

Minutes

Board of Directors Meeting (Public) 28 February 2024

Minutes of the Public Board of Directors meeting held on Wednesday 31 January 2024 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 10:00am and concluded at 1:10pm.

Members present:

Non-executive Directors

- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (& Maternity Safety Champion) - virtual
- Dr Stephen Holmberg
- Mr Jim Dillon
- Mrs Jenny McAleese
- Prof. Matt Morgan

Executive Directors

- Mr Simon Morritt, Chief Executive
- Mr Andrew Bertram, Deputy Chief Executive/Finance Director
- Mrs Dawn Parkes, Interim Chief Nurse & Maternity Safety Champion
- Miss Polly McMeekin, Director of Workforce and Organisational Development
- Mr James Hawkins, Chief Digital and Information Officer
- Dr Karen Stone, Medical Director

Corporate Directors

- Mrs Lucy Brown, Director of Communications
- Ms Melanie Liley, Chief Allied Health Professional

In Attendance:

- Kim Hinton, Deputy Chief Operating Officer – deputising Chief Operating Officer
- Mr Mike Taylor, Associate Director of Corporate Governance
- Sascha Wells-Munro, Director of Midwifery (for item 139 23/24 Maternity Reports)
- Miss Cheryl Gaynor, Corporate Governance Manager (Minute taker)

Observer:

- Adam Laver, Local Democracy Reporter for Yorkshire Post
- Julie Southwell, Staff Governor
- Linda Wild, Public Governor (East Coast)
- Jill Quinn, Stakeholder Governor

Mr Barkley reported that he had made the decision to not livestream the meeting, but sent an MS Teams invite to Governors who would not be able to attend in person.

Mr Barkley welcomed everyone to the meeting and confirmed the meeting was quorate.

126 23/24 Apologies for absence

Apologies for absence received from:

- Mrs Lynne Mellor, Non-executive Director
- Ms Claire Hansen, Chief Operating Officer
- Mr Steven Bannister, Managing Director of YTHFM

127 23/24 Declaration of Interests

There were no declarations of interest to note.

128 23/24 Minutes of the meeting held on 31 January 2024

The Board approved the minutes of the meeting held on 31 January 2024 as an accurate record of the meeting.

129 23/24 Matters arising from the minutes

The Board noted the outstanding actions which were on track or in progress. Of note:

BoD Pub 20 – (Diagnostic capacity and demand) although a presentation had been received at Board previously, it was limited on information and no recovery plan detailed. It was agreed at the time the presentation was delivered, that a detailed diagnostic recovery plan would be shared in due course but this had not yet been presented. Agreed to bring back a recovery plan to Resources Committee in March/April and subsequently Board in April. Due date amended to reflect this.

BoD Pub 24 – (Review of Complaints process) Mrs Parkes advised that there was now a draft new complaints policy being agreed which will include a timeframe. Item closed.

BoD Pub 25 – (CQC new inspection regime) Mr Barkley to agree a date with Mrs Parkes outside the meeting for a planned session as part of a future Board seminar.

BoD Pub 30 – (Waiting List Harms Task and Finish Group proposal for identifying and monitoring patients on waiting lists) Mrs Hinton described a proposal report had been presented to the Executive Committee on 7 February and was discussed with an outcome of further work required before this could be ratified and reported to the Quality Committee. This would sit with the elective programme work going forwards as a specific workstream but required a consistent approach where possible and it was this that was taking the time. It was anticipated that it would be reported to the Quality Committee in April 24, appreciating that this may not be a complete picture but at minimum an update on progress. The deadline was amended to reflect this.

BoD Pub 31 – (Theatre staffing, retention and sickness rates report to the Resources Committee) No report received to date, due date amended to April.

BoD Pub 33 – (104 and 65 week waits metrics) Mrs Hinton described that NHS England (NHSE) methodology was used that included the 24 previous months' worth of data and consequently data points in that were included in setting mathematically the upper and lower control limit and assurance limit. This meant that the 24 months was capturing those earlier months and so assurance was at 0.6 and therefore unable to deliver that until those earlier months were excluded from the calculation. There were discussions underway with NHSE to shorten that timeframe to seven months and once this takes place, the Trust would then move into an assured position. Item closed.

BoD Pub 34 – (metrics on pressure ulcers) Mrs Parkes advised on looking at what model hospital would bring and how the Trust can compare and if not possible there are internal options available. Mr Barkley suggested that it could be included in the narrative of the TPR that accompanies the data. Item complete.

