acuity and dependency needs of the patients, as per the Safer Nursing Care Tool categorisation:

Level 0: Needs met by provision of normal ward cares.
Level 1a: Acutely ill patient requiring intervention (unstable or potential to deteriorate).
Level 1b: Stable patients who are dependent on nursing care to meet most or all the activities of daily living.
Level 1c: Stable patients who require additional intervention to mitigate risks and maintain safety (1 – 1 observation)
Level 1d: Stable patients who require additional intervention to mitigate risks and maintain safety (2 – 1 observation)

Level 2: Require designated beds with expertise resource/staffing level or transfer to Level 2 facility.

As CHPPD does not consider the geographical layout and design of the ward, the number of side rooms, the requirement to provide enhanced care, skill mix, staff competency, or minimum registrant numbers, this metric must be used in triangulation with other quality metrics and professional judgement.

Safe Care Red Flags

Based on the NICE Safe Staffing guidelines released in July 2014, there are several 'Red Flag' events which need to be raised should they occur. SafeCare allows red flags to be raised in real time providing visibility to staff and senior management of potential risk. This live incident mapping helps identify when staffing levels do not meet the needs of the patients and may indicate that the quality of care has declined, and patients are vulnerable. The use of red flags, process of raising them and ensuring they are mitigated or not is still an ongoing process within the organisation and therefore has not offered enough assurance to use for this review.

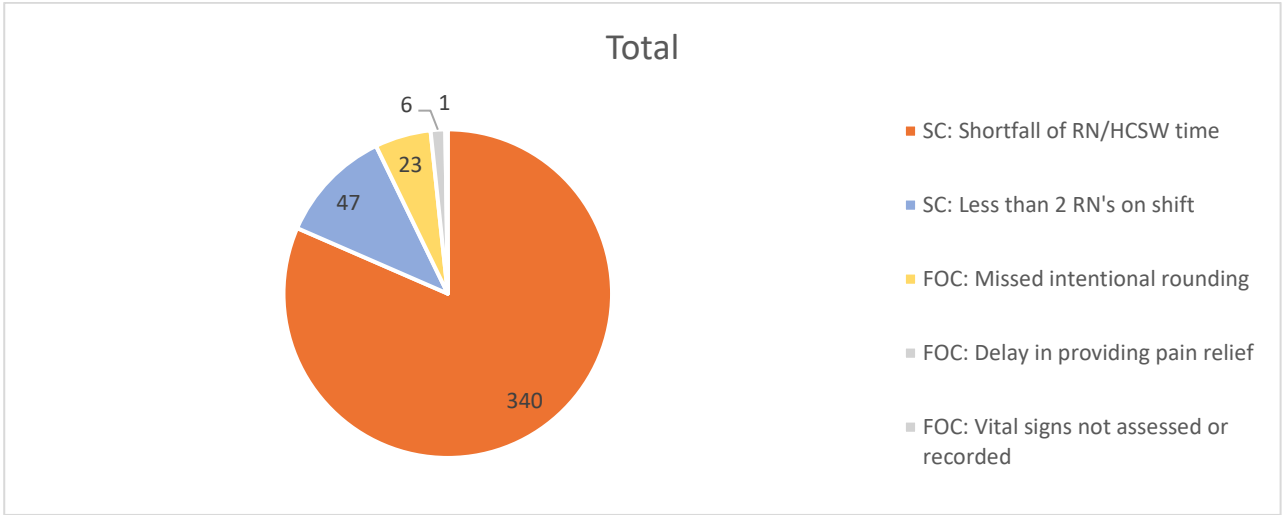
The current red flags that are used within the organisation are in line with the NICE guidelines.

Table 1 below indicates the current NICE recommended red flags:

NICE recommended red flags	
FOC1: Delay in painrelief	
FOC2: Delay in Intentional Rounding	
FOC3: Unplanned omission of medication	
FOC4: Vital Signs not assessed or recorded	
Staff1: Less than 2 RN on shift	
Staff2: Sortfall RN/HCSW hours	

The main theme for red flags that has been identified is 'shortfall RN/HCSW hours' and this will be collated monthly and shared within Care Groups from November 2024

Figure 1: Red flags escalated and reason November 2024.



Patient Quality Indicators

The patient quality metrics available in the Trust are provided through the nursing dashboard on Signal and provides additional evidence to triangulate the sustained demand on our staff, and the increased acuity and dependency of in-patients to measure the impact on avoidable patient harm and poor outcomes and support the decision making in this review. The quality indicators that are measured in the reviews are detailed in Appendix 2.

As part of the review, other factors have been considered as detailed below:

Career Development

The organisation has an ambition to 'grow our own' nursing teams to ensure that the nursing workforce reflects the needs of the patient and ensuring that future roles are available for progression. This means that we will increase all our apprenticeships particularly the Health Care Support Worker (HCSW) and Nursing Associate (NA) apprenticeships. This review has shown an increased requirement for the Band 4 NA role of **13.65 WTE**, from redefining the required workforce model (Table 2).

Table 2: Number of Nursing Associates, current, proposed and variance:

Current budget WTE	Proposed budget WTE	Variance WTE
54.37	68.02	+13.65

There is much more to be done to address the gaps in our workforce across various roles, professional groups, and geographies, and develop appropriate multidisciplinary patient care workforce models. If we are to address the pressures of workload and deliver the care patients need, we need to focus now on what we can do to grow our workforce in the coming years.

Band 2 – 3 Updates

As an organisation we are undertaking the band 2 to 3 role scoping work. This is in alignment with the trade union's 'Fair Pay for patient care' campaign. Phase 2 of this work is complete, and board agreement has been reached in negotiating a settlement offer with trade unions. Trade Union acceptance of this offer by its members is a significant step forward and provides further assurance of continued stability for the vacancy percentage in this staff group.

The next stage will focus on the support of staff seeking to remain at band 2 and relinquish band 3 duties and further provide support, oversight and assurance that those staff members seeking an uplift to band 3 are performing all required duties expected through revised job descriptions. Finally, it will outline the organisational change process**.** Wards included in this process are all the adult and children's inpatient areas within this establishment and is an approximate uplift of 350 WTE.

Priority areas of focus

National Guidance

As part of the review there has been consideration given to specific National Clinical Guidelines; the main one considered in this report is stroke services. This has been undertaken in conjunction with the Associate Chief Nurses, who have utilised professional judgement, in addition to quality indicators, to identify their biggest risks and wards of concern, as agreed within the Care group.

Acute Stroke Unit (ASU) including Hyperacute Stroke Unit (HASU)

The National Clinical Guidelines for Stroke were updated in April 2023 providing authoritative, evidence-based practice guidance to improve the quality of care delivered to every adult who has a stroke in the United Kingdom. The recommendations are:

• People with stroke should be treated in a specialist stroke unit throughout their hospital stay unless the stroke is not the predominant clinical problem.
• A hyperacute, acute and rehabilitation service should provide specialist nurse staffing levels matching the following recommendations:

- 1.35 WTE registered nurses per bed (7 days) for Acute Stroke Care
- 2.9 WTE registered nurses per bed (7 days) for Hyper Acute Stroke Care

The National Stroke Service Model states, in the first 72 hours for every patient admitted with acute stroke and classified as a level 2 patient within Safecare and SNCT.

York and Scarborough Hospitals has 1 Acute Stroke Centre for all sites which is the Acute Stroke Unit (ASU), it is a 25 bedded unit incorporating 8 Hyper acute stroke unit (HASU) beds with the nurse staffing model running over the standard 3 shift pattern – early, late and night shift. There is also a (HASU) service pathway to receive a pre alert by Yorkshire Ambulance Services to meet the patient in the Emergency Department to prevent delays to Thrombolysis.

Table (4) below indicates there is an overall requirement to increase the WTE by **16.83 WTE** to achieve the National Clinical Guidelines for the Acute Stroke Service based on direct calculation of registered nurses required.

Table 4: Stroke Services (Acute/HASU) required WTE: Registered and Non-Registered

	WTE
Current	49.31
Proposed	66.14
Variance	+16.83

The total costs attributed to these changes is **£820,325**, it is a recommendation to prioritise this for investment within this establishment review period.

There is an additional requirement to undertake a full review of the rehabilitation provision for stroke services alongside AHP colleagues over the coming months where it is expected more investment will be required and will be considered during the next establishment review process.

Family Health (Children's Services) – Supervisory Days

In 2018, The Shelford Group published The Children's and Young People's Safer Nursing Care Tool (C&YP SNCT) which is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013. It was designed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards.

Within Child Health budgets, the Ward Manager on Ward 17 is currently funded for 2 supervisory days per week, Rainbow 1 day per week. As part of this establishment review, Children's Services request to be in alignment with the rest of the organisation with a proposed plan to move to 5 supervisory days.

Rainbow ward is the only acute paediatric ward for children and young people on the east coast and provides services to a population that has geographical and socioeconomic challenges. Services provided range from general medical, surgical, paediatric critical care and paediatric specialist care such as oncology and Children's Mental Health Services. With no dedicated Children's Assessment Unit, the ward is the first point of call for all primary care referrals coming directly to the ward. The transfer time to a paediatric specialist tertiary centre is a minimum of a one-hour journey, which necessitates Rainbow to stabilise and hold critically unwell children longer than any other hospital in the region. The night duty ward establishment does not support the ability to provide enhanced care for any sick/deteriorating child awaiting transfer out to a tertiary centre.

In summary, the key priorities that are requested for Children's inpatient wards from this staffing review are outlined below:

1. Ward managers to increase from 1 to 5 supervisory days as part of the ambition to achieve this for all wards across the organisation (this is included in costs identified below).
2. Headroom to increase from 20% to 22%, in line with the adult inpatient wards. The Royal College of Nursing (2013) suggest a headroom of 25% due to the requirement of specific training however the Care Group senior nurse leaders are keen to uplift to 22% in the first instance and then scope additional requirements. The cost of this is **£18,722**
3. Increase Rainbow ward staffing overnight to provide an additional nursing associate, requiring investment of **£109,542**.

Ward Manager Supervisory Time Allocation

Ward Managers are allocated approximately 3 days as supervisory on most of the adult inpatient wards to undertake predominantly administrative tasks such as HR issues, rostering, and recruitment; the time allocated varies and lacks consistency. Front-line leaders in healthcare settings are the people with the strongest and most immediate influence on staff behaviour. Therefore, ward managers are well-placed to improve organisational cultures and implement appropriate changes in their practice settings, if provided with appropriate support and training.

As an organisation we have an ambition to provide every ward leader with the skills to lead their wards effectively and in order to do this be given the training and the time to undertake

this in a full-time capacity. This has been considered as part of this review and viewed as a priority to ensure that this role can be pivotal in ensuring their teams deliver safe and effective care, with clear guidance and utilising the Quality Improvement approach that we endorse.

To enable all ward managers to be in a supervisory role this requires an additional investment of **£514,266** across the organisation to the wards included in this review.

Alongside this there will be an upcoming review of the senior nurse leadership within Care Groups to consider as the Ward Manager role becomes supervisory how the Matron role is refreshed and focusses on quality and safety and how these roles work together. Any further efficiency savings identified following this senior leader review will be reinvested in frontline nursing teams in response to the priority areas identified in this establishment review.

Outcome of the Establishment Review

Nurse staffing establishment reviews have identified the safe nurse staffing level for each inpatient ward, and this requires a degree of investment. Table 5 provides an outcome summary of care group nurse establishment reviews, it annotates current funded WTE roles, desired WTE roles following establishment review and the variance across roles and care groups. Table 5 suggests a total **120.66 WTE** establishment increase is required across Care Groups this includes a further **16.83 WTE** in Acute Stroke Services with Care Group Medicine requiring the highest total uplift of **42.68 WTE**.

Table 5: Summary outcome of nurse staffing reviews

Care Group	Current Funded WTE			Desired WTE			Variance		
	Registered Nurses	Non registered Nurses	Total	Registered Nurses	Non registered Nurses	Total	Registered Nurses	Non registered Nurses	Total
	WTE	WTE	WTE	WTE	WTE		WTE	WTE	WTE
Cancer Specialist & Clinical Support Services Group	22.36	8.92	**31.28**	23.69	11.23	**34.92**	1.33	2.31	**3.64**
Family Health Care Group	94.22	63.88	**158.10**	109.94	78.39	**188.33**	15.72	14.51	**30.23**
Medicine	345.67	393.47	**739.14**	369.95	411.87	**781.82**	24.28	18.40	**42.68**
Surgery	225.87	197.72	**423.59**	241.21	226.49	**467.70**	15.34	28.77	**44.11**
TOTAL	**688.12**	**663.99**	**1,352.11**	**744.80**	**727.97**	**1,472.77**	**56.68**	**63.98**	**120.66**

Appendix 3 is a detailed summary by ward and care group to see current funded WTE roles and desired WTE increase following the nurse establishment review.

The Chief Nurse and Finance Director have reviewed all investment requests and key priorities have been identified based on improving patient safety. These have been identified within this paper as priority areas of focus; these areas carry the most significant risk to patient safety and quality of care delivery. The Stroke Unit is currently operating outside of the National Clinical Guidelines for Stroke service establishment and the Children's and Young People unit is the only acute children's ward on the East Coast. Finally, the ward manager's supervisory time would drive improvements in quality care delivery and improve quality care delivery metrics, by bringing leadership closer to the patient.

This paper offers assurance to the board that the nursing establishment review is complete and has informed a recommended **120.66 WTE** increase. Further financial modelling is required and this work is currently in progress. A supplementary establishment review finance paper will be submitted to the April 2025 Executive Committee. The outcome for all the Care Groups will be to ensure that wards that require investment, as a result of their quality indicators, will be prioritised and agreed with the senior nursing team where it is most needed.

Annual Governance Statement

As noted within this paper, the methodology and governance adopted in this review is compliant with both the NQB (2016) and NHSE guidance and pays due consideration to the RCN Workforce Standards (2021). The Care Groups have triangulated the evidence from the Nursing Quality Assurance Framework, and patient and staff experience, alongside professional judgement, to provide assurance that the proposed required workforce models are safe, sustainable, and effective. The annual governance statement will be signed by the Chief Executive in June 2025.

Summary

This review has demonstrated the ongoing requirement to review the nursing workforce for both registered and non-registered nurses across the organisation, aligned to NQB guidance and specifically against current National Guidance in Acute Stroke for this review. Some clinical areas have been omitted from this review due to current service redesign and the imminent opening of the Urgent and Emergency Care Centre in Scarborough where there will be further workforce changes. These are specific to the Medicine Care Group and a full review and QIA has been undertaken but will be reviewed in the next 6-month report.

In the month of March 2025, finance and senior nursing leaders will work collaboratively to robustly articulate care group efficiency impact and redirection of associated funds to support priority areas identified in this paper; in addition business cases to support implementation of establishment review for care groups in the coming weeks will be undertaken.

Recommendations

- Acknowledge this report within the organisation for completing the required six-monthly nurse safe staffing reviews as per national guidance.

- Support the proposal for the Ward Manager role to become full time (5 days) supervisory, to move clinical leadership closer to the patient, as it is deemed vital to front line leadership and the delivery of high-quality care for patients across all Care Groups.

- Support the changes required in children's services to level up the headroom and supervisory time to align with the adult inpatient wards.

- Work with Care groups and senior nurse leaders to identify and utilise the resource released from long day efficiencies, to target resource for priority areas, including assessment wards in line with the emerging clinical strategy and bed management recommendations.

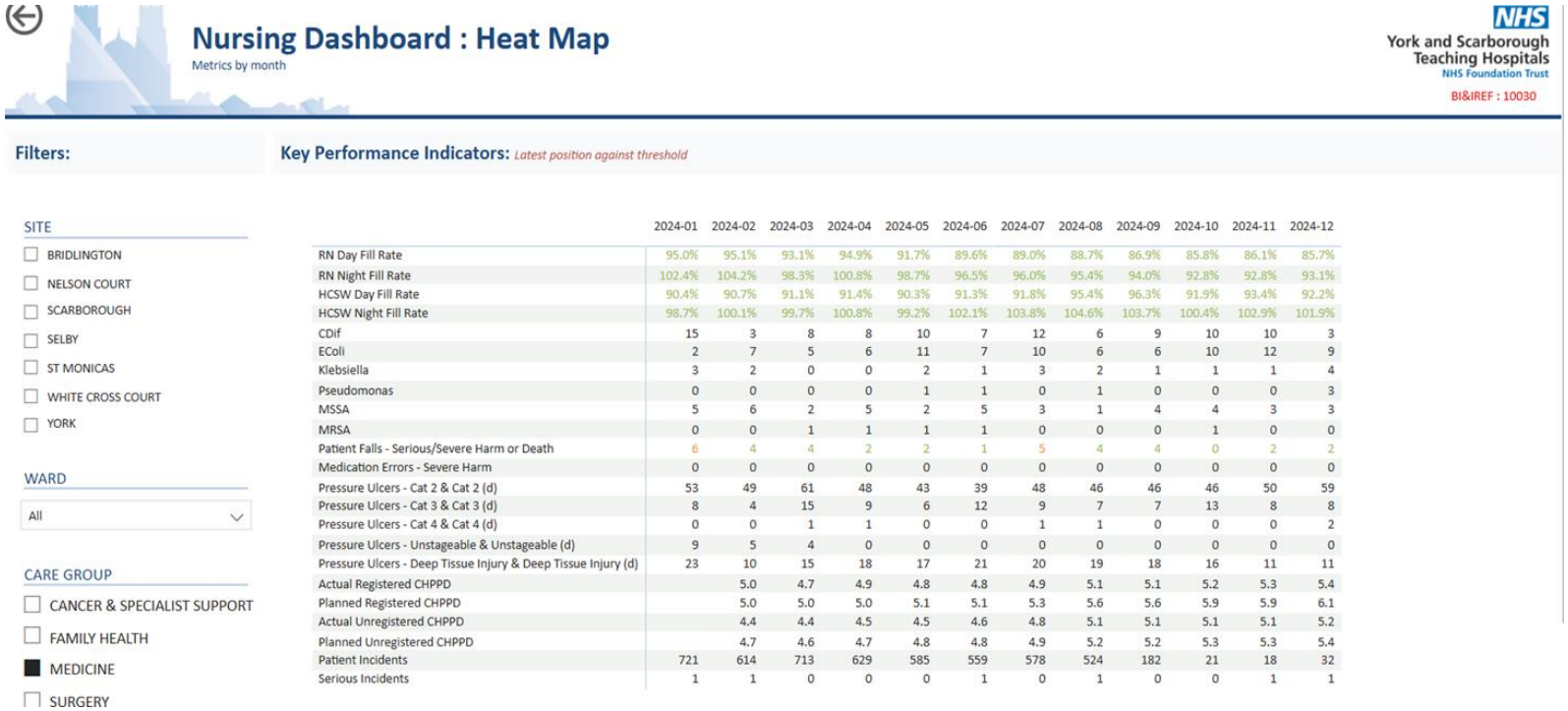
- To support a financial nurse establishment review modelling paper in April 2025 to Executive Committee

Appendix 1 Establishment review process

Establishment Review Flow Chart 2025/26

Stage 1	Accountability	Timeline
Nurse staffing review starts. Email and letter notification sent to Care Group Senior team and copied to Finance Manager	**Chief Nurse**	**Week 1 w/c 29/7/23**
Nurse Staffing Review Toolkit and Standard Operating Procedure, timeline of actions and Care Group Quality Metrics summary paper sent to Care Group Associate Chief Nurses (ACN) Copied to Associate Chief Operating Officer (ACOO) for Care Group	**Assistant Chief Nurse**	**Week 2 05/08/24**
Care Group ACN in collaboration with Heads of Nursing/ Matrons / Ward Managers to review current nursing/midwifery workforce models and develop recommended reviewed nursing workforce models.	**Care Group ACNs**	**Week 2 – 6 max. By 16/09/24**
Associate Chief Nurse to discuss recommendations and gain initial support from Senior Care Group team. Care Group ACN submit and present completed toolkit and workforce model to Assistant Chief for joint review.	**Care Group ACN**	**By Latest Week 8 21/9/24**
Stage 2		
Care Group Senior Team approved revised workforce model to be presented to the Chief Nurse by ACN and Band 7 for professional agreement.	**Care Group ACN Band 7 Assistant Chief Nurse**	**Week 8 w/c 23/09/24**
Professionally approved final Staffing Review Paper of quality metrics and recommended staffing model shared with Senior Care Group team and agreed. Care Group ACN co –authors paper with Assistant Chief Nurse	**Assistant Chief Nurse and Associate Chief Nurse**	**Week 13 21/10/24 onwards**
Paper with quality metrics and recommended workforce model roles and WTE shared with Senior Care Group Triumvirate for information.	**ACN**	**w/c** **07/01/25**
Stage 3		
Chief Nurse presents the annual staffing review paper to resource – Exec Committee	**Chief Nurse**	**January 2025**
Care Group business cases for additional workforce capacity funding written	**Care Group Finance Manager**	**TBC**
Care Group Senior Team agree business case and funding - present back to Exec team for review/ agreement or non-approval	**ACOO**	**January 2025**

Appendix 2 Quality Indicators used to triangulate nurse staffing review



Nursing Dashboard : Heat Map

Metrics by month

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

BI&IREF : 10030

Filters:

