York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Public Council of Governors Meeting
13 March 2025

Chair: Martin Barkley

Public Governors:
Rukmal Abeysekera, City of York; Mary Clark, City of York; Ros Shaw, City of York; Michael Reakes, City of York; Wendy Loveday, Selby; Beth Dale, City of York; Linda Wild, East Coast of Yorkshire; James Hayward, East Coast of Yorkshire

Appointed Governors: Gerry Richardson, University of York; Cllr Jason Rose, CYC; Elizabeth McPherson, Carers Plus; Cllr Liz Colling, NYCC

Staff Governors: Abbi Denyer, York; Julie Southwell, York; Adnan Faraj, Scarborough/Bridlington; Franco Villani, Scarborough/ Bridlington

Attendance: Andrew Bertram, Finance Director; Dawn Parkes, Chief Nurse; Lucy Brown, Director of Communications; Lydia Larcum, Deputy Director of Workforce; Jim Dillon, NED; Helen Grantham, NED; Mike Taylor, Assoc. Director of Corporate Governance

Presenters: Dan Braidley and Kevin Richardson (item 8)

Public: 8 members of the public attended

Apologies: Paul Gibson, East Coast of Yorkshire; Catherine Thompson, Public Governor Hambleton; Gary Kitching, Staff Governor York; Rebecca Bradley, Staff Governor Community; Cllr Jonathan Bibb, Appointed Governor ERYC; Jill Quinn, Appointed Governor Dementia Forward; Graham Healey, Staff Governor Scarborough/Bridlington; Simon Morritt, Chief Executive; Claire Hansen, Chief Operating Officer; Jenny McAleese, NED; Steve Holmberg, NED; Matt Morgan, NED; Julie Charge, NED; Lorraine Boyd, NED; Tracy Astley, Governor & Membership Manager

25/01 Chair's Introduction and Welcome

Mr Barkley welcomed everybody and declared the meeting quorate.

25/02 Declarations of Interest (DOI)

The Council acknowledged the no changes to the Declarations of Interest.

25/03 Minutes of the meeting held on the 11 December 2024

The minutes of the meeting held on the 11 December 2024 were agreed as a correct record.

25/04 Matters arising from the Minutes

Action Log

The Council acknowledged that all actions have been completed.

25/05 Chief Executive's Report

On behalf of Mr Morritt, Mr Bertram gave an overview of the CE report which had previously been circulated with the agenda and highlighted the following.

- The revised Trust Strategy has now been launched.
- Winter pressures have been extreme, and the Board offered its sincere gratitude to the staff for their resilience during such a busy period.
- The Trust is taking ownership of Scarborough UECC building a week on Monday. It will be fully operational by the end of April.
- A new Anti-racism Steering group has been set up which Mr Morritt will be chairing. This will help tackle racism where it exists in the organisation.

The Council discussed the NHS England's Operational Priorities and Planning Guidance for 2025/26, in particular the explicit reference to the potential need for difficult decisions to be made in relation to reducing or stopping activity in order to live within our means as a system, and asked if this would affect patient care and services. Mr Bertram replied that the Secretary of State has asked each trust to decide which services are non-core. Discussions have started at a national level, and our organisation will start talks in the near future in order to produce a list. Any decisions to be made will have to go through the normal consultation processes.

The Council referred to racism from patients to staff and asked if this had risen during the past few years. Mrs Larcum replied that it has become more transparent and therefore there has been an increase in reported cases and possibly actual cases. Initiatives to eradicate racism in the organisation includes, the Anti-racism Steering Group, increase training for staff, and working with staff to ascertain if any other initiatives could be implemented to ensure a safe environment for both staff and patients. It was asked that a report be provided by the Anti-racism Steering Group for the next CoG meeting.

The Committee raised the issue of patients waiting in corridors and patients that cannot be discharged because of lack of community care and asked if processes have been put in place in the new Scarborough UECC to improve this. Mr Bertram replied that improved pathways have been implemented, assessment centres have been moved to within the vicinity of UECC so patients can be seen quicker, and all the improvements should reduce waiting times for patients.