Bod Pub 35 – (Connection issued with BadgerNet and reporting on antenatal risk assessments) Included in the agenda. Item closed.

BoD Pub 36 – (Review of process around non-compliance with monitoring consultant attendance at clinical situations) Included in the agenda. Item closed.

BoD Pub 37 – Mrs Parkes advised that work was ongoing with BadgerNet to pull reports on deprivation which could become part of the regular reporting. Ms Liley added that this would emerge in the information as this work is included as part of the Improvement Programme and can connect this information through the Health Inequalities Steering Group to ensure triangulation. Item closed with the expectation this data will be included in a future maternity report to the Board.

BoD Pub 38 – (amendment to Board Assurance Framework) Mr Taylor advised this had now been completed. Item closed.

130 23/24 Chair's Report

Mr Barkley shared the successful outcome of the Non-executive Director/Chair of York Teaching Hospital Facilities Management and subsequent agreement of the Council of Governors. Julie Charge was offered the position and negotiations were currently underway on agreeing a suitable date of commencement with the Trust. He further advised that there was an additional Associate Non-executive Director appointment made to Helen Grantham which was also subsequently ratified by the Council of Governors, again with a start date yet to be agreed.

Mr Barkley advised that he had recently met with a local MP and a prospective labour party representative in one of their main target seats, both of which were constructive conversations.

He further added that he had attended 2 recent meetings of the Integrated Care Board, a development session and the other a briefing session of the financial situation of the ICB.

Mr Barkley reflected on a recent visit to the Trusts clinical records store which brought home the scale of the challenges around digitisation and storage accommodation which will require fairly urgent consideration .

131 23/24 Chief Executive's Report

Mr Morrill highlighted some key areas:

Industrial action - The British Medical Association (BMA) had announced further industrial action for junior doctors from 24 February to 28 February, impacting elective activity and placing additional pressure on consultants, SAS doctors, and the wider clinical workforce. The BMA's ballot on the proposed pay settlement for consultants was rejected, potentially leading to further action from consultants. The BMA was inviting the Government to improve the offer before deciding on further strikes for consultants. Further dates were yet to be announced. Mrs McAleese questioned the impact of this on patients and also colleagues who were already stretched and demoralised and some assurance around this.

It was acknowledged that there was a general sense of fatigue and Dr Stone assured that cancellations had been kept to a minimum and tightly controlled through the emergency planning response. In answer to a question in relation to the likelihood of further strikes around agenda for change, Mrs McMeekin described that workstreams were underway following the National Staff Council's ratification regarding agenda for change terms and conditions. Discussions were ongoing regarding nursing spine points and whether they should be separated from the agenda for change. Mrs McMeekin advised that the general view was that roles have evolved over time, and adjustments to national profiles and pay grades may be necessary. The focus was generally on nursing and midwifery, rather than the remaining non-medical workforce.

Planning guidance update - The Trust had received new planning information and was working with system partners to prepare initial drafts of plans incorporating activity, workforce, and finance. These plans were expected to be shared at March and April meetings, with final submissions expected in May.

Urgent and Emergency Care Summit – Mr Morritt, along with ICB Chief Operating Officer Amanda Bloor, chaired a system-wide summit to improve urgent and emergency care. Key stakeholders from primary care, local authorities, and the ambulance service discussed solutions to prevent admissions, streamline discharge processes, reduce ambulance handover times, and enhance system-wide working. The session was positive, resulting in several actions for long-term pathway and process improvements and immediate improvements to be implemented in the remaining weeks of this financial year.

See ME First Campaign - The Trust had adopted the See ME First initiative, aiming to create an inclusive and non-judgmental workplace where all staff are valued equally, regardless of ethnicity or other differences. Developed by the Whittington Health NHS Trust in London, the initiative encouraged respect, well-being, and belonging among colleagues, ultimately improving patient experience. It aligned with Trust values of kindness and openness and encouraged staff to pledge their commitment to equality at work. The campaign, supported by the Race Equality Network, encouraged staff to wear the campaign badge to show their support.

Reverse Mentor Programme - The reverse mentoring programme, which began with conversations about race, was now expanding to include colleagues with disabilities, long-term health conditions, or neurodiverse conditions. Mentors were to be matched with executives, non-executives, or senior managers to share their experiences and create mutual learning through confidential conversations. The programme offered a unique opportunity to gain insight into colleagues' challenges and work together to influence change. Mr Morritt encouraged all Board members to participate in the program when it launched.