SITE

- BRIDLINGTON
- NELSON COURT
- SCARBOROUGH
- SELBY
- ST MONICAS
- WHITE CROSS COURT
- YORK

WARD

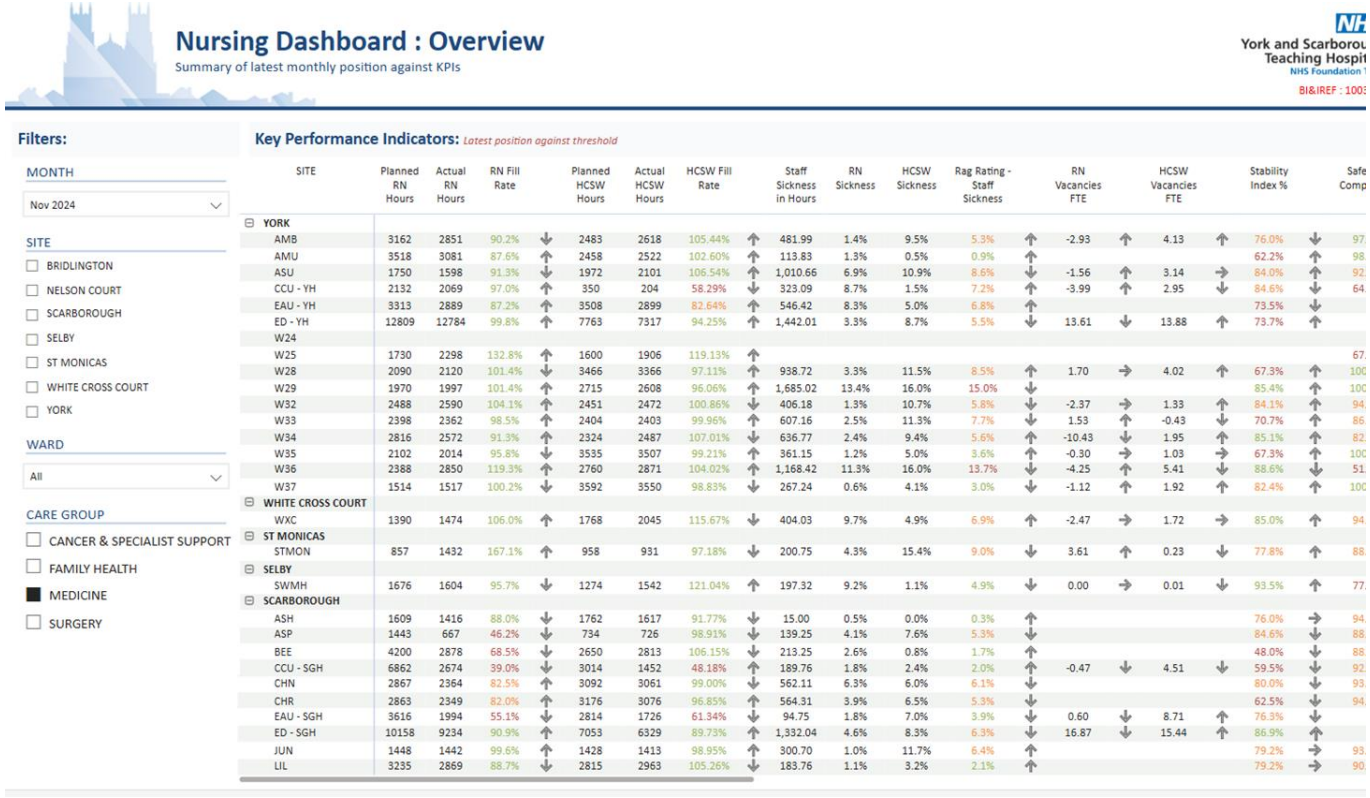
All

CARE GROUP

- CANCER & SPECIALIST SUPPORT
- FAMILY HEALTH
- MEDICINE
- SURGERY

Key Performance Indicators: *Latest position against threshold*

	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12
RN Day Fill Rate	95.0%	95.1%	93.1%	94.9%	91.7%	89.6%	89.0%	88.7%	86.9%	85.8%	86.1%	85.7%
RN Night Fill Rate	102.4%	104.2%	98.3%	100.8%	98.7%	96.5%	96.0%	95.4%	94.0%	92.8%	92.8%	93.1%
HCSW Day Fill Rate	90.4%	90.7%	91.1%	91.4%	90.3%	91.3%	91.8%	95.4%	96.3%	91.9%	93.4%	92.2%
HCSW Night Fill Rate	98.7%	100.1%	99.7%	100.8%	99.2%	102.1%	103.8%	104.6%	103.7%	100.4%	102.9%	101.9%
CDif	15	3	8	8	10	7	12	6	9	10	10	3
EColi	2	7	5	6	11	7	10	6	6	10	12	9
Klebsiella	3	2	0	0	2	1	3	2	1	1	1	4
Pseudomonas	0	0	0	0	1	1	0	1	0	0	0	3
MSSA	5	6	2	5	2	5	3	1	4	4	3	3
MRSA	0	0	1	1	1	1	0	0	0	1	0	0
Patient Falls - Serious/Severe Harm or Death	6	4	4	2	2	1	5	4	4	0	2	2
Medication Errors - Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers - Cat 2 & Cat 2 (d)	53	49	61	48	43	39	48	46	46	46	50	59
Pressure Ulcers - Cat 3 & Cat 3 (d)	8	4	15	9	6	12	9	7	7	13	8	8
Pressure Ulcers - Cat 4 & Cat 4 (d)	0	0	1	1	0	0	1	1	0	0	0	2
Pressure Ulcers - Unstageable & Unstageable (d)	9	5	4	0	0	0	0	0	0	0	0	0
Pressure Ulcers - Deep Tissue Injury & Deep Tissue Injury (d)	23	10	15	18	17	21	20	19	18	16	11	11
Actual Registered CHPPD		5.0	4.7	4.9	4.8	4.8	4.9	5.1	5.1	5.2	5.3	5.4
Planned Registered CHPPD		5.0	5.0	5.0	5.1	5.1	5.3	5.6	5.6	5.9	5.9	6.1
Actual Unregistered CHPPD		4.4	4.4	4.5	4.5	4.6	4.8	5.1	5.1	5.1	5.1	5.2
Planned Unregistered CHPPD		4.7	4.6	4.7	4.8	4.8	4.9	5.2	5.2	5.3	5.3	5.4
Patient Incidents	721	614	713	629	585	559	578	524	182	21	18	32
Serious Incidents	1	1	0	0	0	1	0	1	0	0	1	1



Nursing Dashboard : Overview

Summary of latest monthly position against KPIs

York and Scarborou Teaching Hospit NHS Foundation

BI&IREF : 100

Filters:

MONTH

Nov 2024

SITE

- BRIDLINGTON
- NELSON COURT
- SCARBOROUGH
- SELBY
- ST MONICAS
- WHITE CROSS COURT
- YORK

WARD

All

CARE GROUP

- CANCER & SPECIALIST SUPPORT
- FAMILY HEALTH
- MEDICINE
- SURGERY

Key Performance Indicators: *Latest position against threshold*

SITE	Planned RN Hours	Actual RN Hours	RN Fill Rate	Planned HCSW Hours	Actual HCSW Hours	HCSW Fill Rate	Staff Sickness in Hours	RN Sickness	HCSW Sickness	Rag Rating - Staff Sickness	RN Vacancies FTE	HCSW Vacancies FTE	Stability Index %	Safe Comp
YORK														
AMB	3162	2851	90.2%	2483	2618	105.44%	481.99	1.4%	9.5%	5.3%	-2.93	4.13	76.0%	97
AMU	3518	3081	87.6%	2458	2522	102.60%	113.83	1.3%	0.5%	0.9%			62.2%	98
ASU	1750	1598	91.3%	1972	2101	106.54%	1,010.66	6.9%	10.9%	8.6%	-1.56	3.14	84.0%	92
CCU - YH	2132	2069	97.0%	350	204	58.29%	323.09	8.7%	1.5%	7.2%	-3.99	2.95	84.6%	64
EAU - YH	3313	2889	87.2%	3508	2899	82.64%	546.42	8.3%	5.0%	6.8%			73.5%	
ED - YH	12809	12784	99.8%	7763	7317	94.25%	1,442.01	3.3%	8.7%	5.5%	13.61	13.88	73.7%	
W24														
W25	1730	2298	132.8%	1600	1906	119.13%								67
W28	2090	2120	101.4%	3466	3366	97.11%	938.72	3.3%	11.5%	8.5%	1.70	4.02	67.3%	100
W29	1970	1997	101.4%	2715	2608	96.06%	1,685.02	13.4%	16.0%	15.0%			85.4%	100
W32	2488	2590	104.1%	2451	2472	100.86%	406.18	1.3%	10.7%	5.8%	-2.37	1.33	84.1%	94
W33	2398	2362	98.5%	2404	2403	99.96%	607.16	2.5%	11.3%	7.7%	1.53	-0.43	70.7%	86
W34	2816	2572	91.3%	2324	2487	107.01%	636.77	2.4%	9.4%	5.6%	-10.43	1.95	85.1%	82
W35	2102	2014	95.8%	3535	3507	99.21%	361.15	1.2%	5.0%	3.6%	-0.30	1.03	67.3%	100
W36	2388	2850	119.3%	2760	2871	104.02%	1,168.42	11.3%	16.0%	13.7%	-4.25	5.41	88.6%	51
W37	1514	1517	100.2%	3592	3550	98.83%	267.24	0.6%	4.1%	3.0%	-1.12	1.92	82.4%	100
WHITE CROSS COURT														
WXC	1390	1474	106.0%	1768	2045	115.67%	404.03	9.7%	4.9%	6.9%	-2.47	1.72	85.0%	94
ST MONICAS														
STMON	857	1432	167.1%	958	931	97.18%	200.75	4.3%	15.4%	9.0%	3.61	0.23	77.8%	88
SELBY														
SWMH	1676	1604	95.7%	1274	1542	121.04%	197.32	9.2%	1.1%	4.9%	0.00	0.01	93.5%	77
SCARBOROUGH														
ASH	1609	1416	88.0%	1762	1617	91.77%	15.00	0.5%	0.0%	0.3%			76.0%	94
ASP	1443	667	46.2%	734	726	98.91%	139.25	4.1%	7.6%	5.3%			84.6%	88
BEE	4200	2878	68.5%	2650	2813	106.15%	213.25	2.6%	0.8%	1.7%			48.0%	88
CCU - SGH	6862	2674	39.0%	3014	1452	48.18%	189.76	1.8%	2.4%	2.0%	-0.47	4.51	59.5%	92
CHN	2867	2364	82.5%	3092	3061	99.00%	562.11	6.3%	6.0%	6.1%			80.0%	93
CHR	2863	2349	82.0%	3176	3076	96.85%	564.31	3.9%	6.5%	5.3%			62.5%	94
EAU - SGH	3616	1994	55.1%	2814	1726	61.34%	94.75	1.8%	7.0%	3.9%	0.60	8.71	76.3%	
ED - SGH	10158	9234	90.9%	7053	6329	89.73%	1,332.04	4.6%	8.3%	6.3%	16.87	15.44	86.9%	
JUN	1448	1442	99.6%	1428	1413	98.95%	300.70	1.0%	11.7%	6.4%			79.2%	93
LIL	3235	2869	88.7%	2815	2963	105.26%	183.76	1.1%	3.2%	2.1%			79.2%	90

Appendix 3 – Detailed summary of nurse establishment review outcome

Care Group	Cost Centre	Cost Centre Description	Current Funded WTE			Desired WTE			Variance		
			Registered Nurses	Non registered Nurses	Total	Registered Nurses	Non registered Nurses	Total	Registered Nurses	Non registered Nurses	Total
			WTE	WTE	WTE	WTE	WTE		WTE	WTE	WTE
Cancer Specialist & Clinical Support Services Group	111171	Ward 31 - Haematology/Oncology	22.36	8.92	**31.28**	23.69	11.23	**34.92**	1.33	2.31	**3.64**
Family Health Care Group	111309	Nelson's Court Ward 1	10.95	13.69	**24.64**	14.29	18.06	**32.35**	3.34	4.37	**7.71**
Family Health Care Group	111310	Nelson's Court Ward 2	11.25	13.69	**24.94**	14.29	18.06	**32.35**	3.04	4.37	**7.41**
Family Health Care Group	112104	Child Health - Ward 17 / 18	31.92	8.95	**40.87**	36.49	10.03	**46.52**	4.57	1.08	**5.65**
Family Health Care Group	113648	St Monica's Inpatient Unit	10.24	5.63	**15.87**	11.53	5.79	**17.32**	1.29	0.16	**1.45**
Family Health Care Group	113649	Selby Inpatient Unit	13.19	14.31	**27.50**	14.29	18.06	**32.35**	1.10	3.75	**4.85**
Family Health Care Group	152014	Child Health - Rainbow Ward	16.67	7.61	**24.28**	19.07	8.38	**27.45**	2.40	0.77	**3.17**
Medicine	111131	General Medical Ward 33 (Renal)	20.73	22.99	**43.72**	21.19	26.21	**47.40**	0.46	3.22	**3.68**
Medicine	111180	General Medical Ward 34 (Respiratory)	24.17	25.34	**49.51**	25.27	22.14	**47.40**	1.10	-3.20	**-2.11**
Medicine	111190	General Medical Ward 32 (Cardio/Neuro)	21.03	22.79	**43.82**	22.84	22.91	**45.75**	1.81	0.12	**1.93**
Medicine	111191	Coronary Care Unit	19.01	5.47	**24.48**	19.54	6.61	**26.15**	0.53	1.14	**1.67**
Medicine	111199	General Medical Ward 36 (Gastro)	25.41	26.92	**52.33**	24.50	26.21	**50.71**	-0.91	-0.71	**-1.62**
Medicine	111300	Elderly Whitecross Court (Stroke Rehab)	14.49	20.48	**34.97**	15.47	27.09	**42.56**	0.98	6.61	**7.59**
Medicine	111303	Elderly Ward 29 (Elderly Short Stay)	22.00	26.98	**48.98**	21.19	26.21	**47.40**	-0.81	-0.77	**-1.58**
Medicine	111305	Elderly Ward 28 (Elderly Acute)	21.67	32.52	**54.19**	21.19	31.94	**53.13**	-0.48	-0.58	**-1.06**
Medicine	111306	Elderly Ward 37 (Dementia)	12.08	31.50	**43.58**	15.47	31.94	**47.40**	3.39	0.44	**3.82**
Medicine	111317	Acute Stroke Unit Ward 23	29.00	20.31	**49.31**	44.04	29.52	**73.55**	15.04	9.21	**24.24**
Medicine	111318	Elderly Ward 35	21.67	32.52	**54.19**	21.19	31.94	**53.13**	-0.48	-0.58	**-1.06**
Medicine	152011	Aspen Ward (Gen Med)	11.37	5.77	**17.14**	12.16	0.00	**12.16**	0.79	-5.77	**-4.98**
Medicine	152029	Cherry Ward (Care of Elderly)	25.78	26.95	**52.73**	24.50	29.52	**54.01**	-1.28	2.57	**1.28**
Medicine	152032	Ash Ward (Gastro)	13.34	17.51	**30.85**	13.81	18.06	**31.88**	0.47	0.55	**1.03**
Medicine	152051	Juniper Ward (Gen Med/High Risk Covid)	11.70	11.83	**23.53**	12.16	10.21	**22.37**	0.46	-1.62	**-1.16**
Medicine	152058	Mulberry Ward (Discharge to Assess)	13.65	16.62	**30.27**	12.16	18.06	**30.22**	-1.49	1.44	**-0.05**
Medicine	152061	Chestnut Ward (Care of Elderly)	24.02	25.91	**49.93**	24.50	29.52	**54.01**	0.48	3.61	**4.08**
Medicine	152071	Johnson Ward (Stroke & Rehab)	14.55	21.06	**35.61**	18.77	23.79	**42.56**	4.22	2.73	**6.95**
Surgery	111403	Surgery Ward 14 YH	36.72	23.78	**60.50**	40.04	23.80	**63.84**	3.32	0.02	**3.34**
Surgery	111404	Surgery Ward 11 YH	24.50	18.06	**42.56**	24.50	23.80	**48.30**	0.00	5.74	**5.74**
Surgery	111405	Surgery Ward 16 YH	26.92	20.48	**47.40**	26.93	23.80	**50.73**	0.01	3.32	**3.33**
Surgery	111503	Ward 26 (old Ward G1)	21.19	20.48	**41.67**	21.20	20.50	**41.70**	0.01	0.02	**0.03**
Surgery	111703	Ward 15 (old Ward 28)	21.19	22.13	**43.32**	21.21	27.25	**48.46**	0.02	5.12	**5.14**
Surgery	111704	Ward 39 (old Ward 29)	15.47	22.13	**37.60**	15.47	25.45	**40.92**	0.00	3.32	**3.32**
Surgery	112219	Day Unit	12.13	3.48	**15.61**	15.11	5.92	**21.03**	2.98	2.44	**5.42**
Surgery	112220	ESA Ward 12	15.47	17.10	**32.57**	21.21	21.14	**42.35**	5.74	4.04	**9.78**
Surgery	152013	Maple Ward - SGH	25.94	23.17	**49.11**	26.49	23.81	**50.30**	0.55	0.64	**1.19**
Surgery	152050	Holly Ward - Sgh	15.25	17.71	**32.96**	15.26	23.75	**39.01**	0.01	6.04	**6.05**
Surgery	152072	Kent Ward - BDH	11.09	9.20	**20.29**	13.79	7.27	**21.06**	2.70	-1.93	**0.77**
TOTAL			**688.12**	**663.99**	**1,352.11**	**744.80**	**727.97**	**1,472.77**	**56.68**	**63.98**	**120.66**

Report to:	Board of Directors
Date of Meeting:	26 March 2025
Subject:	2024 Staff Survey results (nationally benchmarked)
Director Sponsor:	Polly McMeekin, Director of Workforce & Organisational Development
Author:	Vicki Mallows, Workforce Lead

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:

- Directors to note the overall results (and particularly the deterioration in participation rates and the staff engagement score, both of which are well below the peer group average).

- Directors to note the themes from the free text comments about what it is like to work in the Trust.
- Directors to ensure all Care Groups, Corporate Directorates and YTHFM are utilising staff feedback effectively, producing co-created action plans to improve staff experience, and implementing those plans.
- Directors to contribute to the corporate improvement plan and support its implementation across the Trust.
- Directors to continue to support the Our Voice Our Future programme, actively role model compassionate leadership, and address inappropriate behaviours whenever they are observed or reported.
- Directors to identify things to celebrate and share good practice widely.

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
Resources Committee	18 03 2025	Report discussed and next steps shared.
Executive Committee	19 03 2025	

2024 Staff Survey Results (nationally benchmarked)

1. Introduction and Background

The 2024 national NHS Staff Survey was open between 7 October and 29 November. It measures how engaged staff are and provides insight into how colleague experiences and ultimately staff retention can be improved. Evidence shows that more engaged staff result in better patient experiences and outcomes.

The Trust results are benchmarked against our national peer group of all Acute/Acute & Community Trusts (122 including this Trust).

2. Results

Our response rate deteriorated further in 2024 and is 13% under the peer group average:

	2024	2023	2022	2021
Trust overall #	**36%**	39%	43%	40%
National peer average	49%	45%	45%	46%

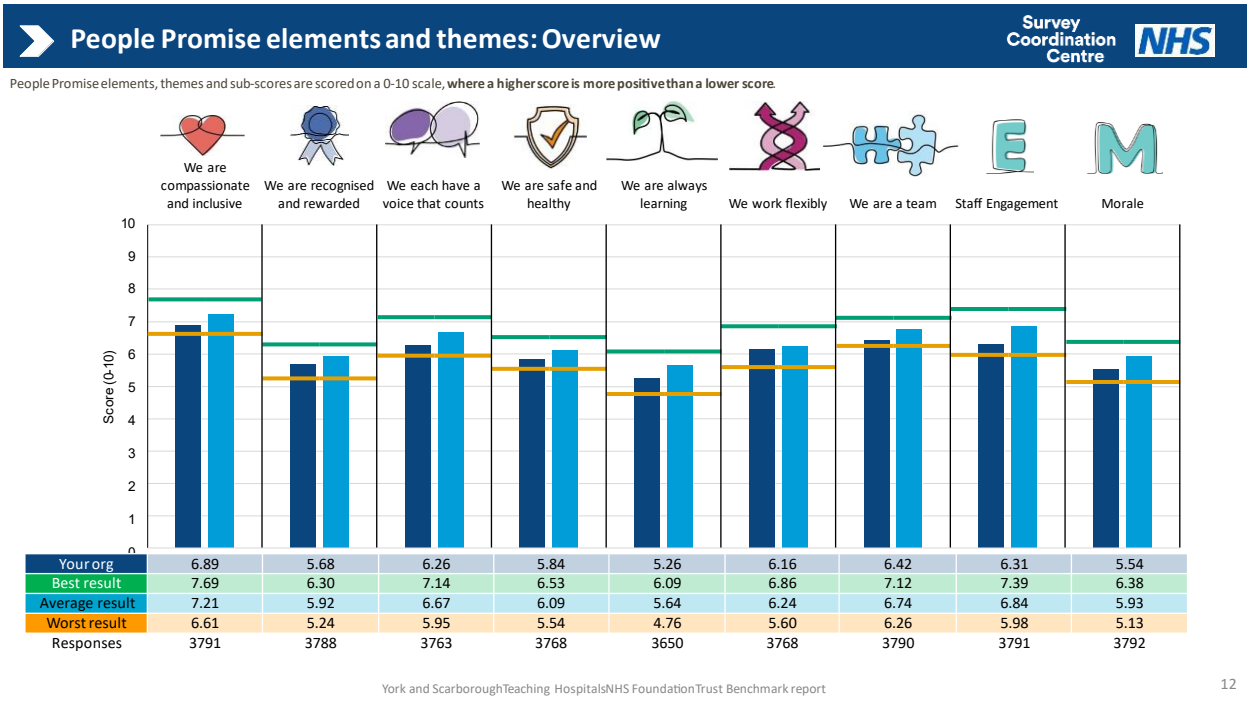
includes YTHFM staff

Each Care Group, Corporate Directorate and YTHFM were set stretch targets in 2024 to encourage more staff to complete the survey and hence make the feedback more representative of the whole workforce. Whilst this resulted in an improvement across all

corporate directorates and a minor improvement for YTHFM, none of the Care Groups saw an increase, and three saw a reduction in participation levels.

The below average response rates evidence that more work is needed to understand the barriers to completion of the survey, and reasons for lack of engagement from colleagues. It also reflects feedback from change makers about the ongoing challenge to achieve effective communication with all colleagues at all sites – particularly those that have irregular / no access to electronic communications.