The Council discussed the measures put in place to help with operational pressures over winter and asked how the organisation measured the effects of the individual measures. Mr Barkley replied that the Board receives a briefing from the Chief Operating Officer at the private Board meeting each month. The latest report stated that the effects of the individual measures put in place to help with operational pressures will not be known until the end of April. There are not enough beds, wards and staff, and added that 50% of non-discharges are due to external factors regarding care in the community and talks are taking place with partners to agree the way forward. He will keep the Council updated.

Mr Bertram then gave a presentation on the Trust finances in relation to NHS England's Operational Priorities and Planning Guidance. He explained how the Trust was achieving on those objectives. Finances are required to continue to improve on those objectives and hard decisions will have to be made within the system as to where finances are best placed. Draft plans have been submitted to the ICB with final plans expected to be submitted in mid-March. It is expected that the Trust finances will not balance at year end and talks are ongoing to mitigate the situation.

The Council:

- **Received the report and noted its contents.**

Actions: Mr Morritt to provide a report from the Anti-racism Steering Group for the next CoG meeting in June.

25/06 Chair's Report

Mr Barkley gave an overview of his report which had previously been circulated with the agenda. He also referred to his report from the CoG/BoD joint workshop on 16 October 2024 around local services for local people, preventing inequalities and tackling existing ones.

The Council asked what factors would prevent out-patient and diagnostic services being at a local level. Mr Barkley replied that it could be cost, staff availability or suitable space.

The Council also discussed DNAs and why it happens. Cllr Colling stated that she had attended a council meeting where this was discussed, and it was highlighted that transport was a major issue. A piece of work is now ongoing to deep dive into this, and she will keep the Council updated.

Mr Barkley said that now the Council have agreed the Joint Workshop report, the Executive Team will form an action plan to implement for the future.

The Council:

- **Received the report and noted its contents.**

25/07 Questions received from the Public

Mr Barkley stated that the questions received from the public have been answered in the agenda pack that was published on the Trust website.

A member of the public asked for her Q&A be written in the minutes around dialysis provision in Ryedale.

Q: I am writing to you re dialysis provision for both locals and visitors to Ryedale. I approached Simon Morritt regarding this at a Governors meeting back in 2023 and Alastair Falconer continued to bring this matter to the fore during his time as a governor. I understand there is no governor representing Ryedale at present hence I am contacting you to ask about an update to the situation.

As I mentioned in my e mail to Simon Morritt in November 2023 my interest in this is due to how no provision impacts my family directly. My son-in-law who lives near Newcastle needs dialysis and has only been able to visit (we live in Slingsby) along with our daughter and family for very short periods (approx 48hrs) before returning home for dialysis. Up to a few

years ago he was able to have dialysis at the Easingwold Unit which was very convenient, but demand locally has been so great, and the population of our market towns is increasing rapidly that the sessions are now fully booked. Sadly, York hospital has not been able to offer any sessions either. Back in 2023 he was able to dialyse at the dialysis room at Selby Hospital, but this does require a 60+ mile round trip from our home.

It seems clear that the demand for this service has been increasing beyond provision provided by the trust. Could some provision of a unit or a dialysis room similar to that in Selby be considered for Malton Hospital? Ryedale is a very popular tourist destination, and the availability of holiday dialysis would allow others suffering from kidney failure to visit and enjoy a holiday. I would be grateful for this matter to receive serious consideration.

A: I am really sorry to read that your family have been impacted by our renal dialysis capacity across Easingwold, York and Selby. The renal dialysis service and capacity is currently an area of priority which we are reviewing. We are currently developing our clinical strategies for all of our specialties including for renal medicine. This will include demand and capacity, and population need analysis to ensure we can model the demand for services. This will then support decisions regarding service expansions and investment, to support the delivery of the Trust Strategic Objectives.

The Council:

- **Received the report and noted its contents.**

25/08 Trust Travel Plan

A presentation was given by Mr Braidley on the revised Trust Travel Plan. He gave an overview of the projects and targets within the plan, and highlighted the work that is currently ongoing. He discussed partnership working with local authorities and funding initiatives to implement the plan. He spoke about the travel and transport initiatives, including the Park and Ride contract. Mr Richardson updated the Council on access to Trust sites. He spoke about relocating the pool cars away from sites to gain extra staff parking.

