NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

Report to:	Council of Governors
Date of Meeting:	11 December 2024
Subject:	NED Assurance Questions from Governors
Director Sponsor:	Martin Barkley, Chair
Author:	Tracy Astley, Governor & Membership Manager

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:

This paper provides the questions collated from the Governors for the NEDs to answer at the meeting. The Council of Governors is asked to note the report and the authors will respond to any questions or comments, as appropriate.

Report History

(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation

NED Assurance Questions from Governors

TRAVEL & TRANSPORT
Q1: In the past there was a free Shuttle transport to and from Scarborough and was free for staff, patients and for hospital small estate transports. The service was stopped few years ago. Having a free service like this will help the local community accessing the hospital without paying taxi or asking family members for transport. It also provides a greener environment reducing pollution. Can the Trust look in to bringing this service back. **A1:** There is a long history to the shuttle bus which was first launched in 2008 and operated between Bridlington and Scarborough Hospitals. It stopped in 2016 when the Clinical Commissioning Group, the body responsible for commissioning and funding services at that time, could no longer fund it. The Trust is not funded to provide transport services for patients. Since that time, along with commissioners, East Riding of Yorkshire Council, and voluntary sector organisations this has been looked at several times and there have been a number of further trials, however on each occasion it was discontinued as the numbers of passengers using the service did not make it viable for those providing the service. As part of our Sustainability Plan we will once again be looking at the practicalities of providing transport (for example, a shuttle bus) between our sites, managed by our in-house team, for use by staff and patients.
Q2: Traffic and parking at the Trust in York continue to be an issue, with reports that some operations in York are being delayed because staff can't get to work and park on time. What have the NEDs done to challenge the Board to come up with solutions? Has this issue been escalated to Board? One proposal would be to have a half-hourly mini-bus service from/to one or more park and ride locations during each working day and combine this with changes to parking restrictions at York Hospital. With this bus service, it should be possible to limit the use of the multi-storey car park at York to just staff, those with a Blue Badge and those attending A&E. Do the NEDs support this or similar suggestions? If not, what other solutions do the NEDs propose? **A2:** Like many cities and towns, York and Scarborough are prone to high traffic congestion, and parking on and around the hospital sites is limited, particularly in York. The primary purpose of the multi-storey care park is for visitor parking, with a blue badge parking areas outside the main entrance. This leaves limited remaining parking areas for staff, which it is not possible to increase to meet demand. Last year we undertook a wholesale review of staff and visitor parking and introduced new systems for managing parking on all of our sites. We also reviewed, in consultation with staff, the permit criteria and introduced new criteria to help alleviate parking pressures. Applying our new criteria significantly reduced the number of parking permits in use on Trust sites, more closely aligning the number of parking spaces with the number of staff who need to park to undertake their job. However, although these changes have improved the situation, the reality is we cannot provide parking for all as we simply do not have the capacity to do so. This was recognised by our Staff Side representatives, who sought to prioritise parking access based on job-related need.

In addition to the review of parking on site, we continue to develop and promote alternatives to car travel, including cycle to work schemes and increasing secure bike parking areas. We have also continued to work with York, North Yorkshire and East Riding Councils and the bus operating companies to negotiate discounted rates for staff travelling to and from work, and these have proved popular. This followed the trial of the ‘hospital bus’ which ran from Rawcliffe Park and Ride to the hospital. As mentioned in the response to Q1, we will once again be looking at the practicalities of providing transport between our site, for use by staff and patients as part of our Sustainability Plan.

The Board recognises the challenges presented by parking at the hospital, and the wider issue of travel for patients who have appointments at different sites. The parking review and subsidised bus transport scheme were both discussed at Board and were supported.

Q3: The older people in Whitby and surrounding areas are experiencing great difficulty attending outpatient appointments. Patients who attend appointments in Bridlington cost of taxis £100-£120 one way, to York £110-£130 one way, Scarborough £50 one way from Whitby. Some taxi drivers to Bridlington charge a £20/hour waiting fee for the patient for the return journey. In Whitby we have no train links other than to Middlesbrough, bus services are very limited.