The results have been categorised into nine themes, seven of these are based on elements of the People Promise plus the two recurring themes of 'Staff Engagement' and 'Morale':



[scores are out of 10]

The results in full are available upon request or via the Staff Survey co-ordination website once the embargo is lifted on 13 March.

There are 102 mandated questions in the survey, we did not ask any additional local questions in 2024.

Free Text Comments

Staff are invited to answer two 'free text' nationally set questions at the end of the survey:

On what grounds have you experienced discrimination? (118 contributors, a similar level of response to 2023). The key themes were:

- Personal Characteristics (accent, nationality, ethnicity, gender, tattoos, hair colour and physical appearance).
- Career Progression & Promotion Bias.
- Health & Disability Discrimination.
- Bullying, Victimisation & Managerial Bias.

Any other comment to make about working for the Trust? (1015 contributors, a 10% increase from 2023). 4.5% of the comments were positive (compared to 8.3% in 2023).

The themes are broadly unchanged from 2023, except for an increase in negative comments relating to perceived discrimination / positive action relating to activities aimed at improving equality and inclusion within the Trust.

Themes:

- Management & Leadership
- Working Environment
- Resources
- Bullying & Workplace Behaviours
- Equality, Diversity & Inclusion
- Workplace Safety

There is significant detail under many of the above categories. A comprehensive summary and spreadsheet have been distributed to Directors via email by Lydia Larcum.

Of the 46 responses that were positive, the following factors were key:

- Feeling a strong sense of job satisfaction, being valued and supported.
- Appreciation for teamwork, supportive colleagues, and professional development opportunities.
- Feeling that patient care is a top priority and proud of their contributions.
- Flexible working arrangements and leadership improvements seen as positive changes.

3. Current Position/Issues

Compared to 2023, the Trust has improved in one element (We are recognised & rewarded); it has maintained in seven areas; and it has deteriorated in one theme (Staff Engagement).

Nationally the scores for all Acute/Acute & Community Trusts have remained similar for eight of the nine elements/themes and have deteriorated slightly for one (Staff Engagement).

The Trust is below our peer group average for every element and theme in 2024 except 'We work flexibly' where we are average (when scores are rounded up/down).

The biggest gaps in performance compared to our peers are for the element 'We each have a voice that counts' (0.41) and the theme 'Staff Engagement' (0.53). This is almost identical to 2023.

Within 'Staff Engagement' the sub-score of 'Advocacy' has the biggest gap (1.04 below our peers – this gap is wider than in 2023).

The Advocacy sub-score has three questions:	Trust 2024	Peer Average 2024
Care of patients is my organisation's top priority	58.86%	74.42%
I would recommend my organisation as a place to work	44.79%	60.90%
If a friend or relative needed treatment I would be happy with the standard of care provided	43.09%	61.54%

Questions not linked to a People Promise Element / Theme

The Trust scores lower than the peer average for all questions relating to discrimination based on a protected characteristic, except for ethnic background and religion.

In relation to questions about errors/near misses / incidents the Trust performs worse than the peer average for the number observed, feeling that staff involved will be treated fairly, and that the organisation takes action to ensure they are not repeated.

On a positive note, for the third year running the Trust is better than the peer average at making reasonable adjustments where required.

Workforce Race Equality Standard & Workforce Disability Equality Standard

The questions relating to the WRES standards continue to show that staff from all other ethnic groups have a worse experience than their white colleagues, and worse than the peer average.

The questions relating to the WDES standards continue to show that staff with a disability / long term health condition have a worse experience than their colleagues; when compared to the peer average the Trust is better for some questions but worse for others.

4. Summary

The results reflect what the Trust is like as a place to work and receive care and echo the feedback gathered in the Discovery Phase of the Our Voice Our Future programme in the first half of 2024. The Design Phase of the programme is focusing upon:

- Values-Led Leadership and Management
- Communication and Engagement
- Quality Improvement and Learning

Care Groups, Corporate Directorates, and YTHFM were explicitly asked to share their results with staff and co-create improvement plans to address feedback that:

- in previous years action has come too slowly after the survey has closed.
- some staff (including some supervisors and managers) never get to see the results for their team or have opportunity to get involved in identifying priorities and actions that will be meaningful to their team.

Professional Leads and Subject Matter Experts were also asked to review the results against their ongoing improvement plans and give feedback.

Not all areas have had opportunity to do this (at the time this paper was produced). However, some common themes from plans received so far include:

- Addressing inappropriate behaviours including bullying and harassment
- Time for managers to listen to staff and support them effectively (includes not relying upon electronic communications, visiting departments / sites)
- Increasing clarity of team objectives, each other's roles, working more effectively with other teams
- Involving staff in improvement and change projects
- Increasing the effectiveness of appraisal conversations (quality of conversation, supporting personal development)
- Trust-wide issues such as developing career progression pathways, car parking/security/cleanliness and tidiness of the premises

Areas to celebrate:

- The investment in enhanced conflict management training appears to be having a positive impact (with experiences of physical violence in 2024 being lower than the peak in 2022). 'Hot spot' areas need support to release more staff to attend this training. Long term funding to support this work still needs to be identified.
- The Staff Health and Wellbeing Team and FTSU Guardian are currently collaborating on wellbeing ward visits. The visits involve both services being more visible to staff on wards and in departments that rarely get time to attend an event or workshop; and was started as a direct result of feedback from staff.

5. Next Steps

The corporate improvement plan needs to have a level of engagement from staff, change makers, Trade Unions, and the Executive Committee. Therefore, the plan will need to return for ratification once more of the plans are received from Care Groups, Corporate Directorates, YTHFM, subject matter experts and professional leads.

As senior leaders we concluded after Michael West's session that we needed to focus upon:

- Management – including the reduction of bureaucracy, removal of duplication/waste, and enabling more effective communication.
- Leadership – embedding the Trust's Leadership Framework.
- Quality Improvement – both to drive culture change and ensure that individuals can influence what goes on in their own areas of work.

In addition, the Board is asked to continue to provide executive leadership and support to the Our Voice Our Future programme which is utilising the model NHSE Culture & Leadership Programme and should lead to improved staff experience and retention.

The Board is asked to actively role model compassionate leadership, and to address inappropriate behaviours wherever they are observed or reported.

The Board will be asked to support the implementation of the improvement plan across the Trust, holding themselves and others to account for delivery of the plan.

Date: 05 03 2025

Report to:	Board of Directors
Date of Meeting:	26 March 2025
Subject:	Quarter 3 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Owen Bebb- Associate Medical Director for Patient Safety Alice Hunter- Patient Safety Specialist

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:

To accept the report. The escalations have been noted at the Quality Committee.

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
Learning from Deaths	10/02/2025	Approved
PSCE Sub-Committee	12/02/2025	Approved
Quality Committee	18/03/2025	Approved

1. Y&SH NHS FT mortality rates

The references in section 6 provide details about the methodologies for measuring mortality and their context.

1.1 Crude Mortality - unadjusted

Crude Mortality rate is the percentage of patients that have died. The crude rate includes all deaths up to 30 days post discharge. The crude mortality rate is the sum of the in-hospital deaths and the out-of-hospital deaths against all discharges. For quarter 3 only one month's data is available October 1.54%, the average for 2024 is 2.32%.

The 12-month crude mortality (Nov 23 to Oct 24) of all non-elective admissions stands at 4.36%. Crude mortality of non-elective admissions was 5.12% during the previous fiscal year (Apr 23 to Mar 24). The 12-month rolling crude mortality is decreasing across all the different sub cohorts.

Benchmarking of crude mortality against other Trusts is not recommended due to significant operational variations between Trusts. Instead, Trusts should monitor local trends comparing data from the same month or quarter each year. This takes account of seasonal variation seen locally and nationally.

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust, including those receiving palliative care, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the Trust. It covers patients who died either while in hospital or within 30 days of discharge.

A standard approach is taken to 'adjust' the figures so that the England average is always reported as '100'. Values below 100 represent a better outcome, ie lower mortality, and vice versa.

Further information regarding the methodology can be found in the references towards the end of the report.

Two risk-adjusted mortality rates are presented:

- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.
- HED HES-SHMI: This is provided by Healthcare Evaluation Data for UK Health Data Benchmarking (HED). It uses Trust hospital episode statistics (HES) to generate the outcomes. Data is available 3 months in arrears.

The latest **NHS-Digital Summary Hospital Mortality Index (SHMI)** to August 2024 shows the SHMI was **96.16** The SHMI in comparison to other Trusts is displayed below (Figure 1).

The **SHMI HES data** reports the SHMI at **96.27**, (Expected deaths 3259, observed deaths 3138). For in-hospital deaths the numbers were as follows; observed 2178, expected 2275. For out of hospital deaths observed deaths were 960, expected deaths 985. These all fall 'within expected range.' (Figure 2)

Figure 3 shows the SHMI trend by month over the last 12 months. Figure 4 shows the rolling 12 month SHMI for the individual sites, York has a lower SHMI than Scarborough.

Figure 1 SHMI benchmarked against all other Trusts (our Trust highlighted yellow)

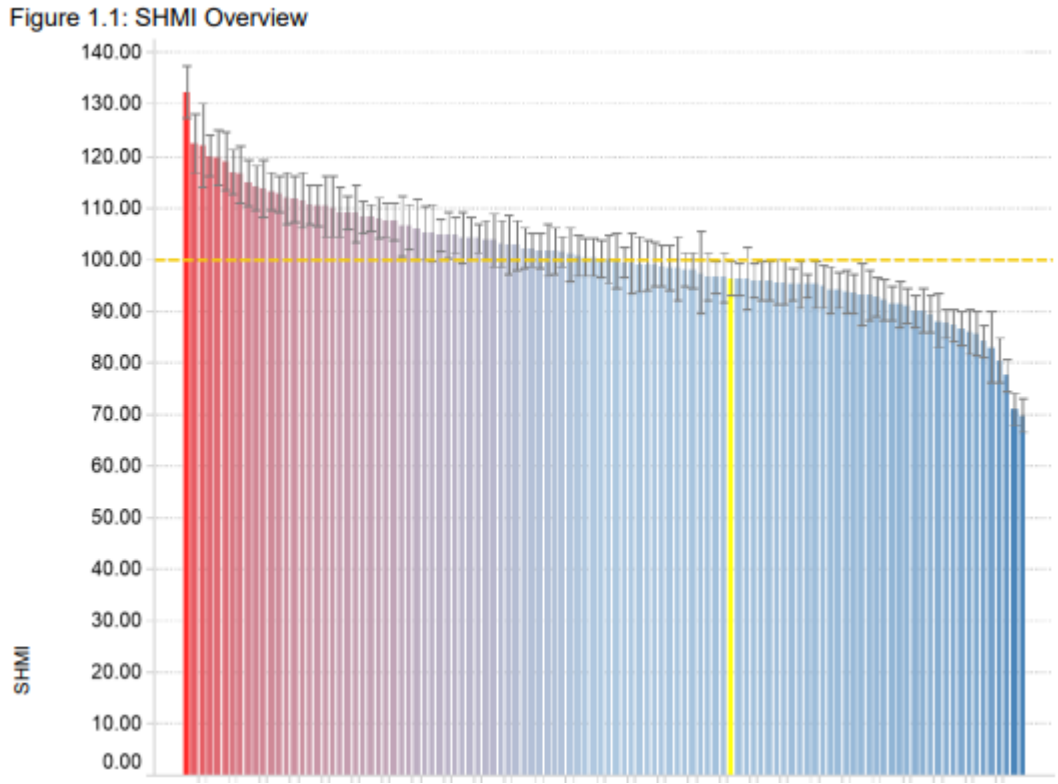


Figure 2 SHMI (HES/HED data) Funnel plots (in comparison with other Trusts)

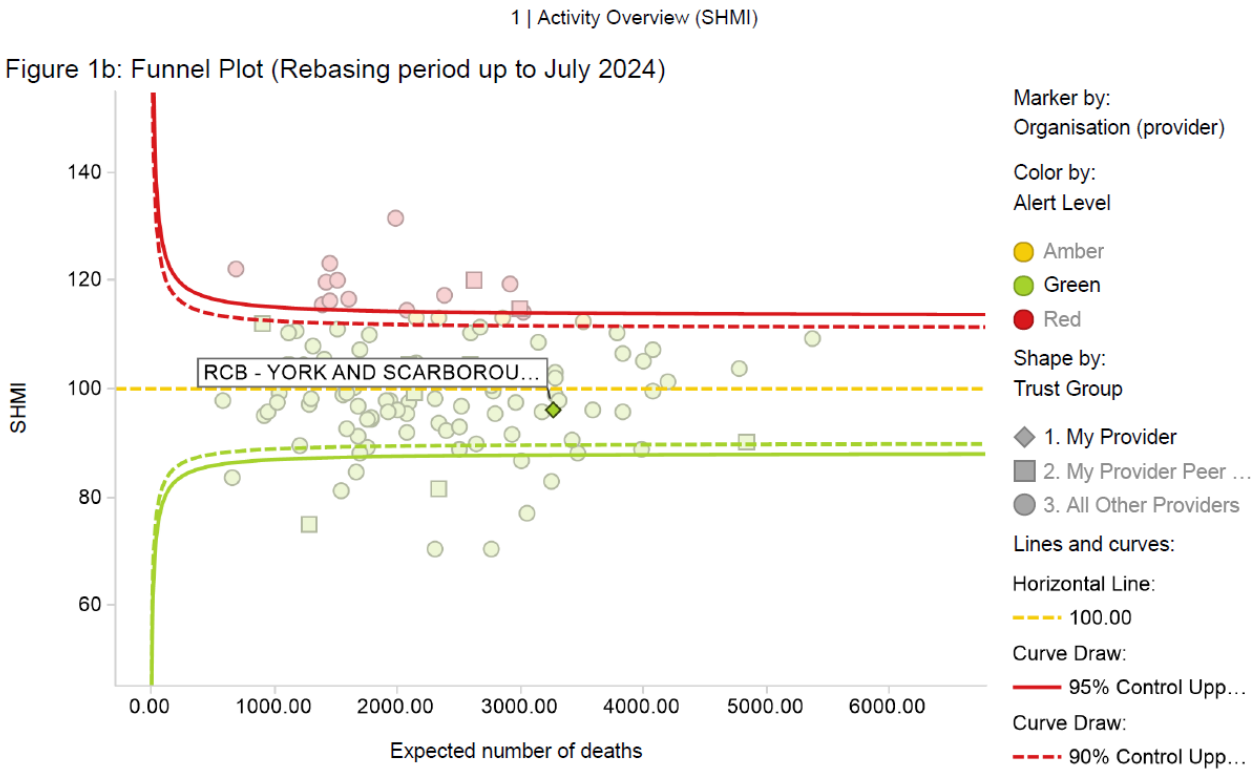


Figure 3: Time series data for SHMI showing trend over time

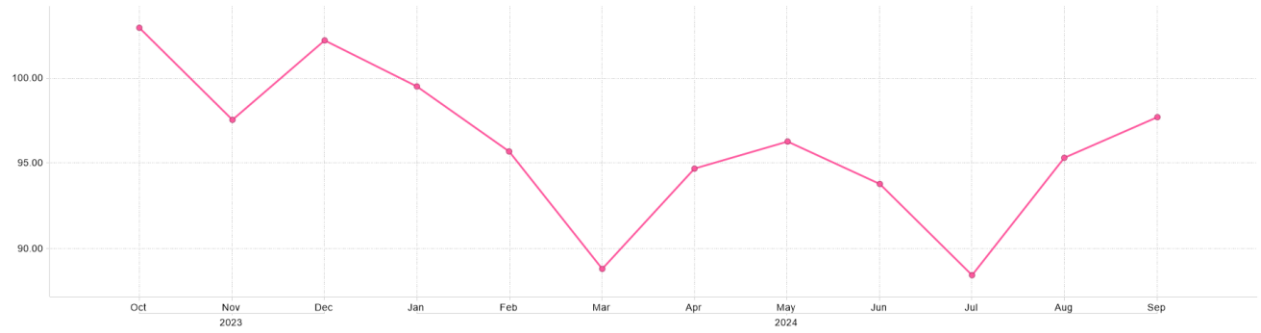
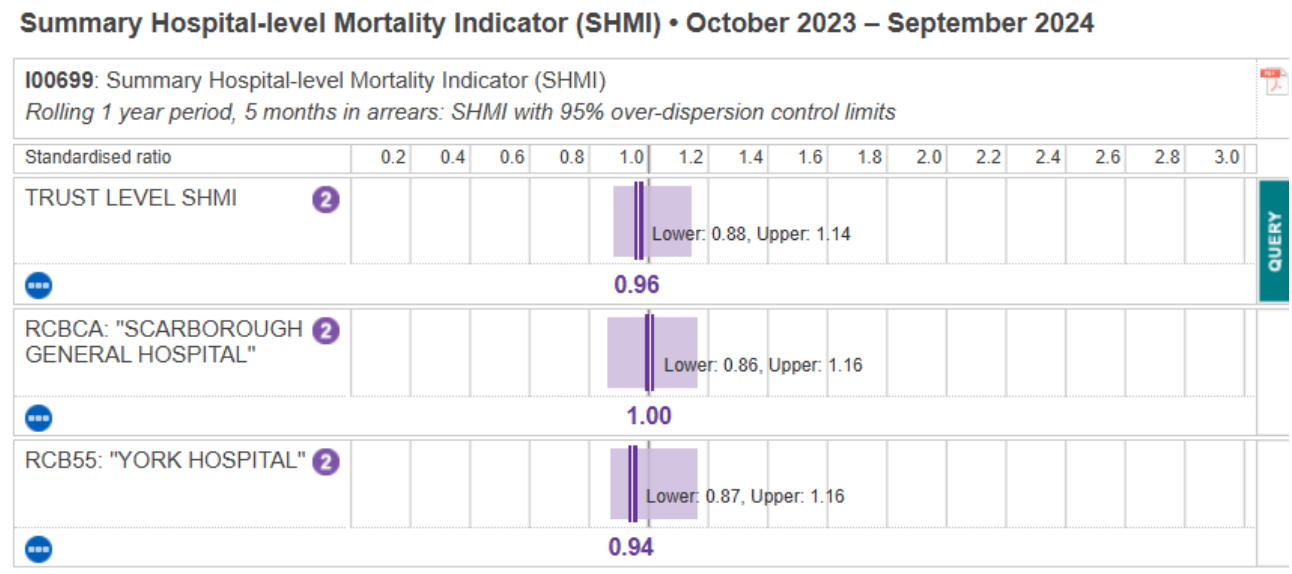


Figure 4 SHMI site comparison



1.3 Hospital Standardised Mortality Ratio (HSMR)

The HSMR measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics e.g., demographics. It does not include as many diagnostic groups as the SHMI (only about 85% of total patient numbers) and this may affect applicability of the measure.

The most recent HSMR covers the period to October 2024 and is reported as follows:

Crude mortality rate 2.85%. (Expected deaths 1633, Observed deaths 1829)

HSMR: 112.02

The HSMR remains higher than would be expected and it is unclear at present as to what might be contributing to this. We are continuing to look at the hospital mortality coding to understand potential influences on this rate, and to understand the variability of the reported rate over time. The rolling 12-month HSMR continues to trend downwards.

Figure 5 shows our position in relation to other trusts, figure 6 shows we remain outside expected limits. Figure 6 shows the HSMR on a month by month basis.