A question was asked about the traffic congestion on Wigginton Road to which Mr Richardson replied that Mr Braidley works closely with York Council, and the Trust has put proposals forward to the Council for an additional filter lane on the inbound road into York. From a Trust point of view, the Trust has put significant funding into car parking for staff and visitors. A piece of work is currently ongoing looking at whether it would be cost effective to provide a shuttle bus, taxis, hired cars to reduce traffic flow and car parking issues. It is very much in the planning stage and the Council will be kept up to date.

The Council asked for the following to be considered:

- Signage directing cars to the overflow car park at Neurosciences.
- Change the entrance to the blue badge car park area to the top end near the entrance to the hospital site.

Mr Braidley will provide the presentation to the governors after the meeting.

Mr Braidley spoke about initiatives in other areas of the Trust. He was in consultation with East Riding Council about a 12 month staff engagement program. This is the same with Scarborough. Mr Richardson added that concessions are widely advertised around the Trust for both the public and staff. Car sharing is also an option.

The Council:

- **Received the report and noted its contents.**

Action: Mrs Astley to email the Travel presentation to all governors.

25/09 Performance Report

Mr Barkley gave a summary of his report which had previously been circulated with the agenda and asked the Council for any questions.

He was asked for the reason behind the poor performance of Urodynamics diagnostic tests to which he replied that there are temporary staffing issues that are being addressed and once this has been rectified there should be an improvement.

Complaints Report

Mrs Parkes gave a summary of her report which had previously been circulated with the agenda. She highlighted that in Q1 and Q2 of last year there had been an increase in complaints, mainly around ED and patients waiting for appointments. Themes were around staff attitude, communication, and expectation of procedures.

Each Care Group now has a Patient Experience Improvement Group which looks at initiatives to implement within their wards/areas. Other improvements include the hand over walkaround which involves talking to patients and discussing their concerns, which should reduce complaints. Also, the Complaints Process is being reviewed to ensure a streamlined service and improvement on national targets.

Referring to maternity, the Council asked if there was any follow up contact with patients once discharged as they tend not to complain at the time of treatment. Mrs Parkes replied that, if required, patients are referred to other services, and they can also contact Maternity Voices Partnership if they wish to talk about a concern rather than make an official complaint.

A question was asked about the poor attitudes of staff to which Mrs Parkes replied that they have introduced a Skills Matrix for each role in the Trust to clarify what is expected of staff doing that role. The highest levels of complaints are in the Emergency Department and Maternity which is recognised as a very pressurised environment for staff. The issue is multi-faceted.

Regarding poor/unsafe discharges, the Council queried why this was happening. Mrs Parkes replied that it was a number of things around medicines, transport, home care, etc. A piece of work is being undertaken with the ICB on the quality of discharge and working with stakeholders regarding community care, and also looking at the Trust's discharge process.

The Council asked what the percentage was of Contacts v Complaints. Mrs Parkes replied that it was 0.1% across care groups, but the majority of complaints are for Medicine because that includes the Emergency Department where a lot of complaints come from and of course ED receive thousands of patients each week.

Friends & Family Test Report (FFT)

Mrs Parkes gave a summary of her report which had previously been circulated with the agenda. She highlighted the improvements made with FFT and added there was more to do on response rates.

The Council welcomed the move towards an electronic system on FFT. Mrs Parkes informed that they were at the procurement stage and will have a system in place by the middle of Sept/Oct.

The Council:

- **Received the reports and noted their contents.**

25/10 CQC Visit

Mrs Parkes gave a summary of her report which had previously been circulated with the agenda and highlighted the following:

- Feedback has been received from the CQC and responses from the Trust have been to Board
- Evidence requests completed and sent to the CQC
- Any gaps will be integrated into the improvement programme
- Work on the previous action plan will continue to ensure all have been embedded
- CQC will be attending the March Board of Directors meeting

The Council:

- **Received the reports and noted their contents.**

25/11 NED Assurance Questions

Mr Barkley stated that he had tabled the Q&A report for the meeting as, apart from questions 1 and 2, the type of questions asked of the NEDs were not reasonable or appropriate for NEDs to know the answers to. However, all questions have been answered by the appropriate executive and will be circulated with the minutes.