A lady reached out who is elderly with arthritis, lives alone and has a small family with no car available to them. She has tried to do the arduous route to Bridlington from Whitby on public transport and was not possible for her to complete the journey. She has now set up an arrangement with someone to take her for £50. she has to have treatment very regularly and cannot afford to keep on paying £50.

Speaking to Patient Transport, it has been told to me that you do a test on the phone and if you mention there is anyone in your family with a car, they stop the test and tell you to ask them to take you. I cannot verify this personally, but I have no reason to disbelieve 2 different people.

Can this serious question of inadequate patient transport be put to the NEDs? Is there currently any dialogue between NED and management taking place about the apparent lack of patient transport and the possible knock on effects of missed appointments, patients not getting treatment and issues arising?

A3: DNA levels are low – there is no evidence of patients not getting the treatment they need. What the Board have requested is that appointments are offered to patients at the hospital nearest to their home, rather than the first available appointment at any hospital. It would be good to know what service/treatment the patient who lives in Whitby has to go to Bridlington for to receive treatment. It would also be interesting to know whether ambulance transport for example has been refused.

STAFF

Q4: In the budget it was announce that the national insurance rate will be increased from April next year, but the NHS are exempt. Does this include YTHFM?

A4: We expect it to be the case that YTHFM will be included in whatever arrangements are put in place for the NHS in relation to the increased NI contributions. All existing arrangements for the NHS in relation to terms and conditions of service, pensions and

costs of employment are mirrored for YTHFM as we have dynamically linked YTHFM to NHS agenda for change principles.

Q5: Over recent months, there have been several appointments of colleagues to senior operational roles at a time when the Trust has increased scrutiny / deferred appointments of front line clinical / nursing / AHP staff who would be involved in direct face-to-face care delivery. Please can the NEDs provide assurances that a consistent approach is being applied to these appointments?

A5: All vacancies are subject to the same level recruitment vacancy vetting policy

ACUTE, URGENT & EMERGENCY CARE (AUEC) SERVICES

Q6: Our EDs are facing significant operational pressures, with focuses currently being placed upon the timeliness of ambulance handovers, improvements in the ECS 4-hour metric along with reducing the number of patients who remain in the departments > 12 hours.

Please can the NEDs provide assurances about how the teams overseeing local AUEC care delivery are being supported by their operational colleagues to develop optimal clinical models of care needed to address these challenges?

A6: The NEDs are having a "deep dive" meeting with relevant executives on 20th December to review the improvement plans, as the NEDs are very concerned about the impact on patients and staff of the delays in ED, especially patients waiting many hours to be admitted and the consequent crowding in EDs.

Q7: The provisional A&E quality indicators for E&W for September 2024 have just been published, which report the median time to initial assessment was 9 minutes for ambulance attendees, the median total time for patients in A&E for all patients was 2h 49m and that a median of 4.7% of patients left before being seen (LBBS).

A number of workstreams are being developed to help support improvements in the initial two metrics, but historically there has been less focus upon the LBBS cases to identify any safeguarding / clinical concerns. Please can the NEDS provide assurances about how these cases are being reviewed?

A7: If clinical team members are alerted to the fact that the patient has decided to leave (eg triage or streaming nurse in the waiting room) they are able to safety net the patient and advise them what to look out for in terms of worsening of their clinical condition. They are also able at that point of contact to make an assessment regarding any safeguarding concerns and decide whether further action is required.

If the patient does not alert the clinical team at point of their departure then there is an inbuilt requirement to send a discharge note to the patient's GP. The completion of this note is compulsory to remove the patient from the computer system and when it is completed the expectation is that the clinician completing this should review the clinical record (albeit likely brief) and make an assessment as to whether any additional action is required at that time (eg contact the patient to ensure that their medical needs have been met etc).

A review of the process for creating this on our Trust CPD system has been undertaken, and a formalised Standard Operating Procedure is in development and will be available for the Emergency Department staff to refer to in the near future.

Q8: The timely management of potential sepsis presentations is a key clinical marker of the quality of care our EDs are providing. Please can the NEDs provide assurances about the current performance metrics in relation to the screening of sepsis and the prescribing and administration of antibiotics within one hour of sepsis markers being triggered in our EDs?