Figure 5. HSMR (to October 2024) – in comparison with other Trusts – Y&S Trust :light blue bar

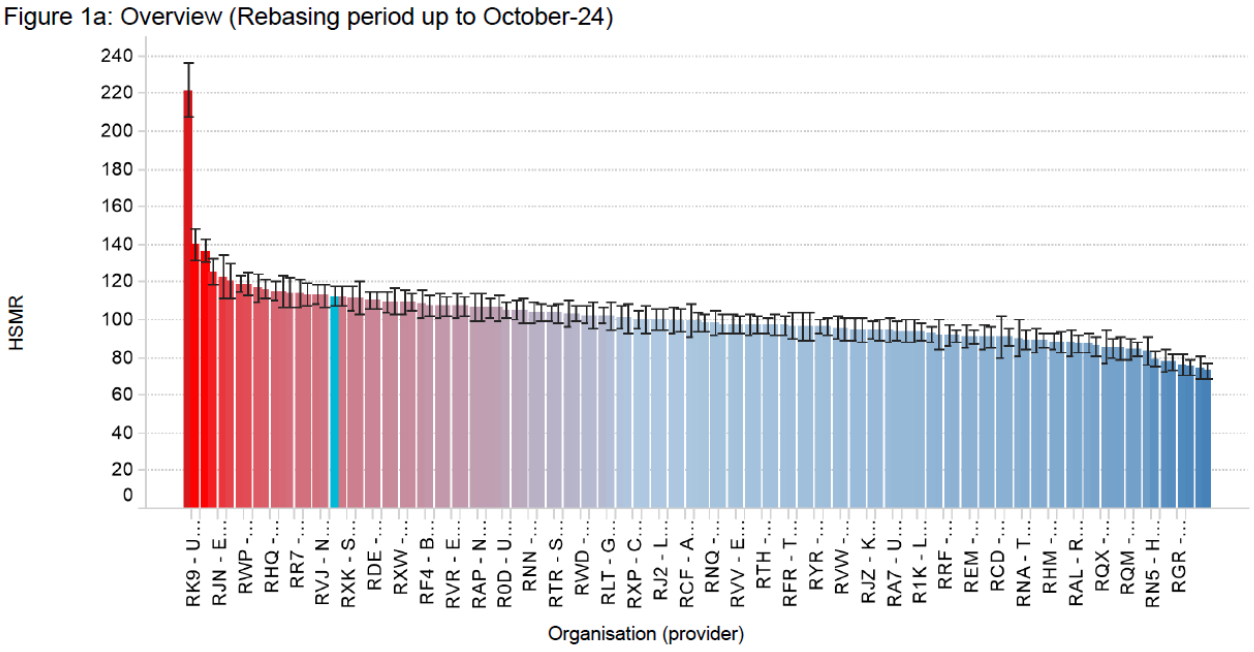


Figure 6 HSMR Funnel Plot (to October2024)

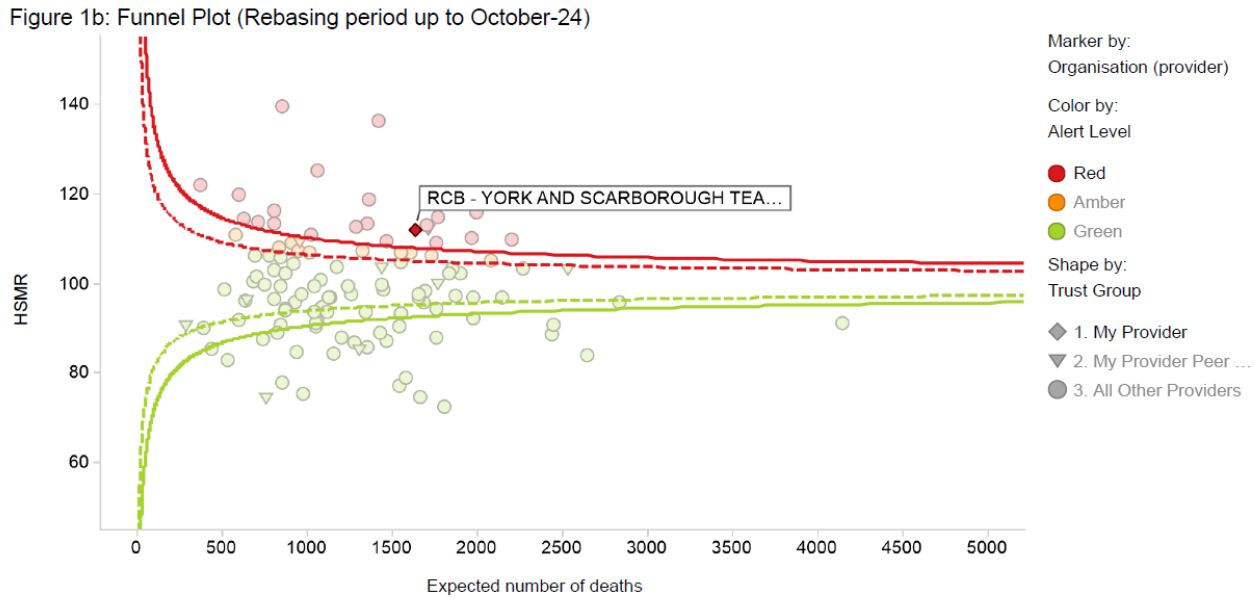
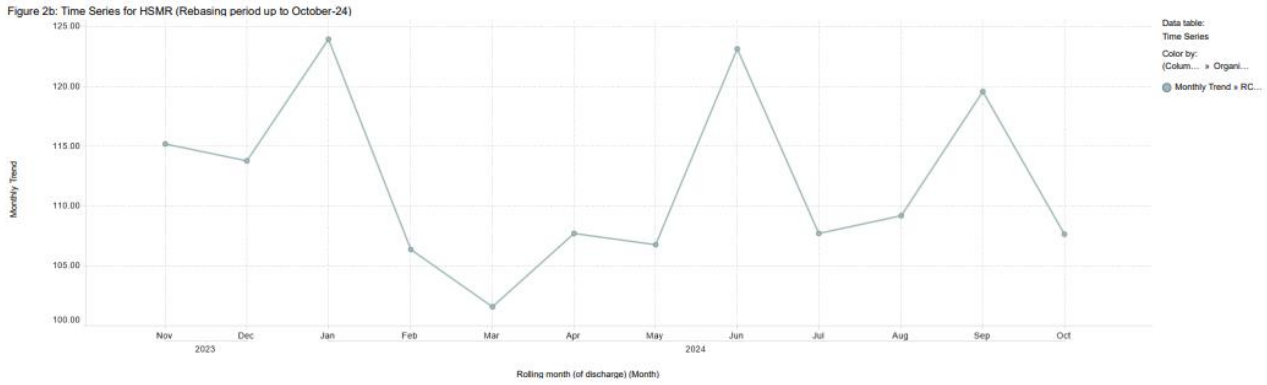


Figure 7 HSMR Time series data



2. Diagnostic groups most contributing to our mortality rates

There are 144 diagnostic groups that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

The way in which coding is applied to patients that die in the Trust can significantly affect mortality statistics. The “depth of coding” (coding of co-morbidities as well as primary diagnosis) is important as it allows for more accurate calculation of the expected number of deaths that should be seen during a specific time period. Coding of the primary diagnosis will also affect mortality statistics in particular diagnostic groups. We continue to work with the coding team to understand how better to managing this reporting and we are using the learning provided from Trust mortality reviews via the Learning from Deaths process to triangulate our current mortality outliers and ascertain if any further investigation is required.

The most recent breakdown of differential SHMI for common diagnostic groups is displayed in figure 8 below. At present there remain no particular diagnostic groups causing concern, however this data does triangulate with other patient safety work that we are undertaking. Acute bronchitis continues to have more deaths than expected but will include lower respiratory tract infections within this code, whilst pneumonia has less deaths than expected so will likely cancel each other out.

Figure 9 shows the groups with highest excess deaths over the last 12 months. Of note is the aspiration pneumonia group as we have had a recent focus on nutrition so will keep this group under review.

Figure 8: SHMI associated with various diagnostic groups (from HES data)

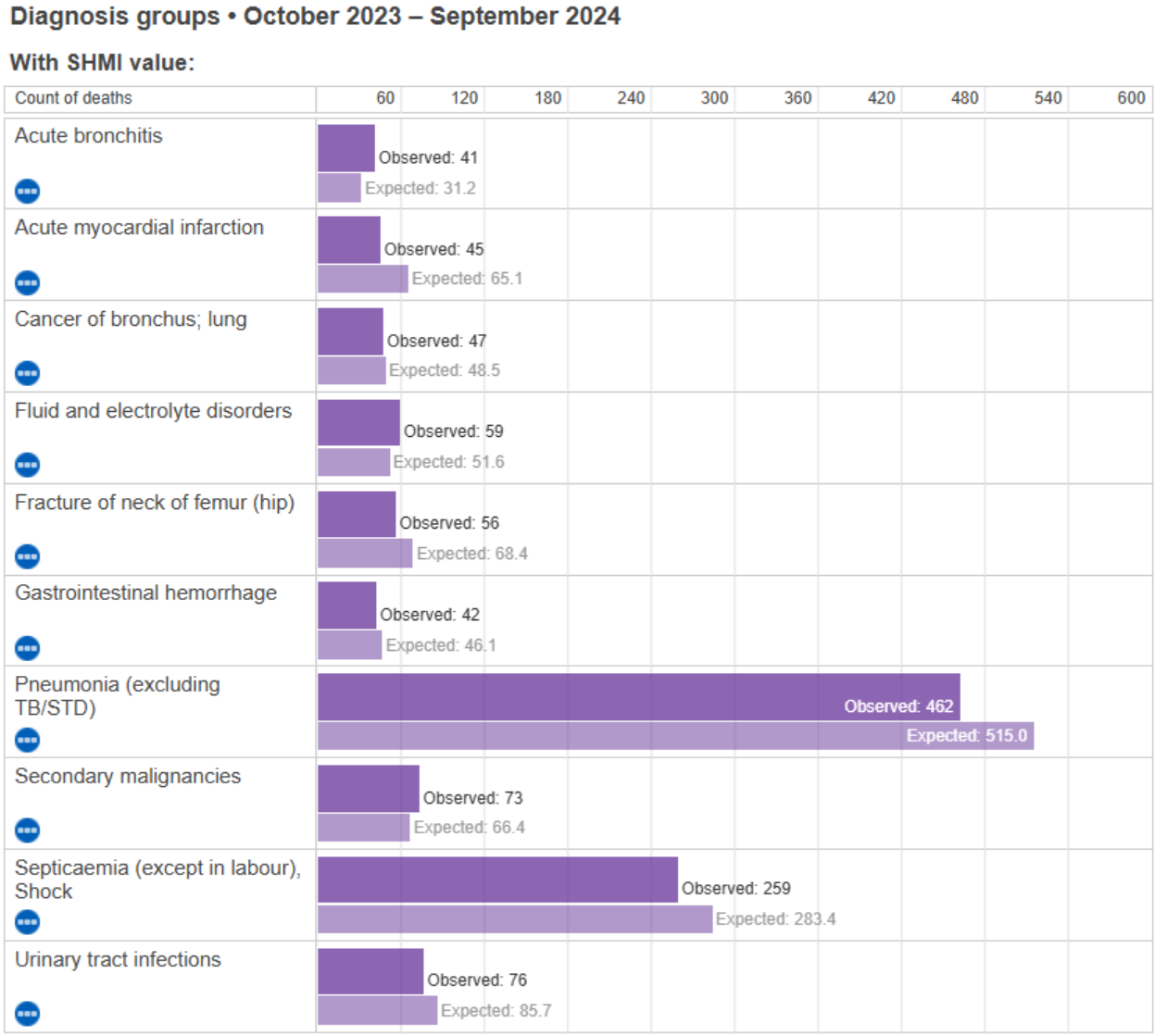
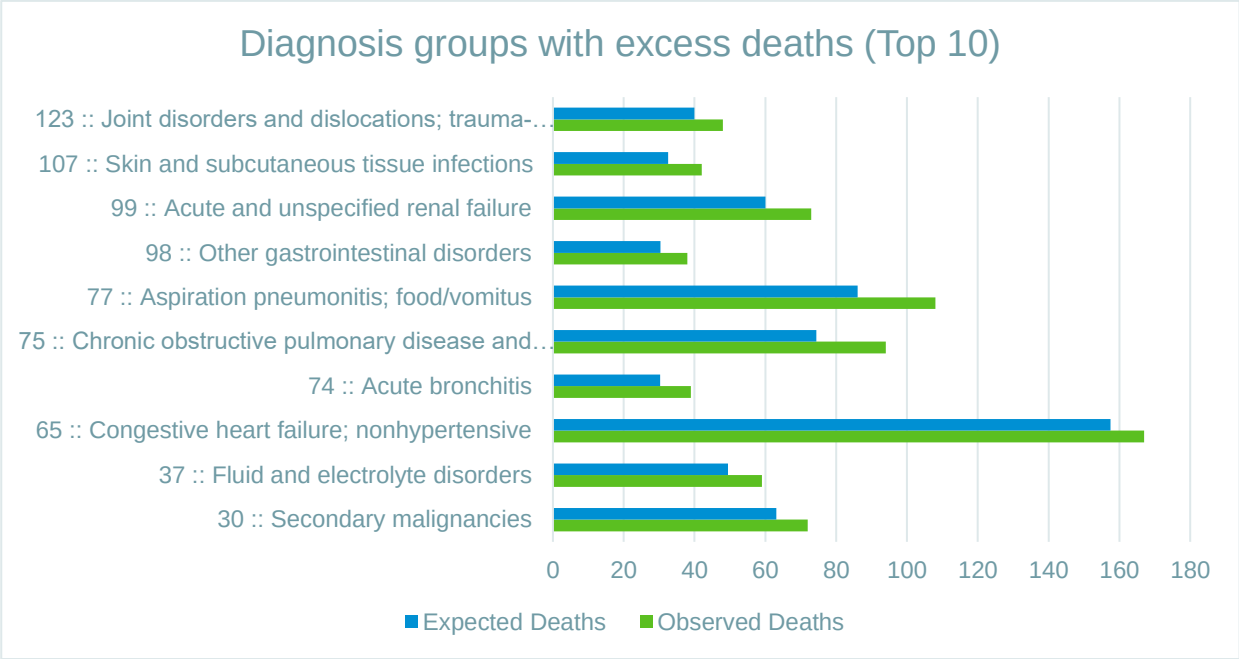


Figure 9: Top 10 Diagnosis Groups with Excess Deaths



3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

This section provides data and outcomes in line with the requirements of the:

- National Guidance on Learning from Deaths (National Quality Board, 2017)
- Trust's Learning from Deaths Policy
- Department of Health and Social Care NHS (Quality Accounts) Amendment Regulations 2017

Whilst the report focuses on quarter 3 data, some information is provided for quarter 1 and 2 for comparison.

3.1 Nationally mandated data and information

The data provided in the table below is mandated by the national LfD framework. A narrative on learning and actions is provided in section 4.

When reading the table, SJCRs are Structured Judgement Case-note Reviews; PSII are Patient Safety Incident Investigation. It should be noted that that PSIIs replaced SIs when the new PSIRF

Table 1 – National data summary

	April	May	June	July	Aug	Sep	Oct	Nov	Dec
	Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)		
Total in-patient deaths (inc ED, exc community)	196	199	183	160	179	200	195	216	200

No. SJCRs commissioned for case record review[1]	7	4	8	7	2	4	2	7	11
No. PSII commissioned of deceased patients	0	0	1	1	0	0	2	0	0
No. deaths likely due to problems in care	See tables below			See tables below			See tables below		

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 24/25).

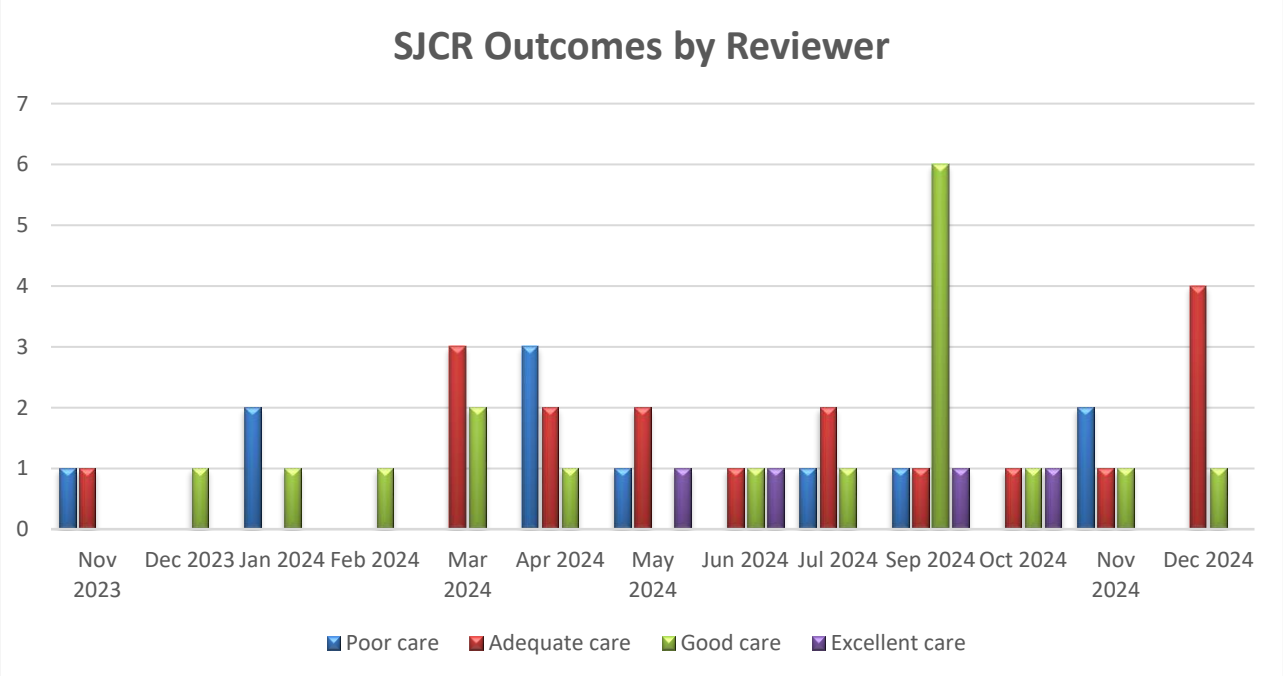
National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Figure 6 shows the outcomes of the SJCRs **completed and reviewed** during Q1, Q2 and Q3 in 24/25:

- Figure 6 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission.
- Figure 7 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q3 21 SJCRs were reviewed (14 in Q2):

Figure 6 – SJCR outcomes assigned by the Reviewer (overall score)



- The overall care score was given in 14 cases.

The Reviewer found there to be:

- Good care in 3/14 cases.
- Excellent care in 2/14 cases

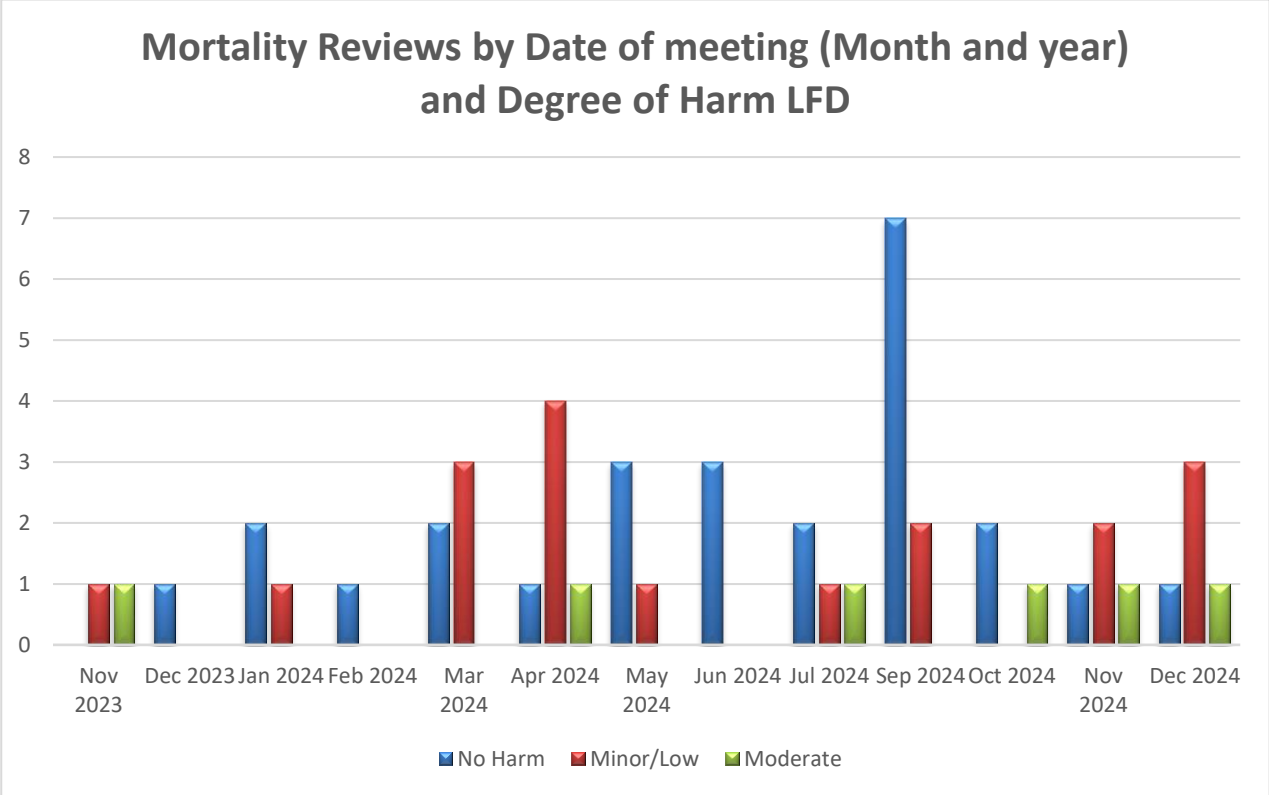
- Adequate care in 6/14 cases (WEB184108 is from old datix and will not be reflected in Figure 6 & 7)
- Poor care in 3/15 cases (ID20447 is not reflected in Figures 6 & 7, as the SJCR is linked to an incident as the patient died in a hospice and therefore not recorded on the mortality module.

6/21 SJCR's required further review and to come back to LFD for level of harm to be agreed.

SJCR 2298 was referred to the Quality and Safety (Q&S) meeting due to very poor care. At Q&S it was discussed and agreed a Patient Safety Incident Investigation was not required and to be taken back through LFD to agree the level of harm.

The LfD group will decide on the level of harm for the SJCRs presented. The degree of harm levels are No harm, Minor, Moderate, Severe and Death.

Figure 7 – SJCR outcomes following review by LfD Group (degree of harm)



The Learning from Death Group agreed harm leading to death in 0 cases, moderate harm in 3 cases, low in 6 of the cases and no harm in 5 cases.