He had also received one more question regarding the cessation of the Nurse led fortnightly Urology Clinic in Bridlington hospital. He explained that the Nurse had retired in December so there were no clinics in January or February because of the vacancy, which will be filled by the end of March. The clinic will commence on 21 March and various members of the team will rotate to the hospital to deliver the service. The demand will be assessed and may move to weekly clinics from June onwards.

25/12 Reports from Board Committee Chairs

Quality Committee

No questions were asked.

Resources Committee

Mr Dillon gave a summary of the report that had previously been circulated as part of the agenda pack and highlighted areas of focus and challenges. Improvements are continuing to be made under challenging circumstances.

The Council asked the purpose of the Engagement room in ED. Mr Parkes replied that it is a room where staff can go and share ideas on a notice board and Executives visit on a rota so staff can ask for updates or share directly with the senior leadership team.

Audit Committee

Mr Bertram gave an update on behalf of Mrs McAleese regarding the report that had previously been circulated as part of the agenda pack. He highlighted the following:

- Internal Audit recommended actions were still ongoing.
- Internal Audit Opinion is well on track to be delivered at year end.
- A new Managing Director of YTHFM is starting at the Trust on 1 April.

No questions were asked.

The Council:

- **Received the report and noted its contents.**

25/13 Mid-Year Governor Elections

Mr Taylor gave a summary of the report that had previously been circulated as part of the agenda pack and asked for questions.

No questions were asked.

The Council:

- **Received the report and noted its contents.**

25/14 Governors Activities Report

Ms Abeysekera gave a summary of her report which had previously been circulated with the agenda. She was delighted to join the Anti-racism steering group with the first meeting attended. A key action from that meeting was to gather data to make informative decisions going forward. Ms Abeysekera will contact Mr Morritt to ask for an actions list to be produced and circulated within 7-10 working days following each meeting to effectively act on the actions.

No questions were asked.

The Council:

- **Received the report and noted its contents.**

25/15 Public CoG Work Program

Mr Taylor discussed the draft strategy which had previously been circulated with the agenda pack.

The Council:

- **Approved the work program for the year 2025/26.**

25/15 Any Other Business

East Coast Constituency Meeting

Ms Abeysekera gave a summary of the meeting held at Scarborough Hospital on 6 March. It was well attended, with over 30 members of the public and a number of governors joining the discussion. It was a really productive meeting, and feedback has been extremely positive. It is proposed that the meetings will continue in each constituency and will be modified accordingly:

- A 6.30pm start will continue
- The format of the meetings will continue
- All constituency meetings are to be held in British summer time
- A meeting to be held in Malton rather than Easingwold

These proposals were supported.

25/16 Items to Note

The Council noted the following items:

- CoG Attendance Register

It was asked that a NED attendance register also be added.

Action: Mrs Astley to add NED attendance register to Public agenda under Items to Note

25/17 Time and Date of the next meeting

The next meeting is on Wednesday 11 June at Malton Rugby Club

Appendix - NED Assurance Questions from Governors

WAITING LISTS
Q1: What assurance can the NEDs provide regarding how patients confirm if they are on a waiting list, and the estimated time before being seen? **A1:** We are completing the roll out using outpatient waiting lists for new patient appointments where the wait time is longer. In practice this means that when the referral has been clinically triaged, the patient is added to a waiting list and a letter is sent to the patient to explain that they are on an outpatient waiting list and will be contacted when an appointment is available. This letter also gives an indication of the wait time to the first outpatient appointment. The roll out of this across the acute specialties is due to be complete by the end of August 2025.
Q2: What assurance can the NEDs provide about patient entitlement to switch to other NHS providers to reduce their waiting times? If and how can patients switch? **A2:** The referral to treatment policy affirms that patients have the right to start consultant-led treatment within 18 weeks from referral and wait no longer than 6 weeks for a diagnostic test. In terms of information provided to patients we don't currently routinely publish this right, although it is stated in the NHS constitution. Patients who are referred via e-RS do have visibility of referral to treatment times for the providers in their shortlist. The wait times that are shown in e-RS are the average referral to treatment wait times and such 50% of patients will wait longer than the wait times stated. If patients wish to switch to another provider, and the referral has not yet been clinically triaged and accepted, patients can cancel their appointment in e-RS and rebook with another shortlisted provider. If the referral has been accepted by the Trust we will need to complete an inter-provider transfer to another trust so that the clock is transferred. When patients do transfer, they will transfer all of their care to the new provider including any diagnostics and follow up appointments. Waiting times are published on the My planned care platform and on e-RS but they are average wait times to treatment by specialty so they may be misleading. All patients are clinically prioritised by our doctors according to their clinical urgency, therefore wait times can vary.
STAFF
Q3: I have read that with regard to recruiting staff from other continents that fraudulent applicants are being employed in Britain. This being for example, people having successful remote interviews with employers in Britain but the person being interviewed is not the person who turns up for work, but instead someone who may be being trafficked against their will or even willingly coming to the UK to do a job they are not qualified to do, facilitated by an established gang set up to do this for large payment. Since the Trust does recruit from other continents, how sure are you that the successful applicant is the person that was interviewed? Also, when this person arrives to work at the Trust how do the people in the assigned work area know that this is the person who applied for the job?