Deputy Chief Operating Officer appointment – The Board welcomed Abolfazi Abdi (known as Ab), a 20-year NHS veteran. Together with Kim Hinton, Ab was to assist Chief Operating Officer Claire Hansen in the design and implementation of the Trust's strategic plan. They will work closely with care groups to ensure safe and effective day-to-day operational management. Ab's experience, including his time as Deputy Chief Operating Officer at Northern Lincolnshire and Goole NHS Foundation Trust, was expected to be beneficial to the team.

Star Award – The Board noted the humbling rationale for staff nominations for the star awards.

132 23/24 Quality Committee Report

Dr Holmberg briefed the Board on key discussion points from the meeting of the Quality Committee on 20 February. In summary:

- Infection Prevention Control (IPC) – had been a long running concern for the Committee. Clostridium difficile(C.Diff) – a particular focus and have had some assurance and encouragement with senior leadership driving some improvement but there was still a way to go. The focus showed encouraging opportunity for improvement and there was acknowledgment that the buildings and environment limited that improvement. Meticillin-Sensitive Staphylococcus aureus (MSSA) – this remained poor and the Committee were intently focussed on that. The recent appointment of a Deputy Director of Infection Prevention provided assurance on the IPC agenda.
- Family Health Care Group – received a report and discussed the Women's unit (gynaecology) at the York site. Concerns had been raised regarding the environment of the Women's Unit at York, with cases of harm linked to long waits and process issues causing excessive waits.
- Paediatrics - The committee discussed concerns about the service at Scarborough. York had been doing some mentoring and the Committee had assurance that this situation had improved.
- Sexual health – Electronic Patient Records (EPR) no longer supported by IT company (April 2024). The committee highlighted the potential patient safety risk if records are lost/inaccessible.
- Maternity – this remained a focus for the committee. Reported high Postpartum hemorrhage (PPH) cases, investigations underway, but initial review suggests overestimating blood loss. Three critical business cases in train for improvement plan: staffing, scanning capacity, and theatre capacity.

In terms of the Sexual Health EPR, Mr Hawkins updated that the company who took over the redundant supplier had since agreed to continue supporting on a rolling quarterly basis and he was in touch with commissioners on how to fund the provision of a new EPR. The longer-term plan was to purchase a new system with longer support arrangements.

Mrs Parkes referenced the maternity business case on staffing which related to a case to the ICB. She advised that herself and Mr Bertram had met with the ICB who recognised the requirement for the Trust to review the staffing model and capacity. Further ICB level maternity staffing discussions were to be planned across the ICB as a recognition of its priority and the similar concerns other organisations were facing given the impacts of national quality standards etc. Mr Bertram clarified that the ICB were seeking to create a provision in next year's plan but it was not yet clear on the allocations at present.

133 23/24 Resource Committee Report

Mr Dillon briefed the Board on the key discussion points from the meeting of the Resources Committee on 20 February. In summary:

- Mr Bertram had informed the Committee about the Trust's financial situation and efforts to address the expected deficit. Discussions with the ICB were ongoing on a system funding solution, and action is needed to reduce spending in the final weeks of the year. Concerns include increased drug spending and £6.2m ahead of 'cap' spending on agency staff.
- Despite assurance that plans were in place to reduce waiting times, the high number of 12+ hour trolley waits remained a concern.

- Vaccination – disappointment with the uptake with assurance that work was ongoing to plan for the next campaign (2024) to increase uptake.
- Impact of Health Care Academy – Committee acknowledged that this was having positive effect on the retention and performance of recruited staff.

Mrs Parkes referred to the agency spend being ahead of the cap and assured the Board around efforts to reduce that spend with the introductions of an Agency Management Efficiency Meeting, looking at nursing midwifery and nursing associates.

Mrs McAleese referenced her concern in relation to the poor vaccination uptakes acknowledging that they were not mandated but there was a level of professional responsibility and duty to take those vaccinations. She questioned whether there was a way in which the Trust could work with national bodies and unions to try and support some leverage from them. Dr Stone reiterated the concern and confirmed that although vaccination requirement was not mandated, it was encouraged through handbooks around duties of a doctor etc. There needed to be further consideration around the approach to obtaining vaccinations such as being easily available/accessible which would be captured through the work and plan that Miss McMeekin had underway. Miss McMeekin confirmed that this was planned to be presented to Executive Committee in March.