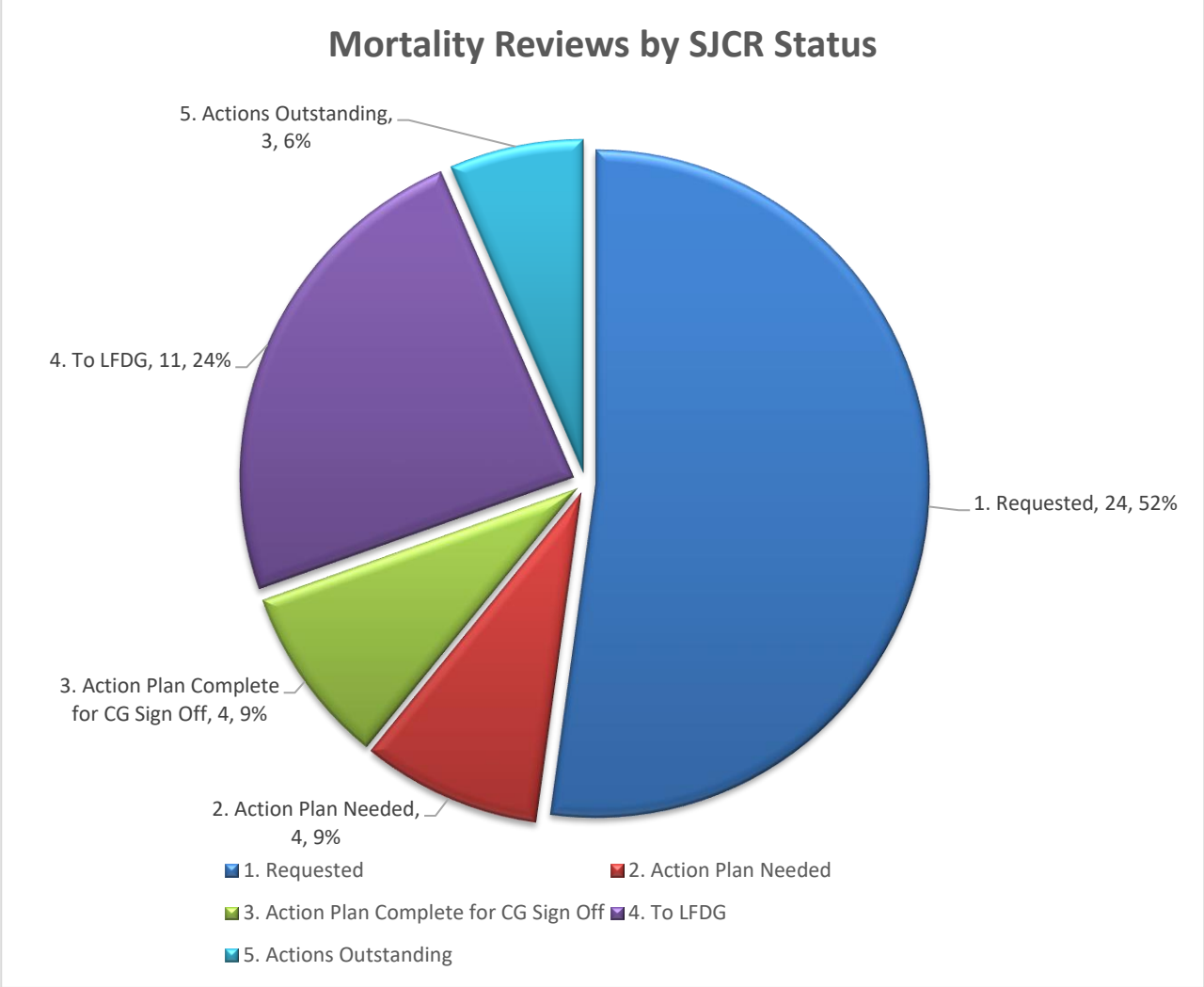
3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance now Medical Examiners review all deaths; and the timely completion of structured judgement case-note reviews.

Data on progress of investigations at point of reporting (23/01/2025)

Overall no. of SJCRs open 50 (previously 41 as of 11/11/2024)

Figure 8 – Status of open SJCRs (date collected 23/01/24)



	Q4 (23/24)	Q1 (24/25)	Q2 (24/25)	Q3 924/25)
Number under review	21	26	20	24
Awaiting action planning	3	2	4	4
Actions outstanding	4	4	3	3
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	10	15	18	12

The status of requested SJCRs has increased since Quarter 2 and will be monitored. An explanation of this is due to SJCR training availability however this is being addressed and a further update will be given in Quarter 4.

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 2 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2024/25. (please note that the numbering of these relate to the numbering dictated by the Quality Account Report which is why they differ from the rest of the report.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2023/24 but were investigated during 2024/25 and hence not reported in the 2023/24 Quality Account.

Item	Requirement	Q1 24/25	Q2 24/25	Q3 24/25
27.1	Total number of in-hospital deaths	578	539	603
27.2	No. of deaths resulting in a case record review or SI/PSII investigation (requested reviews of patients who died in 22/23 and 23/24)	ME:536 SJCRS:21 PSII: 1	ME:539 SJCRS: 13 PSII: 1	ME:603 SJCRS: 20 PSII: 2
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 23/24)	0	0	0
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 1 PSII:0	SJCR: 0 PSII:0	SJCR: 0 PSII:0
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0	0	0
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	0	0	0

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group
[2] Reviews completed in 2024/25 after the 2023/24 Quality Account was published

Items 27.4-6 relate to learning from case record reviews and investigations; a description of actions taken and proposed; and an assessment of the impact of the actions. These items are covered in the next section. The numbering of these are based on the Quality Account

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth

d. Stillbirths or perinatal deaths

Local PSII investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

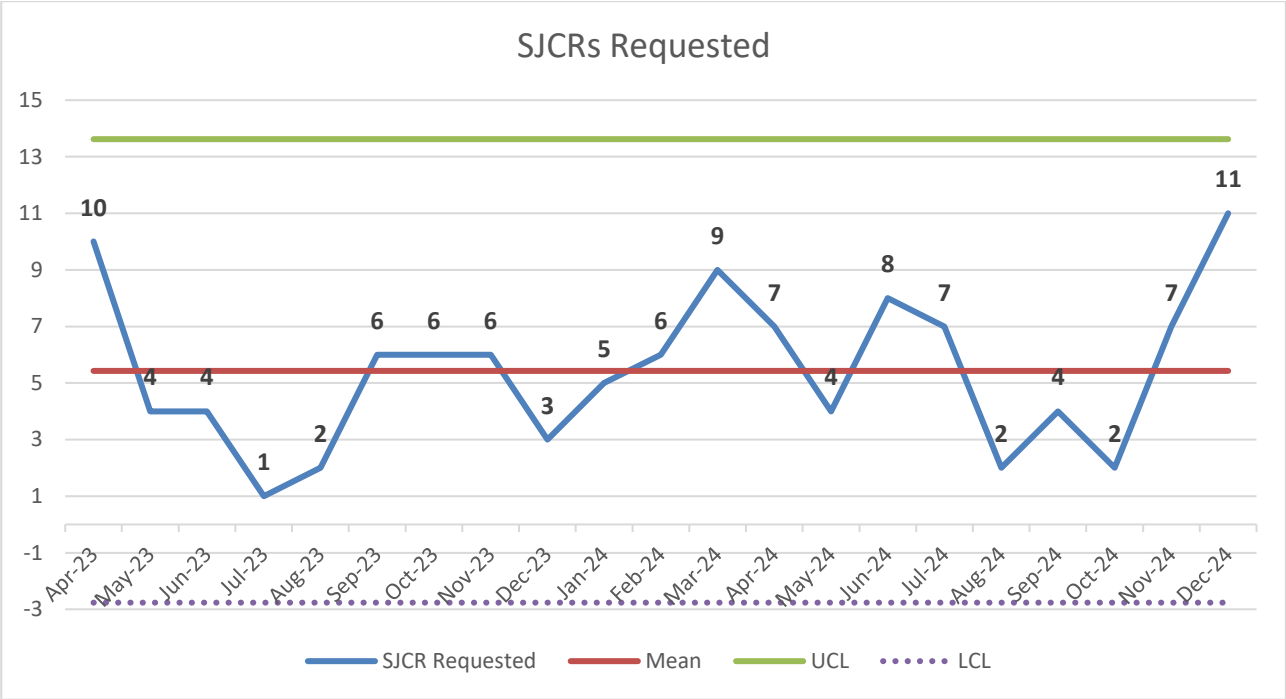
- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.
- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

Table 3 below shows the source of SJCR requests for Q1,Q2 and Q3, it should be noted that there can be more than one source however to avoid duplication only the original inputted source is considered in this table.

Table 3 – Source of request for SJCR

SJCR Request Source	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
1. Care Group	4	2	4	3	2	1	1	3	8
2. Learning Disabilities	3	1	4	4	0	1	1	1	1
3. Medical Examiner Review	0	1	0	0	0	1	0	3	2
4. NoK Concern/ Complaint	0	0	0	0	0	1	0	0	0
5. Initial Mortality Review	0	0	0	0	0	0	0	0	0
6. Elective Admission	0	0	0	0	0	0	0	0	0
7. Q & S	0	0	0	0	0	0	0	0	0

There were 19 requested SJCRs in Q1, 13 requested SJCR's in Q2 and 20 in Q3.



4.1 Themes from SJCRs considered by the LfD Group in Q3:

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work.

The introduction of DCIQ and the mortality module has meant that themes and trends identification has had to be updated. During the creation of the mortality module, it was decided that themes would be based on the same ones as the other modules in DCIQ to allow cross comparison and triangulation of data when required.

The themes are identified within the Learning from Deaths meeting. These themes identified are shown in Table 4.

Table 4 – Themes identified

	04-2024	05-2024	06-2024	07-2024	08-2024	09-2024	10-2024	11-2024	12-2024
Acting on Results	1	0	0	0	0	0	0	0	0
Clinical Assessment	0	0	0	0	0	0	0	0	0
Communication/Documentation	2	0	0	0	0	0	0	0	3
Delayed Diagnosis/Treatment	1	1	0	0	0	0	0	0	0
Learning Disabilities	0	0	0	0	0	1	0	0	0
Nutrition and Hydration	1	0	0	0	0	0	0	0	1
Pathways/Process	1	0	0	0	0	0	0	0	1
No themes identified	0	1	2	0	0	7	0	1	0
Not listed	0	0	0	0	0	0	0	0	1*

***Palliative care could have been initiated sooner.**

5.0 Escalations & Learning

October 2024

Learning from Death (LFD) in October identified no trends from the SJCRS discussed within the meeting.

LeDer and Safeguarding update highlighted main themes from the September reviews:

- Adherence to mental capacity act.
- Lack of reasonable adjustments made by the trust.

The meeting raised there are lots of SJCRs outstanding and the LeDeR panel have started completing their reviews without an SJCR which is not giving them a full overview of the case, and potentially making incorrect judgments and assessments of our care.
The need for SJCR training has been escalated previously.

November 2024

MCA was highlighted as a theme in November's meeting. There is a new approach to compliance, safeguarding is attending all care group board meetings and presenting a paper and asking for assurance / actions from each care group.

November Escalations

- Two SJCRS were sent to Q&S for further discussion.

It was confirmed in the meeting all poor and very poor care SJCRs are to be taken to Q&S meeting for further discussion and to determine whether a PSIRF response is required or where necessary a PSII. This will be reflected in the process updates are also included within an accompanying Datix Mortality Module Standard Operating Procedure.
An update was provided regarding SJCR training and a action given to arrange a meeting to discuss training.

The group were also informed the LFD policy would be updated to link with PSIRF.

December 2024

MCA was a reoccurring theme this month as with the November LFD meeting.

It was raised that each week a spreadsheet will be added to the Q&S agenda to show all coroner referrals for the previous week, and these will be reviewed to see if a PSIRF response is required. This will help the trust / care groups be more proactive if the coroner requires further information.

If an SJCR is rated poor or very poor, this will be discussed at Q&S before an action plan is completed, to determine if it requires to be investigated as a PSII. If it is a PSII, then an action plan will be done during that investigation.
If not a PSII then an action plan will be developed and then the SJCR brought through LFD group for discussion and agreed a level of harm.

The LeDeR and safeguarding update reported lack of professional curiosity is a common theme in safeguarding, the safeguarding nurse now goes to ED each day.
There was an overall improvement with the LeDeR position.

6. Service developments

6.1 Centralise the maternity and paediatric related multi-agency reviews.

A review of the Learning from Death Policy (LFD) is underway. The revised draft policy incorporates all types of death reviews described within the Patient Safety Incident Response Framework (PSIRF) and the national LFD guidance. This has provided an opportunity to centralise the maternity and paediatric related multi-agency reviews into the Datix mortality module. These reviews include the Child Death Overview Panel and the Peri-natal Mortality Review Tool. To date, details of these deaths and their reviews have been maintained locally. Centralising onto the Datix mortality module will simplify how data is collected for LfD reports and better facilitate discussions at the LfD Group meetings. A series of meetings with representatives from the family health,

bereavement and patient safety teams has informed the mortality module revisions and clarified responsibilities for populating the required fields. The process updates are also included within an accompanying Datix Mortality Module Standard Operating Procedure.

6.2 Mental Capacity Act Improvement

Compliance with the Act remains a concern and has been escalated to Care Groups and executive directors. We are also starting to see complaints regarding the trust complying with the Mental Capacity Act, correct application of the DoLS process and not informing patients Lasting Power of Attorney of care and treatment decisions increasing in number. It is agreed that a trust wide approach is required to ensure clinicians understand and apply the act in their day-day practice. This has led to senior strategic support in addressing gaps directly with the clinicians involved. Working with care groups we want to see an 85% compliance rate for care delivered within the legal framework by April 2025, and training compliance at 90%.

The Trust MCA leads have been pivotal (since the CQC Inspection in 2022) in increasing the resources and support available and in July 2024 we secured funding for two MCA and DoLS educators whose role will be to target low compliance areas and support staff understand their responsibility in terms of the Mental Capacity Act and resume robust training offering for clinical areas. Resources and digital tools have reduced the margins for error for those staff using the Act appropriately, but this will not support staff who have not recognised the need to use the principles of MCA when seeking consent for treatment or decision making in a patient whose capacity may be doubt. The lack of completion of capacity assessments and documentation of this and best interest decision making is a recurrent theme found.

Audits have been undertaken to indicate inconsistent application of the Act. See below Quarter 2 figures:

MCA Audit results 43 wards / departments included. Wards are not audited if no patients who meet the criteria are there at the time of audit.

July (37 wards)	August (36 wards)	September (37 wards)
34% compliant	33% compliant	27% compliant.

We have paused auditing until the below self-improvement projects are underway.

We plan to attend each care group board meeting and are proposing a self-improvement project with care groups. The care group are asked to identify 1 ward per site and relevant senior clinicians across the MDT who will be supported by Karen Pearce (MCA lead practitioner) with recognising where improvements need to be made and how to address this. Care group medicine's project has just commenced, CG surgery's board meeting is later this month, and this is on the agenda for that.

7. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -
   a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.

b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.
d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 March 2025
Subject:	Vascular Hybrid Theatre Equipment Business Case
Director Sponsor:	Claire Hansen, Chief Operating Officer
Author:	Liz Hill, Associate Chief Operating Officer

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 approve the business case.

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	19 March 2025	Approved

APPENDIX Ai

Business Case Approvals

- Potential cases should be outlined at Annual Planning
- Business Case Completed (Revenue and/or Capital)
- Care Group Board - Revenue Approval <£50k
- CPMG - Capital Approval <£50k
- Chief Executive, usually through the Executive Committee (Revenue) / CPEG (Capital) - Approval £50k - £500k
- Executive Committee - Revenue & Capital Approval £500k - £1m
- Board of Directors - Revenue & Capital Approval >£1m
- CAP Board / ICB Review of all cases that impact / benefit the wider ICS
- Post Project Evaluation - 12 months after implementation

Stakeholder Considerations

YTHFM LLP	•Is accommodation required? •Is cleaning / maintenance of accomodation required? •Are porters / catering / laundry & linen required? •Is maintenance of medical equipment required?
Digital Information Services (DIS)	•Does the change require a system change? •Does the change require new digital functionality? •Does the change require a new digital solution? •Has the DIS Change Request Process been followed?
Care Groups	•Consider the impact of your business case on other Care Groups - have they been engaged where required? •Mandatory consultation for stakeholder groups is included in section 8 of the business case summary
Sustainability	•Does the business case impact on the Trust's sustainability programme?
Commissioners	•Where additional funding is required this should be discussed with commissioners (i.e the ICB)
Other Providers within the ICS	•Does the business case have an impact or provide a benefit to other provider organisations within the ICS?

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2024/25-114

2. Business Case Title

Vascular Hybrid Theatre Equipment

3. Sponsorship, Management Responsibilities & Key Contact Point

The Business Case 'Owner' should be the appropriate Care Group or Corporate Director, or where appropriate an alternative lead Clinician nominated by the respective Care Group Director. The 'Author' will be the named manager supporting the owner of the Business Case, who will have responsibility for the development and writing of the Business Case, and will be the key contact point for enquiries.

3.1 Sponsorship Confirmation (where neither are the Owner or Author of the Business Case)

Care Group/ Corporate Director	Name	Date of Agreement
	James Stanley	13/02/25

Care Group Manager	Name	Date of Agreement
	Liz Hill	13/02/25

3.2 Management Responsibilities & Key Contact Point

Business Case Owner:	**James Walkington, Clinical Director**

Business Case Author:	**Liz Hill, Associate Chief Operating Officer**
Contact Number:	**01904 725928**

STRATEGIC CASE

The purpose of the strategic section of the business case is to make the case for change and to demonstrate how it provides strategic fit.

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change.

A Vascular Hybrid Theatre is being developed as part of the TIF2 Capital Project which also provides a significant expansion to PACU at York Hospital. Specialist hybrid theatre equipment is required which is much more advanced than that which is currently available in the Trust.

Hybrid theatre equipment combines imaging technology with operating theatre facilities to deliver complex interventional vascular procedures and surgeries. Compared with traditional surgery, hybrid operating theatre surgery is less invasive and less traumatic for patients. The hybrid approach will give patients quicker access to surgery and in some cases could mean the difference between limbs, and lives, being saved. If conversion to open surgery is required, this can take place without having to move to an operating theatre (as would be the current requirement) which is much safer for the patient.

The availability, accessibility and quality of images using the hybrid theatre equipment is far superior to the currently available technology. During an operation or procedure, surgeons can observe the progress and accuracy of their work in real-time on monitors in the theatre. As well as the enhanced technology, the theatre enables the sharing of knowledge and expertise by the different healthcare professionals (radiographers, radiologists, surgeons, anaesthetist, nurses, ODPs etc) in a single environment.

None of our current operating theatres can support the hybrid theatre equipment so a brand-new bespoke theatre is being built to accommodate the requirement. It is crucial for the Trust to have a Hybrid Theatre to retain its vascular arterial centre status. In 2018, NHS England's GIRFT (Getting It Right First Time) Programme recommended that vascular hubs should provide aneurysm repair surgery in a hybrid theatre setting. York Hospital is a vascular hub but has been unable to support hybrid operating due to the poor quality of the current main theatre estate on site.

As part of this development, the equipment in Theatre 10 will not be replaced and can be sold.

The Hybrid Theatre will be used every day (including weekends for acute cases) and we would expect the equipment to last for at least 10 years. The equipment will need to be replaced at the end of its life.

5. Capacity & Demand Analysis

Where a key issue raised concerns of the availability of sufficient capacity to meet anticipated demand on the service, it must be supported by a Capacity and Demand analysis to clearly demonstrate the gap in capacity, with the results presented below. Please refer to the Business Case guidance document for the guidance and access to the preferred capacity and demand model. If required, support in completing the model is available through the Corporate Operations team (contact Andrew Hurren on extension 5639).

N/A – one Hybrid Theatre has been developed.

6. Alignment with the Trust's Strategic priorities

The Trust has identified four strategic priorities that ensure there is a focus for its emerging priorities and objectives, and assists in the communication to staff, patients and other stakeholders.

Indicate using the table below, to what extent the preferred option is aligned with these strategic priorities. It is expected that the preferred option will align with at least one of the strategic priorities.

Strategic Priority	Describe how the case is aligned to the Strategic Theme
Priority 1 – Our People	A dedicated Hybrid Theatre will attract and retain skilled staff. It also provides a modern, safe and well-designed working environment.
Priority 2 – Quality & Safety	The equipment will ensure that patients can be offered the safest procedures with excellent patient outcomes, length of stay and least risk of complications.
Priority 3 – Elective Recovery	The additional theatre will provide increased capacity for elective cases
Priority 4 – Acute Flow	Patients will have access to surgery in the hybrid theatre acutely and electively. A hybrid theatre is required to meet Vascular Centre status which is crucial to ensure acutely unwell patients can access treatment locally.

7. Business Case Objectives

Setting robust spending or investment objectives is essential in making a coherent case for change; the case should identify SMART (Specific, Measurable, Achievable, Relevant, Time bound) to address one or more of the following generic drivers, see page 23 of the guidance for full description of drivers. List the business case objectives and the metrics and measures below:

Description of objective	Metric	Quantity Before	Quantity After
Installation of hybrid theatre equipment	Available - hybrid theatre	0	1

8. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the Business Case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above.

Where external stakeholder support is vital to the success of the Business Case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment. If the Business Case spans more than one Care Group or Directorate the expected/required close collaboration in such circumstances must be evidenced.

Examples of stakeholders include lead clinicians, support services (e.g. Digital Information Services (DIS), Capital Planning re: accommodation, YTHFM LLP re Estates & Facilities support services), Commissioners (e.g. HCV ICB, NHSE, etc.), patients & public, etc.

See page 24 of the guidance for a checklist of potential questions that should be considered when assessing stakeholder involvement.

A 'Not-Applicable' (N/A) response is not acceptable in this section of the case unless accompanied by the name of the relevant stakeholder that has confirmed there is no applicable involvement in the case.

Stakeholder	Confirmation of Stakeholder Support
Mandatory Consultation	
Radiology	Support from Marcus Nicholls (CD) and Tom Skidmore (PACS Manager)
Laboratory Medicine (SHYPS)	No input required
Pharmacy	No input required
AHP & Psychological Medicine	ODPs engaged as part of TIF2 Project
Theatres, Anaesthetics and Critical Care	We are the main stakeholder.
Community Services	No input required
Digital Information Systems (DIS)	Support from Paul Chappell (Platform Manager)
Sustainability	Support from Graham Titchener (as part of TIF2 build)
YTHFM LLP	Fully involved from capital planning (Andrew Bennett) and various members of estates teams
IPC team	Support from Damian Mawer, Neil Todd and Anne Tateson for the design and build of the theatre

ECONOMIC CASE

The purpose of the economic case is to identify the proposal that delivers the best value for money.

The economic case should identify the preferred option when measured against the issues identified in section 4 of the strategic case, how it closes the capacity gaps identified, how it meets the business case objectives outlined in section 7 and how it meets the Trust's strategic priorities.