A3: The Trust has a robust recruitment process which ensures every individual appointed has the appropriate right to work within the organisation. A recruiting manager is identified for every position advertised and they have ultimate responsibility for the recruitment process. It is common practice to find that the recruiting manager is usually the line manager for the role being recruited to. It is a recruiting managers responsibility to arrange to interview every candidate, and if a virtual interview is offered, they would have responsibility to ensure that the identity of the person they are interviewing is verified at that time, in line with the process for in-person interviews. Interviews are undertaken by a panel of at least 2 people, who are usually in a role that would work with the person being appointed.

Once an offer is made, the recruitment team would undertake pre-employment checks, including verifying an individual's right to work. If it is not possible to check documents in person prior to starting, this would be undertaken on commencement. When the new member of staff commences in post, the recruiting manager or member of the interview panel should have made arrangements for their induction, and having already verified the individual's identity at interview, they should be able to identify if there are any concerns about the person who has presented to work.

It is worth noting, that in response to challenges the Trust is experiencing as a result of the emergence of AI within the recruitment process, nursing colleagues have taken the recent decision to default to face-to-face interviews for all nursing and support worker posts. Virtual interviews will still be available for hard to fill posts or where a reasonable adjustment as per the Equality Act is requested, but it is anticipated that this will be by exception and as a result, in person interviews will support in mitigating risks related to identity.

Q4: Ref the awaited outcome in July 2025 of the court case at Fife on the single sex access to changing spaces, involving a claim of unlawful harassment under the Equality Act 2010, and in light of the fact that that the verdict could potentially set precedence in other Trusts, does this Trust's policy currently in place, cover what is being challenged in the Fife case? And in the event of the outcome being upheld on behalf of the complainant, will this Trust's policy have any consequences requiring any changes? Also, boundaries around single sex toilets?

A4: Fife case "At the time the incident took place, it was NHS policy to allow transgender people to use changing rooms that align with their gender identity." Y&S policy states "Facilities such as toilets and changing rooms should be accessed according to the full-time presentation of the employee."

The Transgender and Gender Diverse Communities policy will be updated in line with guidance from NHSE, the ICB and case law. Below is an extract from the current policy :

4.8.9 Advice for all staff

Facilities such as toilets and changing rooms should be accessed according to the full-time presentation of the employee.

Ensure that access to the relevant facilities is available to all employees as far as is practical. Transgender people are not to be regarded as disabled.

Where sex specific facilities do not afford reasonable levels of privacy for male and female staff (shared changing areas etc.) reasonable measures should be taken to upgrade facilities to meet this need. This is not a consideration to 'protect' transgender or non-transgender staff, but rather to ensure that all members of staff, irrespective of their age, disability, sex, trans status, race/ethnicity, religion/belief, or sexual orientation is afforded the right to privacy.

Employers may consider changing the labelling on some facilities so that they are gender neutral. Greater privacy may be provided by having more cubicles, and by having partitions and doors that extend from floor to ceiling. Remember, a person does not need a Gender Recognition Certificate to use the facility appropriate to their gender identity.