A8: Each Emergency department has a Sepsis Improvement Group with key stakeholders and clinical leadership working on key issues. There is need to establish a requirement for these groups to feedback on a regular basis to the Trust Wide Deteriorating Patient Group. Clinical educators have commenced sepsis specific training with front of house areas such as admission and assessment units which has been well received. The last available information the sepsis data shows that:

- Blood cultures taken before antibiotics was at 100% for YDH and 70% for SGH.
- Appropriate fluids administered was at 80% YDH and 80% for SGH.
- Average time from arrival to Antibiotic qdministered was at 100 minutes for YDH and 110 minutes for SGH.
- Average time Antibiotic administered from prescription was at 34 minutes for YDH and 32 minutes for SGH
- Average time Antibiotic administered from identification of sepsis was 70 minutes for YDH and 89 minutes for SGH.

this is overseen by the Quality Committee.

Q9: Evidence suggests that there will be one additional (potentially preventable) death for every 72 patients who remain in the ED waiting for admission for greater than 8 hours. Based upon our current ECS metrics, this suggests up to 20 such deaths occur each month across the Y&S sites. Please can the NEDs provide assurances about any such deaths that have been identified and what plans have been put in place to mitigate further cases?

A9: No patients have been identified who have died directly as a consequence of waiting more than 8 hours to be admitted. As mentioned in Answer 6 a meeting is being held on 20th December.

Q10: The completion of coding following ED attendances (to identify ongoing care needs and safeguarding concerns) in a timely manner is very challenging. Plans are currently in place to address coding that can be attributed to ED clinicians, but to date no similar plans for the timely coding of patients whose care episode has been overseen solely by specialty clinicians ('SPECDOCs'), for whom a number may have safeguarding concerns that go unrecognised.

Please can the NEDs provide assurances about plans being developed to help address this governance concern (eg specialty teams identifying clinicians to undertake this as part of their rostered duties)?

A10: Plans are being put in place to introduce a process on CPD that requires completion of coding before discharge. The standard operating process for this is currently being written along with a risk mitigation plan to support the change in working practices that this will require. The process is to be presented to the Executive Committee and the performance delivery of this will be monitored via the Performance Review and Improvement Meeting (PRIM).

Q11: There are ongoing focuses on ward-to-board assurances, but what about board-to-ward feedback? Colleagues report escalations being directed to board level but feedback about the outcomes of these are often lacking.

Please can the NEDs provide assurances that consistent feedback from board level will be disseminated to ward-based staff to ensure escalations are reaching them and the rationale relating to any decisions that are made about these.

A11: The Board receive the Board visit reports each month at our Board seminar meetings. It is the responsibility of the relevant executive directors to pick up on the actions that have been identified during the visit. A schedule of those arising from the first 6 months was collated as an aide memoire.

Q12: Several initiatives are being explored to support AUEC delivery, including the development of an Integrated Assessment Unit and Continuous Flow models. To date, there has been a lack of clarity about the additional capacity that the former will bring, the impact on patients so effected (being cared for in escalation areas) by the latter or how clinical teams will be supported to optimise their delivery.

Please can the NEDs provide assurances that the rationales for these proposals have been subjected to appropriate evidence-based capacity / demand planning and the outcomes of any ongoing audits about the quality of care being delivered from within escalation areas?

A12: The modelling for an Integrated Assessment Unit has been reviewed and is nearing completion. It takes into account the volume of patients that are in ED that are Clinically Ready to Proceed as well as those currently in an assessment unit that should still be seen in an assessment unit. Furthermore, it looks at the number of patients that should receive SDEC either in an assessment unit or elsewhere and the number of patients that should be seen in a hot clinic/outpatient setting as opposed to an assessment unit. It will also look at the number of patients assessed in base ward settings that should instead be assessed in an IAU.