134 23/24 Trust Priorities Report (TPR)

Operational Activity and Performance

Mrs Hinton presented the TPR which described that January 2024, BMA Junior Doctors took strike action that resulted in the Trust postponing 104 elective procedures and 908 outpatient first attendances. This had resulted in a year-to-date loss of 1,506 elective procedures and 5,389 outpatient first attendances. The Emergency Care Standard (ECS) position in January was 67.3%, against the trajectory of 69.1%. The number of lost bed days due to patients without a 'criteria to reside' (NCTR) was 1,159 in January. In December 2023, the 28-day Faster Diagnosis standard improved to 62.6% but noted that cancer reporting ran one month behind. Overall, the Trust was better than the trajectory for the number of patients waiting over 62 days on a Cancer pathway, with 253 patients waiting over 62 days. There were zero RT 104-week waiters at the end of January 2024, and the Trust reported six 78-week RTT waiters at the end of January 2024. At the end of January 2024, the Trust had 519 RTT patients waiting over 65 weeks, a decrease of 102 from the end of December 2023 position.

Mrs Hinton updated that there were now only four 78-week RTT patients since the publishing of the report. Two of which were planned to be seen by the end of the month which will leave only two. She further explained that there was a cohort that sits behind it, though that has not breached, the Trust was still broadcasting a zero 78-week position by the end of March with a high level of confidence. The Board acknowledged that a significant number of patients that remain on the waiting lists had been waiting a long time which was not acceptable, but there had been a significant improvement in working towards reducing those number of patients.

The Board briefly discussed concerns around the high number of 12hour trolley breaches and were assured with the Urgent and Emergency Care summit work along with a number of accelerated actions that both the Trust and partners were taking, would start to manage those patients more effectively. Mrs Hinton responded to a question in relation to issues of sustainability and how long the ward areas can continue to cope with this additional pressure through the implementation of the new OPEL (Operational Pressures Escalation Levels) Framework and a new Standard Operating Procedure (SOP) for care in unplanned

areas brought in as part of the Reset week: Moving patients on to get home sooner. A reset review was to be carried out which would help to provide more clarity and a framework around escalation out of those beds, ensuring that the Trust can manage as a full capacity surge process, but not become part of the core bed base without any established workforce.

In response to a question from Mrs McAleese, Ms Liley updated on the Virtual Ward Project and the understanding through the Virtual Hospital Delivery Group, the specialties and the numbers of patients who could be managed at home who otherwise would have been in a hospital bed. Those patients remained under the care of a consultant. Ms Liley shared confidence in that the Trust had maximised the resource available and had been clear in discussions both through the Resources Committee and Executive Committee, on the estimation of additional resources that would be required to extend the different virtual ward pathways. This had also been shared with the ICS Place colleagues but as it stood, the current financial position meant that progress could go no further at this stage.

In response to a question around an improvement plan for Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received), Mrs Hinton advised that there had been some workforce challenges within that team, but also some administrative processes that had not been congruent with improved performance. A detailed improvement plan was now underway and expected to see a recovery by June.

Ms Liley highlighted the Outpatients target on the proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) and described that the current value sat at 4.1% however, a large proportion of these patients were through the MSK service. The team had had been testing out a 'Community Assessment Day', of which the Trust was one of the forerunners nationally and results of the most recent day ran at the Community Stadium, 200 patients were seen, 60% were moved into PIFU pathway, 10% were discharged and 30% were returning for a full course of treatment.

In terms of diagnostics, Mrs Hinton described that the Trust now has an internal Diagnostics Board which oversees all of the diagnostics programmes. One of the challenges has been the balance between the acute demands, the urgent demand and the routine demands. There was a significant focus on the fast tracking, urgent demand in order to try and improve cancer performance. The Trust was also working with the North Yorkshire Diagnostics Board who see performance data and allows for effective benchmarking against where the Trust sits.

In response to a question on achieving the Children and Young Persons RTT waits over 65 weeks for incomplete pathways, Mrs Hinton advised that there was an agreed internal trajectory to have zero 52 weeks waits for children and young people by the end of March and the Trust was on target to achieve that.