The use of changing/showering facilities and toilets will be part of the discussion process with the member of staff who is transitioning, with a view to agreeing the point at which the use of facilities should change from one gender to another. An appropriate stage for using the facilities of the new gender is likely to be the change of social gender. Should there be any objections to this; the objections will be dealt with by a manager in a sensitive and understanding way while not denying the transgender person access to facilities appropriate to their lived gender.

It would not be acceptable to expect trans and non-binary people to use facilities designated for use by those of their biological sex. Following transition, whether or not this has involved surgical procedures, the individual should be fully supported in using all facilities appropriate to their acquired gender.

If it is genuinely impossible to adapt such changing/shower facilities to accommodate this, then this is one very limited example of an instance where the law permits an employer to make separate arrangements. Such special arrangements must be time limited unless the trans person has a non-binary gender identity and wishes to keep the separate arrangements in place indefinitely.

If there is difficulty implementing the above, speak to your line manager, Head of Service, Patient Equality, Diversity and Inclusion Lead or Head of Equality, Diversity and Inclusion.

Address intersectionality - recognise the intersectionality of identities and experiences. Transgender, gender diverse, and non-binary individuals may face additional discrimination or marginalisation based on factors such as race, ethnicity, disability, or socioeconomic status. Take proactive steps to address these intersecting forms of discrimination.

CAR PARKING – YORK SITE

Q5: Several consultant colleagues raised concerns on an e-mail forum about damage to their cars whilst parked in the multistorey car park (over a few years, but many quite recently) in which they struggled to secure any CCTV footage to support any claims for damages. A response was posted on the forum from Kevin Richardson, the Head of Resources Support Services, but this was obviously limited in its distribution. It's likely that Trust colleagues from non-medical backgrounds and members of the public have been / are being similarly affected.

I would appreciate if this issue could be raised at the CoG meeting and assurances sought about how the issues will be addressed and how all staff members can be signposted to the help they may need in relation to any future car damage.

A5: The team are aware of the concerns raised in relation to potential RTCs within our public MSCP, and are supporting and giving advice to consultants around accessing CCTV in relation to potential damage to vehicles. For the public there is clear signage (attached) displayed within the car park on each floor directing to the security team, who would then give support and advice around CCTV.

Unfortunately, due to data protection legislation (GDPR) we are not permitted to give out other users 'personal identifiable data' (information) in relation to damage caused, as this would only be allowed to be handled by the Police or the registered keeper of the vehicles insurance company.

This information can be found on the Trust website, and is also on staffroom in relation to CCTV and the purpose of the system at the Trust for more detail.

https://www.yorkhospitals.nhs.uk/about-us/information-governance/privacy-notices/cctv-and-body-worn-camera-privacy-notice/

Vehicles parked within our public and staff car parking areas, and as with any other car park the vehicle is left at the owners own risk however we will support and assist in reducing where we can incidents and supporting in the event they occur.

Off the back of these concerns raised, I have asked the team to review the current CCTV coverage within the MSCP, and the CCTV Manager has advised that it is above adequate for the car park in line with British Parking Association (BPA) standards.

The Car Parking team have also undertaken an assessment of how many incidents in relation to RTCs over the past 3 years have occurred compared to the volume of vehicles entering / exiting the car park each day, which is above 35,000 vehicles per month, with on average less than one incident reported monthly over the course of a year.

The Car Parking and Security Team can be contacted by Trust staff on the below (which is on the staff intranet or via switchboard)

- Security 01904 725636 or 01904 721241
- Car Parking Team 01904 721591
- Kevin Richardson, Head of Car Parking & Security 01904 724762

The general public there is a contact number as attached on every level of the MSCP, Trust website and via switchboard.

SERVICES

Q6: If a patient is admitted to a service and that service has been deemed 'Inadequate' by the CQC is the patient advised of this when being admitted to that service? If yes, and they are admitted if something happens and a claim is made against the Trust, will the claim be dismissed because the patient was advised that it had been deemed 'inadequate ' by the CQC upon admission? What is the risk to the Trust of a service deemed 'inadequate ' in terms of claims from patients?