Continuous Flow is focussed on reducing the volume of patients being 'boarded' in our ED when they are clinically ready to proceed and under the care of the wrong speciality. This pathway is focussed on diminishing risk. This has been developed further following feedback from wards and a revised process documented, with key KPI's that gather measurement. It is important to note that patients who are moved to wards from ED, are usually not the patients cared for in the escalation areas, this is a risk assessment of patients on the ward – and patients who have been on the ward and nearing their discharge are often more suitable to be moved out for new admissions to be added in.

STROKE SERVICE

Q13: Our Trust is a long way off achieving national targets with regards to stroke care and SSNAP performance. The main reason for this is staffing particularly relating to therapy elements of care. Please can the NEDs provide assurances about the strategic plans to ensure we have adequate staff to meet the therapy needs of patients both in hospital and (perhaps more importantly) in the community?

A13: A number of improvement actions have been developed by the Stroke and Therapy teams to address the demands this year. For example, a pre-hospital video

triage service has now had finance approved with funding also existing for clinical support. This should reduce the demand for therapy in these settings which is higher than the national average for physiotherapy particularly.

Further work is required though, and clinical strategies are currently being written by specialities for the 2025/26 financial year. For stroke services specifically these have a focus on improving the SSNAP performance in order to ensure we are improving the care we give to our stroke patients.

We are also undertaking a formal establishment review for both nursing on inpatient areas and AHP provision overall to look to increase to meet national guidance and subsequently improve SSNAP performance.

Finally, it is worth noting that the community provision on the east coast is covered by the Humber Trust. Timescales not being met and lack of appropriate therapy contacts by that provider are on our Risk Register.

Q14: In addition, our Radiology services are struggling to provide up to date stroke imaging services (both CT and MRI provision). Please can the NEDs provide assurances about what is being done to improve both the infrastructure and staffing of diagnostic services?

A14: Radiology services are currently experiencing increased demand from all areas acute, cancer and elective requests. The service has completed an exercise on capacity and demand analysis which is due to be rerun in order to support further planning.

The CT equipment within the radiology department is aging and all 3 York CT machines are on the capital programme to be replaced. CT 3 the oldest machine is being replaced in 2025/26 capital programme year. CT 1 and 2 are planned to be replaced 26/27 and 27/28. We are also exploring AI opportunities to support efficiencies in the use of our radiology staff.

CT radiographer recruitment has been successful however we have experienced a high level of maternity leave within the department. This has not impacted on the team ability to complete acute and cancer imaging and we are utilising the CDC's where possible to undertake elective and some cancer imaging.

MRI imaging capacity does not meet demand therefore we successfully bid for a 3rd MRI scanner at York Hospital. We are currently working through the capital scheme to deliver this in 25/26. This additional MRI machine will be up to date technology and will support inpatient scanning including for stroke services. MRI 1 and 2 are aging machines and are on the capital programme to be replaced in the next 2 years. Our current on-site machines are used for complex and inpatient MRI imaging, and we utilise CDC MRI capacity for elective and some cancer imaging. We are also working in partnership with York St John University to support training of radiographers and research. The University are setting up an MRI suite and we will have access to use this machine for patients requiring imaging at the Trust.

We have also successfully utilised overseas recruitment into vacant radiographer posts.

NEUROLOGY SERVICE

Q15: The most recent Neurology GIRFT review has highlighted that for the population served, the national average number of neurologists is 9. Currently York has 6 whole

time equivalent consultants. Please can the NEDs provide assurances about the strategic plans to correct this shortfall?

A15: The lead consultant in neurology recently attended a meeting of the Trust Board and shared this information. This issue will be considered along with many others when the Board agrees its financial plan for 2025/26, which is in the context of yet another very difficult financial context. We are still awaiting details of what the announcement for funding in the NHS stated in the Budget is likely to mean for the Trust for 25/26.

Q16: York lacks any complex/neurological rehab service provided. The money that the ICB currently spends on private providers could be better spent contributing to strengthen the specialist occupational and physiotherapy services within the Trust. Please can the NEDs provide assurances that this position is being monitored and reviewed?

A16: As above

ELECTIVE OUTPATIENT SERVICES

Q17: The Labour manifesto promised that an additional 40,000 elective appointments will be delivered each week, during evenings and at weekends, a pledge now being reinforced by the SoS for H&SC. Delivering these appointments will place additional demands on our already struggling diagnostic services alongside the recognition that many of our estates are in poor states of repair (especially so in relation to laboratory services) which impacts recruitment and staff well-being and that our outpatient space limits our abilities to do extra work.