Quality and Safety

Mrs Parkes presented the TPR which described that in December 2023, the Trust attributed 8 Methicillin sensitive Staphylococcus aureus (MSSA) cases, with 77 cases reported year to date. The PSIRF (Patient Safety Incident Response Framework) findings were presented at the Staphylococcus aureus bacteraemia reduction group meeting in February 2024. VIP scoring was now included within Nucleus to prompt invasive cannula management and documentation. In January 2024, 19 Clostridioides difficile (C.difficile) cases were reported, with 63% occurring on the Scarborough Hospital site. The Trust's annual C.difficile objective is 116 cases, with 126 reported year to date. PSIRF findings revealed delays in isolation, sampling lapses, and lapses in antimicrobial prescribing. The

Antimicrobial Stewardship Team was addressing these issues. The IPC team was working on the impact of increased Opel scores and unplanned bed spaces, which was adversely affecting the ability to decant and decontaminate the environment using HPV. The C.difficile reduction strategy had been refreshed and overseen by the Trust C.difficile reduction group.

Mrs Parkes described her concern that the C.difficile rate was worrying and looking at the content of the rapid reviews that were carried out, there were some helpful focus on areas that could be improved on. A contributory factor to IPC cases was the link to the unplanned area SOP where there was a struggle to isolate patients in a timely manner. However, a decline and some stability were seen in January but improvement still required. A brief summary of pop up side-rooms was given as an idea the Trust was exploring for enabling quick isolation.

Mr Barkley raised the big increase in the number of complaints received in January. Mrs Parkes assured the Board that there were weekly meetings with Care Groups around their complaints to allow improvement of performance on delivering complaint responses but also to reduce the number of complaints. There was also further work to be done around reporting responses and opportunities into the Quality Committee in particular around the Friends and Family Test feedback. Many of the complaints in January related to the delays in the emergency department and accessing beds.

Workforce

The Board received and noted the workforce performance update. Mr Barkley questioned the reference to FTE (Full Time Equivalent) on totals for nursing (registered and nursing support), medical and dental temporary staffing requests. Miss McMeekin acknowledged this caused confusion, the calculation was based on a full time and a full week as opposed to actual numbers of shifts or hours requested. After further discussion, the Board agreed that it would be helpful if the information was shared by the number of hours, this would be a more accurate and clear reflection of the position.

Mr Barkley reference that the Trust had lost 874.5 WTE (Whole Time Equivalent) to sickness in December with anxiety, stress or depression still being the highest contributing factor at 29.8% which was a 4.8% increase on the previous month. The reckoner of 874.5 was effectively 9% of the workforce which did not feel to be reflected in the report. Miss McMeekin agreed to clarify this calculation through email outside of the meeting.

Action: Miss McMeekin

Post meeting note.

the data in the TPR charts/tables is from ESR (our payroll system). The percentages are calculated on the 'WTE absence' vs 'WTE available'. What this really means is the no. of days when people were absent from work vs the total no. of days available for work. And so over a year to the end of Jan-24, the calculation of the annual absence rate looks like this:

*Total no. of days of absence across the workforce during the year = 158,018.39
Divided by total workforce availability during the year = 3,171,266.57 days (8,688.40 WTE * 365 days)
= 4.98% annual absence rate.*

When we convert the no. of days' absence into a WTE figure for the year, you'd divide 158,018.39 by 365 = 432.93 WTE.

Digital and Information Services

Mr Hawkins presented the TPR describing that there were three P1 incidents (significant loss or degradation of service experienced by users, impacting the operating efficiency of the Trust and its employees) related to CPD, two related to the authentication system controlling users loading CPD, and one related to a technical effect from testing on a development copy.

Other priority 1 incidents included a temporary PACS at York, an operational dashboard report being affected for 24 hours, and a Summary Care Record (SPINE) being unavailable due to a national level incident. Demand returned to higher levels following December's reduction and was in line with January 2023.

The Trust continued to promote IT Self Service and inform staff through "Bits & Bots" communications of key resources available, such as FAQs and how-to guides for Multi-Factor Authentication. Month-on-month improvements in the creation and consumption of Knowledge Articles were being observed.

Information security incidents had increased due to audits and data disclosed in error, with a peak in July and an increase in data disclosed in error in the Autumn. Targeted communication had helped reduce this trend.

The recent reduction trend in Patient Subject Access Requests (SARs) continued through the Autumn, with an increase in requests where patients needed their notes as they had chosen to access private healthcare.

Finance

Mr Bertram presented the TPR describing that the Trust had an actual adjusted deficit of £32.1m, compared to a planned deficit of £15.8m for January. This resulted in a £16.3m deficit adversely adrift from the plan, a deterioration from December. NHS England had requested providers to reflect the net impact of strikes in both December and January within their forecast outturn, which had deteriorated the forecast outturn by £1.9m. Despite this, the Trust was reporting that it will still meet its plan at year-end, but there was a risk to achieving this. The Trust had committed to bridge this shortfall through the deferral and avoidance of all expenditure, save those that would negatively impact patient health and safety, over the final months of the year.