A6: Information posters regarding our CQC rating are in place within the main entrances to our sites and on our website. The CQC actually mandate how we do that, they have a 'widget' we have to embed on our site that shows the rating and takes you to the report if

you click on it. They ask that it's prominently displayed, ideally on the homepage, which we've done. We don't automatically tell anyone of the CQC rating on arrival, as first and foremost we want to establish trust and confidence with them that we can meet their needs. We would respond honestly to questions from patients and their families if they asked for information about the rating of the service.

If a claim is made against the Trust, then an investigation would be taken into the concern/issue raised, to understand root cause and contributing factors. The CQC is only one of a number of ways we're regulated for the services we provide. Having an inadequate rating doesn't absolve a service from providing care to the standards we expect; there's no formal link between the two from a legal perspective. In terms of claims, advising a patient of our inadequate rating would not act as a "disclaimer" for any claim. A claim is indefensible when acts or omissions in the care have fallen below a reasonable standard and led to harm.

PATIENT CARE

Q7: Maintaining oversight of medical inpatients including outlier patients

Concerns were raised by a Renal Consultant colleague (note – the renal team deliver a 'consultant of the week model') in relation to trying to safely maintain oversight of all the patients under the renal team.

On this day, 11 outlier patients were under renal team, a further 5 on Ward 23 and 10 more around the hospital that needed renal expertise. The base renal ward (W 33) numbers had increased to between 33 and 35, meaning there were around 60 patients to be seen. This is quite common.

It's well recognised that the renal patients tend to have the most complex needs of all inpatients and that they can deteriorate rapidly in terms of their renal function resulting in potentially serious life-threatening electrolyte derangements.

A Coroners' inquest was recently held in relation to a patient who died due to very high potassium levels that had being missed that should have been spotted and managed more appropriately.

Another potential near miss has been attributed to the patient not being reviewed by senior renal clinicians due to the sheer volume of inpatient work they are currently trying to deliver.

In addition to the inpatient work, the renal team also need to deal with GP referrals, referrals from Harrogate and Scarborough and requests for reviews and advice from the dialysis units.

Internal discussions have failed to find sustainable solutions to addressing this workload despite attempts to secure efficiencies by cutting handovers down to essential staff and sharing oversight of outliers as efficiently as possible.

Further Datixes are being submitted in relation to the number and complexity of medical outlying patients with renal needs who remain at risk of succumbing to further suboptimal care outcomes, that may include preventable deaths.

I would like to raise this ongoing concern on behalf of my renal colleagues to discuss at the CoG to seek assurances about how these issues will be explored and what mitigations can be put in place pending a definitive solution being found.

A7: Thank you for raising these concerns on behalf of our renal colleagues. We fully acknowledge the significant challenges currently faced by the renal service, particularly regarding inpatient demand, the complexity of patient needs, and the associated patient safety risks.

As part of our Medicine Service Review, we are undertaking a comprehensive assessment of Renal Medicine across all sites to address the misalignment between demand and capacity. The review will have been undertaken by end of June 2025, and includes:

- An in-depth analysis of inpatient numbers and workforce capacity, including consultant cover for both base ward patients and outliers.
- A review of referral pathways, including GP and inter-hospital referrals, to identify opportunities to streamline workload.
- Assessment of risk associated with current models of care, ensuring patient safety remains the highest priority.

We also recognise the immediate need for mitigations to ensure safe oversight of renal patients while the review is ongoing. To that end, we are:

1. Exploring additional consultant support and workforce solutions to alleviate pressures on the existing team.
2. Reviewing options for enhanced clinical prioritisation and triage of referrals to ensure that the most acutely unwell patients receive timely senior review.
3. Strengthening governance and escalation pathways for at-risk renal inpatients, ensuring that deteriorating patients are identified and managed promptly.
4. Engaging with operational and clinical leaders to assess how outliers can be better supported through targeted interventions.

We take the concerns raised very seriously, particularly given the recent Coroner's inquest and ongoing Datix reports, and are committed to working with the renal team to find both immediate and sustainable solutions.

We welcome the opportunity to provide further assurance at the upcoming Council of Governors meeting, where we can outline both the short-term actions being taken and the longer-term strategy for renal services.

Thank you again for bringing this to our attention, and please be assured that this remains a priority area for review and intervention.