9. Options Considered

List, and describe briefly below the alternative options considered to resolve the issue(s) presented in Section 4 above. This should just be a factual description of the option, without at this stage, any comments on the pros and cons of the option. The inclusion of alternative workforce and clinical models should be considered when generating the list of options. Option 1 should always be Business as Usual (BAU) as a comparison to the options considered

Description of Options Considered
1. Purchase hybrid theatre equipment
2. Do nothing – continue without hybrid theatre

10. Benefit and Cost Analysis

All identified options must be subject to a Benefit and Cost analysis, using the 'Investment Appraisal Scoring Sheet' (Appendix Aiii) and summarised below:

Summary Benefit Cost Analysis						
	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Objectives Score	0	0	0	0	0	0
	£000	£000	£000	£000	£000	£000
Net Income & Expenditure	0	0	0	0	0	0
Net Present Value	0	0	0	0	0	0
Net Present Value Per Objective Point Scored (£000)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Overall Ranking (manually enter)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

11. The Preferred Option

Detail the preferred option together with the reasons for its selection over the other options. This must be supported with appropriate description and data in demonstrating how it will address the issue(s) described in Section 4 above.

The case for the preferred option should include how the option closes any capacity gaps identified in section 5, with the results of the closed gap after using the preferred capacity and demand model. This section should also confirm that the preferred option meets the business case objectives identified in section 7.

The preferred option should be cross referenced to key attributes identified in the Benefit and Cost Analysis in section 10.

Confirm the preferred option
Option 1 is the preferred option – purchase the hybrid theatre equipment
Describe how the preferred option addresses any capacity gaps identified in section 5
N/A
Describe how the preferred option meets the Trust's strategic priorities in section 6
The preferred option fully delivers the Trust's strategic priorities in terms of providing modern, high-quality estate and facilities to enable clinicians to deliver the safest and most effective care. The equipment will benefit both elective and acute patients, enabling them to access the most up-to-date vascular procedures. Having access to the latest technology and an improved working environment will help us to attract and retain staff, especially those who have trained in such facilities. Strategically, the Trust is vulnerable to lose it's vascular centre status without access to a Hybrid Theatre so it is crucial to invest in this technology. The Trust provides a vascular surgical and interventional radiology service to a population of over one million. Not only would losing vascular centre status mean that patients would have to travel much further for diagnosis and treatment, but our neighbouring vascular centres also (Leeds and Hull) do not have enough capacity to support this increase in demand.
Describe how the preferred option meets the Business Case Objectives identified in section 7
The preferred option will provide funding (already identified in the Trust's capital equipment programme) to procure the hybrid theatre equipment from the preferred supplier. The TIF2 build provides a brand-new theatre to house the equipment.
Describe how the outcome of the IASS in section 10 supports the preferred option?
N/A - an IASS has not been completed

12. Consultant, and other Non-Training Grade Doctor Impact

*(Only to be completed where the preferred option **increases** the level of Consultant / non-Training Grade input)*

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the Business Case.

	Before	After
Average number of PAs		
On-call frequency (1 in)		

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**

12.2 Job Plan Approval:

The Medical Director or Deputy, along with the Medical Workforce Manager must review all proposed Job Plans for new Consultant posts, as well as any Job Plans of existing Consultants where the proposed new post would have an impact on current working practices. The date that the Job Plans were approved must be provided below.

Date of Approval	
Comments by either the Medical Director or Deputy, or the Medical Workforce Manager	N/A

13. Accommodation

If the delivery of this Business Case is reliant on the Care Group or Directorate submitting the case being allocated additional space (e.g. to accommodate new staff or to expand its services) the availability of this additional space should be established prior to the submission of the Business Case for approval.

If assistance is required in assessing the space requirements / availability of space to support this Business Case then help is available from Tony Burns (01904) 721856 or tony.burns@york.nhs.uk).

Does the implementation of the Business Case require additional space to be found and allocated?	**Yes**	**No**
	✓	
Has the space identified been confirmed available?	**Yes**	**No**
	✓	
Have the costs associated with maintaining the space been included in the financial analysis?	**Yes**	**No**
		✓

Please tick

14. Benefits of the Preferred Option

The identification of the benefit(s) that are expected to arise from the Business Case is crucial to ensuring that a robust evaluation of the progress and delivery of the Business Case objectives is possible during any post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will arise from implementing the preferred option below. The benefits identified must be aligned to the business case objectives in section 7 and be tangible and capable of being evidenced through some form of measurement. The timings of when the benefits will materialise should be realistic.*

It is acknowledged that some benefits may not materialise until at least 6m, dependent on the purpose of the Business Case and, as the Guidance Manual indicates, in a small number of instances there may be a need to consider adjusting the timings of the reviews, dependent on the forecast timeframe for benefit delivery.

				(* from Estimated Implementation date)		
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m***	**At 6m***	**At 12m***
Installation of one hybrid theatre at York Hospital	Number of hybrid theatres	0	1	1	1	1

Sale of Artis Equipment in Theatre 10 *(this has not been included in the financial proforma due to uncertainty around the income that will be received)*	£ (income from sale)	0	£TBC	£TBC	£TBC	£TBC
How will information be collected to demonstrate that the benefits have been achieved?						

15. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

In light of the difficulties being experienced both locally and nationally in successfully recruiting across a broad range of staff groups, the author should pay particular attention to the risks associated with fully recruiting to any new posts identified in the business case, supported by current market intelligence. Such risks need to be considered in the context of the likelihood (and timeframe) of the need to use agency or locum staff incurring premium costs for the Trust.

*The likelihood of any additional costs of risk **after** mitigation should be acknowledged in this section, and its impact recognised in the financial assessment of the case.*

Identified Risk	Proposed Mitigation	Value of Risk £'000
No current theatre environment which will be able to house the hybrid theatre at York Hospital	External TIF2 funding has been secured to build a new theatre where the hybrid equipment will be installed. There is a comprehensive project plan and management to deliver this capital build.	

COMMERCIAL CASE

The commercial case should demonstrate that the preferred option has considered additional approval routes required for the purchase of equipment or that a viable procurement route has been identified where required.

16. Is there a requirement to apply for funding via the Medical Equipment Resources Group (MERG), linked to this Business Case?

If 'yes', the completed and approved MERG form must feature as an attachment to the Business Case document.

Yes	✓
No	

Please tick

If 'Yes' please state below what proportion of the overall Capital costs associated with the Business Case (see the Financial Pro-forma), relate specifically to equipment

Overall Capital Costs for the Business Case	£1,304,500
State the value of the Equipment within the above	£1,304,500

17. Is there a requirement to involve or liaise with the Procurement Department with regard to any aspects associated with this Business Case?

Yes	✓
No	

Please tick

If 'Yes' please provide a brief summary to evidence the involvement and the outcome.

A full procurement exercise has been undertaken inviting bids from all suppliers on the framework. A preferred supplier has been chosen on the basis of value for money and delivering the specific service specification.

FINANCE CASE

The finance case should demonstrate that the business case is affordable and the relevant source of funding is identified.

18. Financial Summary

18.1 Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the Care Group or Directorate as a result of this Business Case. The figures should summarise the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure		1305	1305
Income	160,674	160,674	0
Direct Operational Expenditure	137,334	137,334	0
EBITDA	23,340	23,340	0
Other Expenditure		65	65
I&E Surplus/ (Deficit)	23,340	23,275	-65
Existing Provisions	n/a	65	65
Net I&E Surplus/ (Deficit)	23,340	23,340	0
Contribution (%)	14.5%	14.5%	#DIV/0!
Non-recurring Expenditure	n/a		0

Supporting Financial Commentary:

This business case is to seek approval to replace the Artis in Theatre 10 (lease number LG24907 & serial number 148305) as part of the Hybrid Theatre/TIF2 capital build. This equipment is currently on the Surgery capital plan for 2025/26 under capital reference number S25-012 with an overall value for the hybrid theatre equipment of £3m. The capital quote consists of the capital purchase cost, initial one-off software and training costs and a discount from the framework pricing.

The revenue costs shown above (£20k per annum) is the additional cost of maintenance of the equipment. The maintenance cost for the new equipment is £74,894 including the LLP £500 admin fee and is expected to increase by 3% each year after year 2. The existing equipment is currently maintained by Siemens at a cost of £55,133 per year, leading to an increase in maintenance costs of £20k per year which will be resourced from Surgery Care Group's maintenance funding. Year 1 maintenance costs have been discounted due to the warranty period. There is no increase in consumable costs due to the purchase of this equipment and there is no expected ongoing training requirement following the initial training that has been included on the quotation.

This business case has assumed that the equipment will come into operation from October 2025 with depreciation of the equipment starting from January 2026 (Depreciation rate of return costs fully provided for).

18.2 Estimated Impact on Run Rate

Summarise the impact on current monthly income and expenditure run rate as a result of this Business Case. The current run rate should reference the average monthly income and expenditure over the last six months. Demonstrate how the run rate will change as a result of this business case in full, and at 6 months and 12 months following approval of the case. Show income as positive figures and expenditure as negative.

	Current Run rate	Revised Run Rate	Change	Change at 6 months	Change at 12 months	Change in later years
	£000	£000	£000	£000	£000	£000
Income (+ve)						
Clinical Income	13061	13061	0			
Non Clinical Income	329	329	0			
Expenditure (-ve)						
Pay	-8928	-8928	0			
Non Pay	-2518	-2520	-2	0	-2	-2
Non Operational expenditure			0			
Total	1944	1942	-2	0	-2	-2

Run Rate Supporting Commentary:

Due to the purchase of this equipment, there will be an impact on operational revenue of £2k per month linked to the increased cost of the maintenance contract covered within Surgery Care Group's maintenance budget and there will also be a depreciation and rate of return charge of £3.8k per month.

MANAGEMENT CASE

The management case should demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the preferred option.

19. Delivery

Describe the process put in place for successful delivery of the preferred solution, this should include the management of any potential risks, delivery of benefits, recruitment timescales and budgetary changes.

There is a full project plan and documentation outlining the theatre build and installation of the hybrid theatre equipment.

The project is on track to be completed in November 2025. The equipment will be delivered at the end of the build phase (likely October 2025) with an aim to undertake the first procedures in the theatre in December 2025.

20. Post Implementation Review (PIR)

Provide a self-assessment of the risk score and summarise below to determine whether a PIR is required, this will be validated at the time of approval of the business case, by the approving authority, see section 20 of the business case guidance:

Self-assessment score	Level of Risk	Outcome
4	*Low*	*No PIR required*

21. Estimated Implementation Date

State the estimated implementation date. This will be used as the start point of the review period where the Business Case is selected for Post Implementation Review (PIR).

Estimated Implementation Date	**December 2025**

22. Date of Completion:

Note: This date should be kept current on each occasion that the documentation is refreshed/ updated.

The use of version control is recommended to aid the auditing and tracking of current documentation, particularly if the Case spans more than one Care Group or Directorate with multiple contributors. The 'Final' version must be clearly indicated as such.

Date	14/03/25
Version No.	2

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	**BC 24/25 - 114**
TITLE:	**Vascular Hybrid Theatre Equipment**
OWNER:	**James Walkington, Clinical Director**
AUTHOR:	**Liz Hill, Associate Chief Operating Officer**

Capital

		Total £'000	Planned Profile of Change 2024/25 £'000	2025/26 £'000	2026/27 £'000	Later Years £'000
Capital Investment	(-ve)	0	0			
Equipment	(-ve)	-1,305	0	-1,305		
Property Transactions (Leases)	(-ve)	0	0			

Capital Notes *(including reference to the funding source)* :

The costs shown above are to replace the Artis in Theatre 10 (lease number LG24907 & serial number 148305) as part of the Hybrid Theatre/TIF2 capital build. This equipment is currently on the Surgery capital plan for 2025/26 under capital reference number S25-012 with an overall value for the hybrid theatre equipment of £3m. The capital quote consists of the capital purchase cost and initial one-off software and training costs and a discount from the framework pricing.

Revenue

		Total Change Current £'000	Revised £'000	Change £'000	WTE	Planned Profile of Change 2024/25 £'000	2025/26 £'000	2026/27 £'000	Later Years £'000
(a) Non-recurring set up costs	(-ve)					0			
(b) Recurring									
Income									
Income from Patient Care Activities:	(+ve)	156,727	156,727	0		0	0	0	0
Other Operating Income	(+ve)	3,947	3,947	0		0	0	0	0
Total Income		**160,674**	**160,674**	**0**		**0**	**0**	**0**	**0**
Operating Costs:									
Pay									
Medical	(-ve)	-43,504	-43,504	0		0	0	0	0
On-Call Budget (paid via WLIs)	(-ve)	-502	-502	0		0	0	0	0
ECP Budget	(-ve)			0		0	0	0	0
Nursing	(-ve)	-43,028	-43,028	0		0	0	0	0
Other (please list):									
Scientific, Therapeutic and Technical	(-ve)	-12,058	-12,058	0					
Non-Medical - Non-Clinical	(-ve)	-9,216	-9,216	0					
WLIs	(-ve)	-1,107	-1,107	0					
Staff Vacancy Factor		2,298	2,298	0					
Total Pay Costs		**-107,117**	**-107,117**	**0**		**0**	**0**	**0**	**0**
Non-Pay									
Purchase of Healthcare from NHS Bodies	(-ve)	0	0	0		0	0	0	0
Purchase of Healthcare from non NHS Bodies	(-ve)	-6,985	-6,985	0		0	0	0	0
Clinical Supplies & Services	(-ve)	-20,713	-20,713	0		0	0	0	0
General Supplies & Services	(-ve)	-307	-327	-20		0	0	-20	-20
Drugs	(-ve)	-4,595	-4,595	0		0	0	0	0
Establishment	(-ve)	-146	-146	0		0	0	0	0
Premises - (incl Business rates)	(-ve)	-273	-273	0		0	0	0	0
Transport	(-ve)	-420	-420	0		0	0	0	0
Education & Training	(-ve)	-41	-41	0		0	0	0	0
Other (please list):									
Other Non-Pay Costs	(-ve)	-184	-184	0		0	0	0	0
CIP		3,449	3,449	0		0	0	0	0
Total Non Pay Costs		**-30,217**	**-30,237**	**-20**		**0**	**0**	**-20**	**-20**
Total Operational Expenditure		**-137,334**	**-137,354**	**-20**		**0**	**0**	**-20**	**-20**
Impact on EBITDA		**23,340**	**23,320**	**-20**	**0.00**	**0**	**0**	**-20**	**-20**
Depreciation	(-ve)		-23	-23		0	-6	-23	-23
Rate of Return	(-ve)		-23	-23		0	-23	-23	-23
Lease Ammortisation	(-ve)			0		0	0	0	0
Overall impact on I&E		**23,340**	**23,274**	**-65**	**0.00**	**0**	**-29**	**-65**	**-65**
									+ favourable (-) adverse
Less: Existing Provisions	(+ve)	**n/a**	**65**	**65**		**0**	**29**	**65**	**65**
Net impact on I&E		**23,340**	**23,340**	**0**		**0**	**0**	**0**	**0**
									+ favourable (-) adverse

Revenue Notes *(including reference to the funding source)* :

This business case is to seek approval to replace the Artis in Theatre 10 (lease number LG24907 & serial number 148305) as part of the Hybrid Theatre/TIF2 capital build. This equipment is currently on the Surgery capital plan for 2025/26 under capital reference number S25-012 with an overall value for the hybrid theatre equipment of £3m. The capital quote consists of the capital purchase cost, initial one-off software and training costs and a discount from the framework pricing.

capital purchase cost, initial one-off software and training costs and a discount from the framework pricing.

The revenue costs shown above (£20k per annum) is the additional cost of maintenance of the equipment. The maintenance cost for the new equipment is £74,894 including the LLP £500 admin fee and is expected to increase by 3% each year after year 2. The existing equipment is currently maintained by Siemens at a cost of £55,133 per year, leading to an increase in maintenance costs of £20k per year which will be resourced from Surgery Care Group's maintenance funding. Year 1 maintenance costs have been discounted due to the warranty period. There is no increase in consumable costs due to the purchase of this equipment and there is no expected ongoing training requirement following the initial training that has been included on the quotation.

This business case has assumed that the equipment will come into operation from October 2025 with depreciation of the equipment starting from January 2026 (Depreciation rate of return costs fully provided for).

			Board of Directors Only
	Owner	Finance Manager	Director of Finance
Signed	Liz Hill	Richard Blair	
Dated	14/03/2025	13/03/2025	

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2024/25	2025/26	2026/27	Later Years
Fixed Contract Element							
Non-elective admissions	17,920	17,920	0	0	0	0	0
Outpatient Follow Ups	203,204	203,204	0	0	0	0	0
A&E							
High Cost Drugs							
Other (please list):							
Audiology	55,474	55,474	0	0	0	0	0
Critical Care	7,267	7,267	0	0	0	0	0
Variable Contract Element							
Elective Inpatients	4,834	4,834	0	0	0	0	0
Elective Day Cases	31,820	31,820	0	0	0	0	0
Outpatient First Attendances	95,200	95,200	0	0	0	0	0
Outpatient Procedures	24,081	24,081	0	0	0	0	0
High Cost Drugs				0	0	0	0

Income (*+ve*)

		Total Change			Planned Profile of Change			
		Current £'000	Revised £'000	Change £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	Later Years £'000
Fixed Contract Element								
Non-elective admissions	(+ve)	**55,631**	**55,631**	0	0	0	0	0
Outpatient Follow Ups	(+ve)	10,721	10,721	0	0	0	0	0
A&E	(+ve)							
High Cost Drugs	(+ve)							
Community Services	(+ve)							
Other (please list):								
Audiology		4,540	4,540	0	0	0	0	0
Critical Care		9,393	9,393	0	0	0	0	0
Variable								
Elective Inpatients	(+ve)	22,844	22,844	0	0	0	0	0
Elective Day Cases	(+ve)	30,043	30,043	0	0	0	0	0
Outpatient First Attendances	(+ve)	18,341	18,341	0	0	0	0	0
Outpatient Procedures	(+ve)	4,029	4,029	0	0	0	0	0
High Cost Drugs	(+ve)	463	463	0	0	0	0	0
Other NHS Clinical Income								
	(+ve)							
	(+ve)							
Non NHS Clinical Income								
Private patient income	(+ve)	723	723	0	0	0	0	0
Other non-protected clinical income	(+ve)			0				
Total Income from patient care activities		**156,727**	**156,727**	**0**	**0**	**0**	**0**	**0**
Other income								
Research and Development	(+ve)							
Education and Training	(+ve)	9	9	0	0	0	0	0
Other (please list):								
Direct Credit Income	(+ve)	3,938	3,938	0	0	0	0	0
	(+ve)							
Total other income		**3,947**	**3,947**	**0**	**0**	**0**	**0**	**0**

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE RUN RATE SUMMARY

		Total Change				Planned Profile of Change		
		Current £'000	Revised £'000	Change £'000		6 months £'000	12 months £'000	Later Years £'000
Income								
Income from Patient Care Activities:	(+ve)	13,061	13,061	0				
Other Operating Income	(+ve)	329	329	0				
Total Income		**13,389**	**13,389**	**0**		**0**	**0**	**0**
Operating Costs:								
Pay								
Medical	(-ve)	-3,625	-3,625	0		0	0	0
On-Call Costs (paid via WLIs)	(-ve)	-43	-43	0		0	0	0
Reduction in ECP costs	(-ve)	0	0	0		0	0	0
Nursing	(-ve)	-3,586	-3,586	0				
Other (please list):								
Scientific, Therapeutic and Technical	(-ve)	-1,005	-1,005	0		0	0	0
Non-Medical - Non-Clinical	(-ve)	-768	-768	0		0	0	0
WLIs	(-ve)	-92	-92	0		0	0	0
Staff Vacancy Factor		192	192	0		0	0	0
Total Pay Costs		**-8,928**	**-8,928**	**0**		**0**	**0**	**0**
Non-Pay								
Purchase of Healthcare from NHS Bodies	(-ve)	0	0	0		0	0	0
Purchase of Healthcare from non NHS Bodies	(-ve)	-582	-582	0		0	0	0
Clinical Supplies & Services	(-ve)	-1,726	-1,726	0		0	0	0
General Supplies & Services	(-ve)	-26	-27	-2		0	-2	-2
Drugs	(-ve)	-383	-383	0		0	0	0
Establishment	(-ve)	-12	-12	0		0	0	0
Premises - (incl Business rates)	(-ve)	-23	-23	0		0	0	0
Transport	(-ve)	-35	-35	0		0	0	0
Education & Training	(-ve)	-3	-3	0		0	0	0
Other (please list):								
Other Non-Pay Costs	(-ve)	-15	-15	0				
CIP		287	287	0				
Total Non Pay Costs		**-2,518**	**-2,520**	**-2**		**0**	**-2**	**-2**
Total Operational Expenditure		**-11,446**	**-11,447**	**-2**		**0**	**-2**	**-2**
Impact on EBITDA		**1,944**	**1,942**	**-2**	**0.00**	**0**	**-2**	**-2**
Depreciation	(-ve)		-1.90	-1.90		-1.90	-1.90	-1.90
Rate of Return	(-ve)		-1.90	-1.90		-1.90	-1.90	-1.90
Lease Ammortisation	(-ve)			0				
Overall impact on I&E		**1,944**	**1,938**	**-5.45**	**0.00**	**-3.80**	**-5.45**	**-5.45**
Less: Existing Provisions	(+ve)	**n/a**	**3.80**	**3.80**		**3.80**	**5.45**	**5.45**
Net impact on I&E		**1,944**	**1,942**	**-2**		**0**	**0**	**0**

Run rate notes:

Due to the purchase of this equipment, there will be an impact on operational revenue of £2k per month linked to the increased cost of the maintenance contract covered within Surgery Care Group's maintenance budget and there will also be a depreciation and rate of return charge of £3.8k per month.