Please can the NEDs provide assurances that the additional challenges these promises will bring are being considered in terms of the Trust's short to medium term plans?

A17: In 2024/25 year to date the Trust has made a number of improvements in the number of patients waiting diagnostics and elective care. The number of patients waiting less than 6 weeks for a diagnostic test (included in the DM01 standard) has improved from 62% in April 2024 to 75% in October 2024. The number of patients waiting over 65 weeks from referral to treatment (RTT) has reduced and total number of patients waiting on an RTT waiting list has decreased by over 2,000 patient since April 2024.

The need to improve access to elective care and diagnostics is part of the Trusts Elective Recovery Plan and Clinical Estates Strategy. This includes a number of key schemes / workstreams that will deliver additional outpatient, theatre and diagnostic capacity.

- Development of Community Diagnostic Centres (CDC) - We have developed two CDCs in Selby Hospital and at Askham Bar in York and in March 2025 the new CDC Hub will be completed in Scarborough. These CDCs deliver additional imaging, phlebotomy and physiological measurement tests for patients. Between April 2024 and August 2024 we have delivered an additional 49,747 tests.
- Use of ring fenced external capital money to improve our clinical estate and increase capacity include the replacement of a CT at York Hospital, additional MRI at York Hospital, development of the vascular imaging unit, delivery of additional outpatient procedure capacity at York and Bridlington and funding to relocate the laboratories at Scarborough Hospital.

- Development of a clinical estates strategy which includes the delivery of additional outpatient space at York and Scarborough during 2025.
- Productivity workstream including theatre efficiencies and improving use of our theatre capacity and outpatient improvements increasing rates of patient initiated follow up's and decreasing did not attend rates.
- Demand, capacity and workforce planning is ongoing to understand the future workforce required. The Trust works closely with the ICB on a number of workforce initiatives to improve recruitment and retention.

The NHS England Priorities and Operational Planning guidance is published annually, this outlines the actions that acute providers are expected to take to focus on recovery of core services through continuous improvement in access, quality and productivity. We are awaiting the Operational planning guidance for 2025/26.

COMMUNICATION

Q18: I know from many people and from my own experience, trying to get through to a service is nigh impossible. No answer, answer machines that don't tell you the availability of the person you are phoning, answer machines full, recorded messages stating all operators are busy then cutting you off.

Trying to make an appointment, change an appointment, getting advice re ongoing treatment is impossible. Waiting in a queue and you are told you are 7th in the queue then getting to No 1 in the queue and a recorded male voice cuts in and tells you all operators are busy and cuts you off. This is after 2 attempts at nearly an hour each time. This is not a unique situation, is it a fault no one knows how this happens, but the staff know it happens!? Then the terrible frustration of having no one to phone to help you, or tell you why you are being cut off. I have had people contact me to ask for help to speak to someone (anyone)!

The switchboard, when you get to talk to an operator they have the same terrible frustrations, they put you through to an extension that is invariably an answer machine with all problems as outlined above, then you have to wait in a queue to speak to the switchboard again. Without doubt the communication problem is chronic. It feels sometimes like an impenetrable shell! Patients say when they get to have an appt or treatment the staff are good.

Could the NEDs let us have information on actions that are being taken or in place to recognise and rectify the chronic communications problem for patients across the Trust?

A18: We are actively prioritising improvements in this area, and are currently reviewing our overall approach, including switchboard, appointment booking processes and message-handling capabilities. These efforts aim to reduce patient frustration and improve accessibility. In the immediate short term, we are focusing on quick, practical actions such as enhanced call queues, ensuring answer machines provide helpful information, reviewing staffing levels during peak times, and implementing clearer escalation pathways for unresolved issues.

We are committed to integrating patient concerns/insights into our design process to ensure that any potential solutions we seek to implement effectively meet user needs. Addressing these challenges is a priority for the Trust, and we remain dedicated to improving how we communicate and engage with our patients.