Capital charges calculation

	Enter Total Value £K	Discounted Value £K
Total Capital Cost	**1,304,500**	-
Total capital Spend	Building	
	Engineering Plant	
	External works	-
	Capital Equip incl IT	**1,304,500**
	Initial equipping revenue equipment to capitalise	-
	Total	**1,304,500**

Enter Total Capital Cost in C5
Enter Capital Equipment in E9
Enter Total Initial Equipment in E10
Enter Total External works in E9
Amend % for new or refurb scheme E5 see below for %

Assumes DV Assesses building value :

70% less than cost for a refurb scheme	The DV revalues all capital additional works each year and the revaluation amount is what is then used to calculate depn costs.
75% cost for new building ,	We usually find that the value is less than the actual cost to build therefore when calculating depn costs we revalue the build costs down.
split usually 60% Buildings 40% engineerings	For building costs, we have to split between buildings and engineering works, we usually do this on a 60:40 basis , unless it is all build or all engineering works. External works are outside ground works, eg garden area's or roads etc.

Enter here, equipment, including IT equipment

Initial equipment are costs made up of items that would normally fall into revenue e.g cutains, desks etc items that would normally individually cost <£5k, on a refurb scheme we can group these together and capitalise as initial equipment.

Charitable funded schemes - Are exempt from PDC charges, therefore delete the PDC charge calculated on that asset . EG for equipment delete cell F36

Capital equipment

Purchase Price **£1,304,500** k
Useful Life **10**

ROCE **3.5%** **Depreciation per annum (straight line)** **£130,450**

	Value at Year End £	Mid Year Value £	ROCE - PDC charges £	**Capital Charge £**
Year 0	1,304,500			
Year 1	1,174,050	1,239,275	43,375	**173,825**
Year 2	1,043,600	1,108,825	38,809	**169,259**
Year 3	913,150	978,375	34,243	**164,693**
Year 4	782,700	847,925	29,677	**160,127**
Year 5	652,250	717,475	25,112	**155,562**
Year 6	521,800	587,025	20,546	**150,996**
Year 7	391,350	456,575	15,980	**146,430**
Year 8	260,900	326,125	11,414	**141,864**
Year 9	130,450	195,675	6,848	**137,299**
Year 10	0	65,225	2,283	**132,733**
PDC charges based on average of 10 years			**22,829**	
Total Capital ChargeBased on average ROCE:				**£153,279**

Initial purchase of revenue equipment write off over 10 years

Purchase Price - k
Useful Life **10**

ROCE **3.5%** **Depreciation per annum (straight line)** **£0**

	Value at Year End £	Mid Year Value £	ROCE - PDC charges £	**Capital Charge £**
Year 0	0			
Year 1	0	0	0	**0**
Year 2	0	0	0	**0**
Year 3	0	0	0	**0**
Year 4	0	0	0	**0**
Year 5	0	0	0	**0**
Year 6	0	0	0	**0**
Year 7	0	0	0	**0**
Year 8	0	0	0	**0**
Year 9	0	0	0	**0**
Year 10	0	0	0	**0**
PDC charges based on average of 10 years			**0**	
Total Capital ChargeBased on average ROCE:				**£0**

Plant 20 years

Purchase Price **£0**
Useful Life **25**

ROCE **3.5%** **Depreciation per annum (straight line)** **£0**

	Value at Year End £	Mid Year Value £	ROCE - PDC charges £	**Capital Charge £**
Year 0	0			
Year 1	0	0	0	**0**
Year 2	0	0	0	**0**
Year 3	0	0	0	**0**
Year 4	0	0	0	**0**
Year 5	0	0	0	**0**
Year 6	0	0	0	**0**
Year 7	0	0	0	**0**
Year 8	0	0	0	**0**
Year 9	0	0	0	**0**
Year 10	0	0	0	**0**
Year 18	0	0	0	**0**
Year 25	0	0	0	**0**
PDC charges based on average of 25 years			**0**	
Total Capital ChargeBased on average ROCE:				**£0**

Building
Fees and Construction costs

Purchase Price **£0**
Useful Life **40**

ROCE **3.5%** **Depreciation per annum (straight line)** **£0**

	Value at Year End £	Mid Year Value £	ROCE - PDC charges £	**Capital Charge £**
Year 0	0			
Year 1	0	0	0	**0**
Year 2	0	0	0	**0**
Year 3	0	0	0	**0**
Year 4	0	0	0	**0**
Year 5	0	0	0	**0**
Year 6	0	0	0	**0**
Year 7	0	0	0	**0**
Year 8	0	0	0	**0**
Year 9	0	0	0	**0**
Year 10	0	0	0	**0**
Year 15	0	0	0	**0**
Year 30	0	0	0	**0**
Year 40	0	0	0	**0**
PDC charges based on average of 10 years			**0**	
Total Capital ChargeBased on average ROCE:				**£0**

External works
Fees and Construction costss

Purchase Price -
Useful Life **40**

ROCE **3.5%** **Depreciation per annum (straight line)** **£0**

	Value at Year End £	Mid Year Value £	ROCE - PDC charges £	**Capital Charge £**
Year 0	0			
Year 1	0	0	0	**0**
Year 2	0	0	0	**0**
Year 3	0	0	0	**0**
Year 4	0	0	0	**0**
Year 5	0	0	0	**0**
Year 6	0	0	0	**0**
Year 7	0	0	0	**0**
Year 8	0	0	0	**0**
Year 9	0	0	0	**0**
Year 10	0	0	0	**0**
Year 15	0	0	0	**0**
Year 30	0	0	0	**0**
Year 40	0	0	0	**0**
PDC charges based on average of 10 years			**0**	
Total Capital ChargeBased on average ROCE:				**£0**

Total Depn	**£130,450**
Total Rate of Retur	**£22,829**
Total ROCE	**£153,279**

Depreciation starts 3 months after the asset comes into use, so if complete at year end (31st March), then the following year (year 2) will only have 3/4's of depn charges.

PDC is calculated from when the asset is invoiced so include in year 1 full cost

So an asset that completes (or comes into use) between 31st Dec - 31st March won't have any depn costs in year 1 but will have PDC charges

Total Depreciation **£130,450**
Total Cost of Capital (PDC) **£22,829**

Total Capital Charge based on Ave ROCE **£153,279** k

Assumes DV assesses building value to be 50% less than cost for arefurb scheme

Report to:	Board of Directors
Date of Meeting:	26 March 2025
Subject:	Corporate Governance Update
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 consider the Audit Committee Annual Report and Effectiveness Review and approve the Committee terms of reference amendments, the 2025/26 Board of Directors work plan and the 2025 Modern Slavery Statement.

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
Group Audit Committee	4 March 2025	Approved (effectiveness review)
Quality Committee	18 March 2025	Approved (terms of reference)
Resources Committee	18 March 2025	Approved (terms of reference)

Corporate Governance Update

1. Introduction and Background

Annual Committee Effectiveness reviews are an important process to reflect on the achievements of the Board of Directors Committees and where they could improve in the future. The Group Audit Committee Annual Report and Effectiveness Review has now been concluded for the Board to consider.

Terms of Reference amendments, the 2025/26 Board work plan and the 2025 Modern Slavery Statement are also provided for Board approval.

2. Committee Annual Report and Effectiveness Review, and Terms of Reference

The 2024/25 Audit Committee Annual Report and Effectiveness Review is presented at appendix 1 for the Board to consider.

With all Committee Annual Reports and Effectiveness Reviews concluded, the terms of reference have been reviewed for the Quality, Resources and Group Audit Committees and are presented at appendix 2, 3 and 4 respectively for approval.

3. 2025/26 Board Work Plan

The Board Work Plan has been reviewed for the coming year and is presented at appendix 5 for Board approval.

4. Modern Slavery Statement

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act. The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking, and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36 million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors and YTHFM LLP Management Group.

The aim of the statement is to encourage transparency within organisations. There are potential consequences for organisations who fail to produce a slavery and human trafficking statement for a particular year. The statement has been prepared on a Group basis.

The Board is asked to approve the Modern Slavery Act Statement for publication on the Trust's website as presented at appendix 6.

Group Audit Committee Annual Report and Effectiveness Review 2024/25

1. Introduction

This report has been prepared to provide the Board of Directors with a summary of the work of the Group Audit Committee and its effectiveness during the period April 2024 – March 2025, and, in particular, how it has discharged its responsibilities as set out in its Terms of Reference.

The Board of Directors approved the terms of reference for the Committee in December 2022 with no subsequent amendments made since that time. This report also forms the annual report of the Committee over this period.

2. Governance

The membership of the Group Audit Committee is as follows:

- Non-Executive Director (Chair)
- 2 x Non-Executive Director (inc Associate Non-Executive Director)

Attendees of the Committee are:

- Director of Finance
- Deputy Finance Director
- Associate Director of Corporate Governance
- Head of Internal Audit
- Internal Audit Manager
- External Audit Partner
- External Audit Manager, if required
- Counter Fraud Specialist
- YTHFM Representative
- Executive Directors (as and when required)

Table 1: Group Audit Committee Attendance

	May 2024	Jun 2024	Sep 2024	Dec 2024	Mar 2025	Total
Jenny McAleese (Chair)	✓	✓	✓	✓	✓	5/5
Lynne Mellor	Ap	✓	✓	✓	N/a	3/4
Stephen Holmberg	✓	✓	✓	Ap	✓	4/5
Helen Grantham	✓	Ap	✓	✓	✓	4/5

Ap - Apologies, Deputy - Deputy provided, ✓ - in attendance

The Group Audit Committee met on 5 occasions during 2024/25 (including the Annual Report and Accounts Year-End meeting), and all meetings were quorate.

The Committee received secretarial and administrative support from the Chair and Chief Executive Office with minutes taken of all Group Audit Committee meetings. The Chair provided an escalated items report of those matters that the Committee considered should be drawn to the attention of the Board.

The Chair of the Group Audit Committee is also the Trust Board of Directors Vice-Chair.

3. Duties of the Committee

The Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance and which support the achievement of the Trust's objectives. At a high-level this involves:

- The Committee reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's and YTHFM's activities (both clinical and non-clinical) that supports the achievement of the Trust's or YTHFM's objectives.
- The Committee ensuring there is an effective Internal Audit function established that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive (Accounting Officer), the Board and YTHFM.
- The Committee reviewing and monitoring External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee reviews the work and findings of the External Auditors and considers the implications and management's responses to their work.

The Committee on reviewing financial reporting:

- Monitors the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- Ensures that the systems for financial reporting to the Board/YTHFM and the Council of Governors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- Reviews the Annual Report and financial statements before submission to the Board/YTHFM, focusing particularly on:
  - the wording in the Annual Governance Statement and other disclosures relevant to these Terms of Reference
  - changes in, and compliance with, accounting policies and practices and estimation techniques
  - unadjusted misstatements in the financial statements
  - significant judgements in preparation for the financial statements
  - significant adjustments resulting from the audit
  - letter of representation
  - explanations for significant variances
- Considers the Trust's/YTHFM's in-year financial position.
- Reviews the Trust's/YTHFM's annual financial plan.
- Approves changes to accounting policies and practice.

On other assurance duties:

- Reviews the findings of other significant assurance functions, both internal and external to the Trust, and considers the implications for the governance of the Trust/YTHFM.
- Reviews the Trust's/YTHFM's Standing Orders, Standing Financial Instructions and Schemes of Delegation.
- Receives details of waivers to standing orders approved by the Executive Director of Finance.
- Reviews the schedule of Losses and Compensations and approve write-offs as appropriate.
- Satisfies itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and reviews the annual fraud report and other fraud updates and any outcomes from the work.
- In accordance with 3.2 of the NHSCFA's Fraud Commissioners Standards, the Group Audit Committee has: 'stated its commitment to ensuring commissioners achieve these standards and therefore requires assistance that they are being met via NHSCFA's quality assurance programme.'
- Refers any suspicions of fraud, bribery or corruption to the NHSCFA.
- Requests and reviews reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.
- Receives reports from any sub-groups of the Committee as appropriate.
- Requests specific reports from individual functions with the organisation (eg: Clinical Audit).
- Reviews the adequacy and security of the organisation's arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee ensures that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.
- Receives investment reports and agrees investment limits.
- Supports and advises the Council of Governors and any sub-Committee as requested.
- Escalates any areas of concern identified to the Board/YTHFM for further discussion and resolution.
- Submits a report of escalated items and minutes to the Board following each of its meetings (at least 5 times per year) and the Chair of the Committee draws to the attention of the Board any issues that require disclosure or require Executive action
- Prepares an Annual Report for presentation to the Board and the Council of Governors on its work in support of the Annual Governance Statement, specifically commenting on:
    - the fitness for purpose of the assurance framework
    - the completeness and embeddedness of risk management in the organisation
    - the integration of governance arrangements
    - the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
    - the robustness of the processes behind the quality accounts

The Annual Report also describes how the Committee has fulfilled its terms of reference and give details of significant issues that the Committee considered in relation to the financial statements and how they were addressed.

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:

- Internal Audit: Trust and YTHFM
    - Plan review and approval
    - Progress Reporting
    - Overdue recommendations reporting
- External Audit
    - Group Plan Approval
    - Progress Reporting
- Risk Management
    - Board Assurance Framework
    - Corporate Risk Register
    - Annual Review of the Risk Management Policy
- Governance Framework Review: Powers of Reservation and Scheme of Delegation, Standing Orders and Standing Financial Instructions, Trust Constitution
- Board Assurance Committee reporting
- Freedom to Speak Up processes reporting
- Counter Fraud Annual Plan and Progress Reporting
- Executive Director reporting of areas of concern, overdue internal audit actions and review of Board Assurance Framework risks
- Year-End review and recommendation:
    - Annual Accounts and Financial Statements
    - Annual Governance Statement
    - Head of Internal Audit Opinion
    - External Auditors completion report and letter of representation

5. Assessment of Effectiveness

Highest self-assessment scores

- The committee chair allows debate to flow freely and does not assert his/ her own views too strongly.
- The committee provides a written summary report of its meetings to the Board of Directors.
- The committee has set itself a series of objectives for the year.
- The committee has made a conscious decision about the information it would like to receive.
- Committee members contribute regularly to the issues discussed.

- The committee receives assurances from third parties who deliver key functions to the organisation.
- Equal prominence is given to both quality and financial assurance.
- The committee has the right balance of experience, knowledge and skills to fulfil its role.
- The committee environment enables people to express their views, doubts and opinions.
- Committee members understand the messages being given by external audit, internal audit and counter fraud specialists.
- Debate is allowed to flow, and conclusions reached without being cut short or stifled.

Lowest self-assessment scores

- The committee receives clear and timely reports from other Board committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.
- The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives.
- Management fully briefs the committee on key risks and any gaps in control.
- Decisions and actions are implemented in line with the timescale set down.

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 Audit Committee continues to be of significant importance in the context of increasing pressure on the NHS, both in terms of finance and operational performance. The Audit Committee ensures control processes and procedures are fit for purpose and continue to function effectively alongside the drive for ever more cost reductions.

The Audit Committee continues to provide an overarching link between the Board Committees to ensure that audit work and risk is covered in the appropriate forum and that governance processes are working and are fit for purpose.

Members of the Committee are pleased to note the continued support for audit work from the organisation. This endorsement and support are both extremely important, as is the culture of openness and the desire always to learn and to improve.

This year I again pay tribute to the finance, Internal and External Audit teams and the Chair and Chief Executive's Team support team for their hard work in relation to the preparation and audit of the Annual Accounts and the associated reports. The timetable is brutal and necessitates much hard work by a relatively small team of people.

Finally, I thank the Board for the strong support you have given me and the work of the Audit Committee over the past nine years and am sure that you will continue to give this to Jane Hazelgrave, my successor as Audit Chair.

Jenny McAleese, Chair of the Audit Committee
February 2025

Terms of Reference for: **Quality Committee**	NHS York and Scarborough Teaching Hospitals NHS Foundation Trust
Lead Executive Director: Dawn Parkes, Chief Nurse	
Authors Name: Adele Coulthard, Director of Quality, Improvement and Patient Safety	
Contact Name: Mike Taylor, Associate Director of Corporate Governance	
Trust Priorities: Quality, patient experience, safety and clinical effectiveness	**Scope:** Trust wide
Keywords: Quality, Safety, Patient Experience, Clinical Effectiveness	**Replaces:** N/A
To be read in conjunction with the following documents: Trust Strategy and Priorities, Board Assurance Framework, Corporate Governance Manual, Care Group Quality Governance Arrangements	

Unique Identifier: QC	**Review Date: March 2025**	
Issue Status: Draft	**Issue No: v2.0**	**Issue Date:** March 2025
To be Authorised by: Quality Committee and Board of Directors	**Authorisation Date:** Quality Committee: 18 March 2025 Trust Board: TBC	
Document for Public Display: Yes		

After this document is withdrawn from use it must be kept in an archive for 6 *years.*	
Archive:	**Date added to Archive:**
Officer responsible for archive: Associate Director of Corporate Governance	

QUALITY COMMITTEE

Terms of Reference

1. Status	
1.1	The Board has resolved to establish a Committee of the Board to be known as the Quality Committee ("the Committee").
1.2	The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.
2. Purpose of the Committee	
2.1	The purpose of the Quality Committee is to gain assurance, on behalf of the Board of Directors, that there are systems, processes and controls in place to deliver and monitor the achievement of consistently high-quality care to meet the Trusts legal and regulatory obligations.
2.2	The Committee will gain assurance that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner.
2.3	The Committee will ensure that any risks to delivery of quality standards are escalated to the Trust Board and appropriate mitigations and remedial actions are implemented.
2.4	The Committee ensures that the Trust Board receives regular and reliable assurance on the quality of clinical services including safety, effectiveness and patient experience.
2.5	The Committee fosters the development of a learning organisation ensuring that feedback from patients and carers is heard, that there is learning from concerns, complaints, compliments, risks and incidents and acts to improve care.
2.6	The Committee ensures that there is appropriate planning in place around current and future statutory and mandatory quality and patient safety standards, and that best practice is identified, delivered and shared.
2.7	The Committee will review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function.

3. Authority	
3.1	The Committee is a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference.
3.2	The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, external and internal auditor and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required.
3.3	The Committee is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever independent professional/legal advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).
3.4	The Committee shall have the power to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board.
3.5	In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.
3.6	The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the Trust Board of Directors and reviewed on an annual basis.
4. Legal requirements of the committee	
4.1	There are no specific legal requirements attached to the functioning of the Committee. The Committee will however be made aware of any future legal requirements the Trust is expected to fulfil relating to its role and function.
5. Role and duties	
5.1	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 on a rolling basis a deep dive from each of the care groups escalating issues, actions, risks and mitigations reported 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.

5.2	The Committee will work closely with the following in escalations and in sharing information via Chair's reports to: • Board of Directors (in informing of significant issues, underperformance, and deviation from plans)
5.3	The Committee will support the Audit Committee to review and oversee the effectiveness of the Trust's internal control framework, in considering material issues communicated to it by the Audit Committee arising from the work of the Internal Audit function, relating to matters which fall within the scope of the objective and responsibilities of the Committee. The Committee shall provide feedback on its review of such referred internal audit work, in particular, any shortcomings perceived in the scope or adequacy of the work. Additionally, the Committee shall respond to any other matters of an internal audit nature that are referred to it by the Audit Committee as appropriate.
5.4	To examine any other matter referred to the Committee by the Board of Directors.
5.5	The Committee will escalate items to the Board of Directors following each meeting and will submit minutes to the Board of Directors for information.
6. Membership	
6.1	**Full Members** Three Non-Executive Directors, one of which is the Chair. Associate NEDs can contribute to the membership but must not act as chair. Medical Director Chief Nurse Chief Operating Officer **Attendees** Deputy Medical Director – Quality Associate Medical Director – Quality Director Nursing & Deputy Chief Nurse Director of Quality, Improvement and Patient Safety Chief Clinical Information Officer Chief Pharmacist Chief of Allied Health Professionals YTHFM Representative 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.) **Other/Supplementary Attendees**

	The Associate Director of Corporate Governance will have a standing invitation to the Committee. Representation from Humber and North Yorkshire Integrated Care Board and a patient representative will also have a standing invitation.
6.2	The duties of members and attendees shall be to: • attend and contribute • have read the papers and materials in advance and be ready to work with them • actively participate in discussions pertaining to Committee business ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact Trust-wide • disseminate the learning and actions from the meetings
7. Quoracy	
7.1	The quorum of any meeting shall be a minimum of two Non-Executive Directors and two Executive Directors. The Chair of the meeting will ensure that a deputy is appointed to preside over a meeting when the Chair is unavailable or has a conflict of interest.
7.2	It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year in the annual report of the Committee to the Board. A named deputy must be identified for members of the Committee and must attend when a member is unable to be present. A named deputy will count towards quorum. Senior representatives from each Care Group are expected to attend when presenting but do not count towards quorum.
7.3	The Chair may request attendance by relevant staff at any meeting.
8. Changes to the Terms of Reference	
8.1	Changes to the Terms of Reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.
9. Establishment of sub-groups	
9.1	The Quality Committee may establish sub-groups and/or sub-committees made up wholly or partly of members of the Quality Committee to support its work. The terms of reference of such sub-groups and sub-committees will be approved by the Quality Committee and reviewed at least annually. The Committee may delegate work to the sub-group and/or sub-committee in accordance with the agreed terms of reference. The Chair of each sub-committee will be expected to provide a Chair's report to the Quality Committee after each meeting. The Chair of each sub-group will be expected to provide a report to the Committee either bi- monthly, quarterly or annually dependent on their function.

	Sub-Committees in place: Patient Safety and Clinical Effectiveness Sub-Committee Patient Experience Sub-Committee Maternity Assurance Sub-Committee (time limited)
10. Frequency of meetings	
10.1	Meetings of the Committee shall be held up to 12 times per year, scheduled to support the business cycle of the Trust and at such times as the Chair of the Committee shall identify, subject to agreement with the Chair of the Trust and the Chief Executive. Meetings will be expected to last no more than three hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Committee may be called by any member of the Committee, with the consent of the Chair.
11. Administrative support	
11.1	The Committee will be supported administratively by the Corporate Services Team, who will ensure: • Agreement of the agenda with the Committee Chair • Collation and distribution of papers at least 7 days before each meeting • Minutes are taken and records are maintained of matters arising and issues to be carried forward. • Support the Chair and members as required. • Executive members are supported in carrying out their duties in delivery of Committee roles and duties
12. Reporting to the Trust Board	
12.1	The Chair of the Quality Committee will provide a 'Chair's Report' monthly to the Trust Board outlining key actions taken with regard to quality and safety issues, key risks identified, and key levels of assurances given.
13. Status of the Meeting	
13.1	All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee.
14. Monitoring Effectiveness and Compliance with Terms of Reference	
14.1	The Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives against its forward-looking work programme and

	complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.
15. Review of Terms of Reference	
15.1	The terms of reference of the Committee shall be reviewed at least annually by the Committee and approved by the Board of Directors.

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Owner	**Chief Nurse**
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Terms of Reference for: **Resources Committee**	NHS York and Scarborough Teaching Hospitals NHS Foundation Trust
Authors Name: Mike Taylor, Associate Director of Corporate Governance	
Contact Name: Mike Taylor, Associate Director of Corporate Governance	
Scope: Trust wide	**Trust Priorities: Trust Strategy 2025-2030: Towards Excellence**
Keywords: People, Finance, Performance, YTHFM	**Replaces: N/A**
To be read in conjunction with the following documents: **Trust Strategy and Priorities, Board Assurance Framework, Corporate Governance Manual**	

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RESOURCES COMMITTEE

Terms of Reference

1	**Status**
1.1	The Board has resolved to establish a Committee of the Board to be known as the Resources Committee ("the Committee").
2	**Purpose of the Committee**
2.1	The purpose of the Resources Committee is to lead on behalf of the Board of Directors the acquisition and scrutiny of assurances to ensure: (i) The Trust delivers the six strategic objectives of the Trust Strategy 2025-2030: Towards Excellence (ii) The reviewing and seeking of assurance regarding the operational and strategic plans and activities for Finance, Performance and People aspects of the Trust. This will include areas such as York Teaching Hospitals Facilities Management (YTHFM) estates and facilities, and sustainability (iii) The meeting of regulatory requirements of CQC and NHS England
3	**Authority**
3.1	The Committee is authorised by the Board to investigate any activity within its terms of reference. Changes to the terms of reference can only be approved by the Board of Directors. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.
3.2	The Committee may invite any Director, Executive, external or internal auditor, or other person to attend any meeting(s) of the Committee as it may from time to time consider desirable to assist the Committee in the attainment of its role and duties.
3.3	The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.
4	**Legal requirements of the committee**
4.1	There are no specific legal requirements attached to the functioning of the Committee. The Committee will however be made aware of any future legal requirements the Trust is expected to fulfil relating to its role and function.
5	**Role and duties**
5.1	The Resources Committee shall on behalf of the Board of Directors review assurances in delivery of the Trust Strategy 2025-2030: Towards Excellence and key enablers in the following areas as part of the Trust's longer-term strategy: (i) Workforce strategy

	(ii) Trust operational performance plans and processes; (iii) Financial performance, material variance and remedial plans; (iv) YTHFM and Sustainability strategies
5.2	To do this it will receive reports including the Trust Priorities Report (TPR) where applicable, across the following areas: • Finance • Performance • People • YTHFM
5.2.1	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.
5.2.2	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.
5.2.3	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
5.2.4	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)
5.3	The Committee will work closely with the following in escalations and in sharing information via Chair's reports to: • Board of Directors (in informing of significant issues, underperformance, and deviation from plans to deliver the Trust Strategy 2025-2030: Towards Excellence • Quality Committee; • Digital Sub-Committee, and • Audit Committee
5.4	The Committee will support specifically the Audit Committee to review and oversee the effectiveness of the Trust's internal control framework in considering material issues communicated to it by the Audit Committee arising from the work of the Internal Audit function relating to matters which fall within the scope of the objective and responsibilities of the Committee. The Committee shall provide feedback on its review of such referred internal audit work, in particular as to any shortcomings perceived in the scope or adequacy of the work. Additionally, the Committee shall respond to any other matters of an internal audit nature that are referred to it by the Audit Committee as appropriate.

5.5	To examine any other matter referred to the Committee by the Board of Directors.
5.6	The Committee will escalate items to the Board of Directors following each meeting and will submit minutes to the Board of Directors for information.
6	**Membership**
6.1	The membership of the Committee shall be comprised of the following core members: • Three Non-Executive Directors – (one of whom will be the Chair of the Committee) • Director of Finance • Chief Operating Officer • Director of Workforce and Organisational Development • Managing Director of YTHFM • Chief Nurse • Medical Director • Chief Digital Information Officer The following Directors and officers will be attendees: • Chief of Allied Health Professionals Other attendees: • Any Director, the Chair or Chief Executive is able to attend at any time on an occasional basis subject to notifying the Chair in advance. • The Associate Director of Corporate Governance will have a standing invitation to the Committee. Representation from Humber and North Yorkshire Integrated Care Board will also have a standing invitation.
6.2	The duties of members and attendees shall be to:- • attend and contribute; • have read the papers and materials in advance and be ready to work with them; • actively participate in discussions pertaining to Committee business ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact Trust-wide; • disseminate the learning and actions form the meetings; • to attend at least 75% of meetings of the Committee per year.
7	**Quoracy**

7.1	The quorum of any meeting shall be a minimum of two Non-Executive Directors and two Executive Directors. The Chair of the meeting will ensure that a deputy is appointed to preside over a meeting when the Chair is unavailable or has a conflict of interest.
7.2	It is expected that all members will attend meetings of the Committee. An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.
7.3	If Executive Directors are unable to attend a meeting, they may nominate a deputy subject to consultation with the Committee Chair. Deputies will be counted for the purpose of the quorum.
7.4	The Chair may request attendance by relevant staff at any meeting.
8	**Frequency of meetings**
8.1	Meetings of the Resources Committee shall be held up to 12 times per year, scheduled to support the business cycle of the Trust and at such times as the Chair of the Committee shall identify, subject to agreement with the Chair of the Trust and the Chief Executive.
8.2	The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.
8.3	Meetings of the Committee shall be set at the start of the calendar year.
9	**Administrative support**
9.1	The Committee will be supported administratively by the Corporate Services Team, who will ensure: • Agreement of the agenda with the Committee Chair • Collation and distribution of papers at least 7 days before each meeting • Minutes are taken, actions followed up prior to the next meeting and records are maintained of matters arising and issues to be carried forward. • Support the Chair and members as required. • Executive members are supported in carrying out their duties in delivery of Committee roles and duties
9.2	Where members of the Committee are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the group and provide a deputy.
10	**Monitoring Effectiveness and Compliance with Terms of Reference**
10.1	The Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on

	relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.
11	**Review of Terms of Reference**
11.1	The terms of reference of the Committee shall be reviewed at least annually by the Committee and approved by the Board of Directors.

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Terms of Reference for: **Group Audit Committee**	NHS York and Scarborough Teaching Hospitals NHS Foundation Trust
Authors Name: Mike Taylor, Associate Director of Corporate Governance	
Contact Name: Mike Taylor, Associate Director of Corporate Governance	
Scope: Trust wide	**Trust Priorities: N/a**
Keywords: Internal/External Audit, Risk, Governance, Counter Fraud, Control, Assurance	**Replaces: N/A**
To be read in conjunction with the following documents: **Internal Audit and External Audit Plans, Board Assurance Framework, Corporate Governance Manual**	

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GROUP AUDIT COMMITTEE

Terms of Reference

1	**Status**
1.1	The Group Audit Committee ('The Committee') is a formal committee of the Board of Directors ('The Board'). The Committee is a Non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.
1.2	The business of the Committee meetings shall be formally recorded. The formal minutes shall be distributed to the committee members for any immediate comments. Escalation reports shall be provided to the Trust Board at its next meeting proceeding the reported Group Audit Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or require Executive action.
2	**Purpose of the Committee**
2.1	The Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance and which support the achievement of the Trust's objectives. At the corporate level, this will include a Risk Management System and a Performance Management System, underpinned by an Assurance Framework and Corporate Risk Register. The Committee also has a pivotal role to play in reviewing disclosure statements that flow from the organisation's assurance processes. The Committee also reviews the governance and assurance processes in place around the York Teaching Hospital Facilities Management Limited Liability Partnership (YTHFM).
3	**Authority**
3.1	The Committee is authorised by the Board and YTHFM to investigate any activity within its Terms of Reference and to take appropriate action.
3.2	The Committee is authorised to seek any information it requires from any employee of the Trust or YTHFM and all employees are directed to co-operate with any request made by the Committee.
3.3	The Committee is authorised by the Board and YTHFM to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers it necessary.
3.4	The Committee is authorised by the Board and YTHFM to establish and develop working groups as required by the activities of the Committee and the business needs of the Trust.
4	**Legal requirements of the committee**
4.1	The Committee must ensure that all legal requirements with regard to any new or amended legislation are reviewed on behalf of the Trust and addressed accordingly. Key documents include, but are not limited to: • NHS Audit Committee Handbook 2024 • NHSE Code of Governance for NHS Provider Trusts 2023

	The Committee should have due regard to the Trust's and YTHFM's obligations under legislation relating to equality.
5	**Role and duties**
5.1	**Governance, Risk Management and Internal Control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's and YTHFM's activities (both clinical and non-clinical) that supports the achievement of the Trust's or YTHFM's objectives. In particular, the Committee will review the adequacy and effectiveness of: • All risk and control related disclosure statements, in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to submission to the Board or YTHFM. • The underlying assurance processes that indicate the degree of achievement of the Trust's or YTHFM's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications. • The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA. • In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources of assurance. It will also seek reports and assurance from Directors and Managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. • This will be evidenced through the use of an effective Assurance Framework to guide its work and the audit and assurance functions that report to it. • The Committee will have effective relations with other key Committees so that it understands processes and linkages. However, these other Committees must not usurp the Committee's role.
5.2	**Internal Audit** The Committee shall ensure there is an effective Internal Audit function established that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive (Accounting Officer), the Board and YTHFM. This will be achieved by: • Considering the provision of the Internal Audit service and the costs involved. The Committee should review the performance of the Internal Audit service on an annual basis. • Reviewing and approving the annual Internal Audit Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.

	• Considering the major findings of Internal Audit work (and management responses) and ensuring co-ordination between the Internal and External Auditors to optimise the use of audit resources. • Reviewing the Annual Report of Internal Audit. • Receiving the Head of Internal Audit Statement on the effectiveness of Internal Controls. • Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust. • Discussing problems and reservations arising from Internal Auditor's work and any matters Internal Audit wishes to discuss (in the absence of Executive Directors and other management where necessary). • Monitoring the effectiveness of the Internal Audit and carrying out an annual review.
5.3	**External Audit** The Committee shall review and monitor External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by: • Considering the appointment and performance of the External Auditors, as far as the rules governing the appointment permit (and make recommendations to the Board/YTHFM when appropriate). • Providing support to the Council of Governors in order that they can appoint External Auditors when necessary. • Reviewing all External Audit reports including the report to those charged with governance (before its submission to the Board/YTHFM) and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management responses, including agreement of the Annual Audit Plan. • Discussing the nature and scope of the External Audit Plan with the External Auditor prior to commencement of the audit and agreeing the extent of reliance to be placed on Internal Audit. Where the timing of the Committee meetings makes this impractical, work may proceed with the approval of the Executive Director of Finance which will be subject to later consideration for approval by the Committee at its next meeting. • Discussing with External Auditors their evaluation of audit risks and assessment of the Trust/YTHFM and how the Audit Plan addresses these risks together with the impact on the audit fee. • Discussing issues and reservations arising from External Audit's work and any matters External Audit wish to discuss (in the absence of Executive Directors, Internal Audit and other management where necessary). • Keeping the performance of External Audit under regular review and raising any concerns with them in the first place. Any serious concerns should be drawn to the attention of the Council of Governors. • Ensuring that there is in place a clear policy for the engagement of External Auditors to supply non-audit services.
5.4	**Financial Reporting** The Committee will: • Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

	• Ensure that the systems for financial reporting to the Board/YTHFM and the Council of Governors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. • Review the Annual Report and financial statements before submission to the Board/YTHFM, focusing particularly on: - the wording in the Annual Governance Statement and other disclosures relevant to these Terms of Reference - changes in, and compliance with, accounting policies and practices and estimation techniques - unadjusted misstatements in the financial statements - significant judgements in preparation for the financial statements - significant adjustments resulting from the audit - letter of representation - explanations for significant variances • Consider the Trust's/YTHFM's in year financial position. • Review the Trust's/YTHFM's annual financial plan. • Approve changes to accounting policies and practice.
5.5	**Other Assurance Duties** The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust/YTHFM: • These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc). • The Committee shall review the work of the other Committees and work groups, whose work can provide relevant assurance to the Group Audit Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established and will satisfy itself on the assurance that can be gained from the clinical audit function. • The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.
5.6	**Other Duties** The Committee will: • Review the Trust's/YTHFM's Standing Orders, Standing Financial Instructions and Schemes of Delegation. • Receive details of waivers to standing orders approved by the Executive Director of Finance. • Review the schedule of Losses and Compensations and approve write-offs as appropriate. • Satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and

	review the annual fraud report and other fraud updates and any outcomes from the work. • In accordance with 3.2 of the NHSCFA's Fraud Commissioners Standards, the Group Audit Committee has: 'stated its commitment to ensuring commissioners achieve these standards and therefore requires assistance that they are being met via NHSCFA's quality assurance programme.' • Refer any suspicions of fraud, bribery or corruption to the NHSCFA. • Request and review reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control. • Receive reports from any sub-groups of the Committee as appropriate. • Review the adequacy and security of the organisation's arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action. • Receive investment reports and agree investment limits. • Support and advise the Council of Governors and any sub-Committee as requested. • Escalate any areas of concern identified to the Board/YTHFM for further discussion and resolution. • Submit a report of escalated items and minutes to the Board following each of its meetings (at least 5 times per year) and the Chair of the Committee will draw to the attention of the Board any issues that require disclosure or require Executive action • Prepare an Annual Report for presentation to the Board and the Council of Governors on its work in support of the Annual Governance Statement, specifically commenting on: -the fitness for purpose of the assurance framework - the completeness and embeddedness of risk management in the organisation - the integration of governance arrangements - the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business - the robustness of the processes behind the quality accounts The Annual Report will also describe how the Committee has fulfilled its terms of reference and give details of significant issues that the Committee considered in relation to the financial statements and how they were addressed.
6	**Membership**
6.1	The membership of the Committee shall comprise three Non-Executive Directors (NEDs). One of the members shall be appointed as Chair of the Committee by the Trust Board.
6.2	The Committee shall be appointed by the Board from amongst its independent Non-executive Directors and shall consist of not less than three members one of whom

	will have a financial qualification or relevant background in finance. The Chair of the Trust shall not be a member of the Committee.
6.3	Only members of the Committee have the right to attend committee meetings and have a single vote for any decisions to be taken by the Committee.
6.4	The following, or their nominated deputies, shall be expected to normally be in attendance at meetings: • Executive Director of Finance • Associate Director of Governance/Trust Secretary • Deputy Finance Director • Head of Internal Audit • Manager of Internal Audit • Audit Director for the External Auditor • Counter Fraud Specialist (attendance – minimum of 2 Committees a year) • YTHFM Managing Director (for the YTHFM section only) • Executive Directors will be invited to attend as required
6.5	In addition, other senior specialist officers may attend from time to time to provide specialist advice and support.
6.6	The Chief Executive (Accounting Officer) will be invited to attend annually to discuss with the Committee the process for assurance that supports the Annual Governance Statement and should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.
7	**Quoracy**
7.1	The Committee will be quorate with not fewer than 2 members attending. The Chair of the meeting will ensure that a deputy is appointed to preside over a meeting when the Chair is unavailable or has a conflict of interest (if required).
7.2	Members should normally attend all meetings, and it is expected that members will attend a minimum of 75% of meetings held per annum.
7.3	Where members of the Committee are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the Committee and provide a deputy. The deputy will form part of the quoracy.
8	**Frequency of meetings**
8.1	The Committee will meet as a minimum 5 times per year (including the year-end meeting and time out) and all supporting papers will be circulated 7 days in advance of the meeting.
8.2	The Chair of the Committee has the right to convene additional meetings should the need arise and/or in the event of a request being received from at least 2 members of the Committee.

9	**Administrative support**
9.1	The Committee will be supported administratively by the Chair and Chief Executive's Office, whose duties will include: • Agreement of the agendas with the Chair and attendees; • Advising the Committee on pertinent issues/areas of interest/policy developments; • Formally recording the minutes of the Committee • Ensuring that action points are taken forward between meetings; • Ensuring that Committee members receive the development and training they need; and, • Other duties as required.
9.2	Minutes of the meetings and action log will be circulated to all members as soon as reasonably practical. Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of the report and key issues.
9.3	At least once a year the Committee should meet privately with the External and Internal Auditors. The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee.
9.4	Copies of all agendas and supplementary papers will be retained by the Chair and Chief Executive's Office in accordance with the Trust's requirements for the retention of documents.
10	**Monitoring Effectiveness and Compliance with Terms of Reference**
10.1	The Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.
11	**Review of Terms of Reference**
11.1	The Terms of Reference of the Committee (including membership) shall be reviewed annually or in light of changes in practice or legislation and approved by the Trust Board.

Author	**Associate Director of Corporate Governance**
Owner	**Associate Director of Corporate Governance**
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Appendix 5

York and Scarborough Teaching Hospitals NHS Foundation Trust

Board of Directors Public Meeting Work Plan 2025/26

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Governance Standing Items													
Apologies	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Declarations of Interest	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Approval of previous meeting's minutes	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Matters Arising	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chair's Report	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chief Executive's Report	Chief Exec	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Items													
Trust Priorities Report (TPR): - Performance - Quality & Safety - Workforce - Digital - Finance	Each Exec Director	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Maternity: - Maternity & Neonatal Quality & Safety Report - CQC Section 31 Update	Chief Nurse	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
CQC Compliance Update Report	Chief Nurse	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Summary Reports of Assurance Committees	Comm Chairs	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Quarterly Items													
Risk Management report - Board Assurance Framework	Asso Dir CG	✓			✓			✓			✓		

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mortality Review (Learning from Deaths) Report	Medical Director		✓				✓		✓				✓
Emergency Preparedness Resilience and Response (EPRR) Action Plan Update	Chief Operating Officer	✓			✓			✓			✓		
Journey to Excellence Report	Chief Nurse	✓			✓			✓			✓		
Annual Items													
Annual Plan (final)	CDIO												✓
Infection, Prevention and Control Annual Report	Chief Nurse			✓									
Safeguarding Annual Report	Chief Nurse						✓						
Freedom to Speak Up Report	FTSU Guardian						✓						
Complaints Report (half-yearly Jan)	Chief Nurse				✓						✓		
Responsible Officer Annual Report	Medical Director						✓						
Medical Education Report	Medical Director						✓						
Guardian of Safe Working Hours Annual Report	Medical Director		✓										
Staff Survey Report	Dir Work & OD												✓
WRES & WDES inc Action Plan	Dir Work & OD	✓						✓					
Gender Pay Gap Report	Dir Work & OD							✓					
Equality, Diversity and Inclusion Annual Report	Dir Work & OD		✓										
Equality Delivery System	Dir Work & OD										✓		

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Winter Plan	Chief Operating Officer						✓						
EPRR Annual Report	Chief Operating Officer								✓				
Governance Framework Review: - Constitution - Standing Orders - Scheme of Reservation and Delegation - Standing Financial Instructions	Asso Dir CG										✓		
Fit & Proper Persons Annual Report	Asso Dir CG		✓										
Modern Slavery Act Statement approval	Asso Dir CG												✓
Assurance Committees Annual Reports approval (ToR as required)	Asso Dir CG												✓
Board Register of Interests	Asso Dir CG	✓											
Research and Development Strategy	Medical Director							✓					
Research and Development Annual Report	Medical Director		✓										
Premises Assurance Model (PAM)	YTHFM MD						✓						
Board Work Plan - Public													✓

Last updated 20 March 2025

Appendix 6

Modern Slavery and Human Trafficking Act 2015
Annual Statement 2025

York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospital Facilities Management LLP (the Group) offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chain.

The Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospital Facilities Management LLP provide 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 annual turnover is approximately £0.8bn. We manage 8 hospital sites, circa 1000 beds (including day-case beds) and have a workforce in excess of 10,000 staff working across our hospitals and in the community.

The Group has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. There are robust recruitment policies and processes in place, including conducting eligibility to work in the UK checks for all directly employed staff and agencies on approved frameworks.

There are a range of equal opportunities controls in place to protect staff such as a Freedom to Speak Up Guardian, Fairness Champions and a Raising Concerns and Whistleblowing Policy.

The Group has in place a Standards of Business Conduct Policy which covers the way in which the organisation and staff behave.

The Procurement Department's senior team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPS code of professional conduct. The intranet includes a link to an ethical procurement training module which is available to all members of staff. Competency assessments are currently being developed for all bands in the department some of which will include requirements around modern slavery.

The top 50% of suppliers nationally affirm their own compliance with the modern slavery and human trafficking act within their own organisation, sub-contracting arrangements and supply chain. The Group has written to its top suppliers requesting them to affirm their compliance with the legislation.

Modern Slavery is referenced in the Safeguarding Adults Policy and features as part of the safeguarding adults training following the changes in the Care Act. The Safeguarding Adults Staff intranet resource includes signposting to help and provide advice for patient's affected by Modern Slavery. Modern Slavery is included on the Safeguarding work programme with plans to review processes over the next 12 months.

The Group has evaluated the principal risks related to slavery and human trafficking and identify them as:

- Reputational
- Lack of assurances from suppliers
- Lack of anti–slavery clauses in contracts
- Training staff to maintain the Group's position around anti-slavery and human trafficking.

Aim

The aim of this statement is to demonstrate the Group follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

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Martin Barkley
Chair

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Simon Morritt
Chief Executive

1 April 2025

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Julie Charge
Chair (YTHFM LLP)

……..
Chris Norman
Managing Director (YTHFM LLP)

1 April 2025