Mr Bertram noted that the Trust was in active discussions with the Integrated Care Board as to whether there were opportunities to provisionally support some of the pressures within the system, particularly around high-cost drugs and devices and the stretch savings ask that the Trust had not been able to deliver. Mr Bertram confirmed that he was not at this stage in a position to confirm where those discussions were at but the Board were to be aware that all parties within the integrated care system were now investigating what reserves and scope there may be to return the ICB back to its original deficit plan (£30m for the system). Mr Bertram advised that he would ensure the Board were update as and when discussions progressed and clarity on the position was clear.

Mr Bertram made reference to the agency controls and highlighted that the Trust agency spend was capped at 3.7% of its overall pay spend and at the end of January, expenditure on agency staffing was £6.2m ahead of the cap. There was approximately £3m spend in month against a capped position of approximately £1.5m so the highest spend in month.

Mr Bertram further highlighted the Elective Recovery Fund, describing that the Trust had achieved 107% of the elective levels of activity that would have been performed in pre-pandemic times. The target was 100% (previously 104 but was reduced because of the anticipated strike impact) illustrating significantly ahead of plan and brought in nearly £8m of additional income into the organisation.

Dr Holmberg questioned what caused the stepped increase in agency expenditure in June that seemed to continue. Mr Bertram agreed to look into this and share an explanation following the meeting.

Action: Mr Bertram

Post meeting note:

There were a multitude of posts coming into agency spend and dropping out but there was a significant clear step within medicine relating to action taken with acute medicine and including other significant posts. To explain further, the main area of increase was Medical and Dental agency (£713k average Apr/May; £1.2m average Jun-Jan – a £526k increase), and in that the main area of increase was Medicine (£230k average Apr/May; £649k average Jun-Jan - £419k increase). The Care Group analysis showed this was largely due to PSG (starting in the summer), cover for an Elderly consultant who had left, an acute medicine locum, and an agency Consultant who had started in Hepatology. In all cases the Trust had replaced a leaver with an expensive agency locum and significantly stepped up spend. PSG is a company that specialised in Acute medicine provision and there were issues with staff leaving in this area. The Trust continued to use PSG to uphold the Acute Medicine Service. Dr Stone, Ms Hansen and Mr Bertram were in discussions with the Medicine Care Group Team to agree on staffing Acute Medicine with senior decision makers going forward and how to remove the Trust from reliance on expensive agency provision. This was a concern for the Executive Team and would update the Board as plans developed.

Action: Dr Stone, Ms Hansen and Mr Bertram

In answer to a question, Mr Bertram confirmed that the Trust was going to spend its capital budget.

135 23/24 Q3 Guardian of Safe Working Hours Report

Dr Stone presented the report and summarised two key areas for the Board to note.

Junior doctors in Renal Medicine (York) had contacted the Guardian with concerns in relation to overtime, missed breaks and patient safety. These concerns had been escalated.

The pursuit of robust and easy access to emergency rest facilities throughout the year continued to prove challenging however, Dr Stone assured the Board that the accommodation had been resolved but were working through with junior doctors on ensuring this was clear. The challenge was primarily on the York site as the accommodation had to be obtained elsewhere to support the rest facilities requirement.

Dr Stone highlighted the exception reporting tool (all junior doctors are given access to the online Exception Reporting tool and can highlight variation in working hours, missed breaks and missed training opportunities) and noted that less than 2% were in relation to education which demonstrated a good position considering the extent of the pressures that staff were currently under. It was positive to see a route for junior doctors to demonstrate if they were not getting educational opportunities and informing about their experience of their working day.

Dr Stone also highlighted the change in the clocks in October 2023 which resulted in three fines for shifts exceeding 13hours across different specialities. Not all reports submitted for the extra hour triggered a Guardian fine. Remuneration in such cases was being led by Medical Employment and the Medical Deployment Team was working with the LNC to determine a solution for next year.

Finally, Dr Stone shared that high fill rates at the bank and agency shifts were positively impacting Junior Doctors experience as it meant that they were not on shift with additional work of others.

136 23/24 Equality Delivery System Report

Virginia Golding attended the meeting to present the report which detailed the Equality Delivery System (EDS) 2022 as a tool for the Trust to improve its services, workforce and leadership. It comprised on 11 outcomes across three domains:

1. commissioned or provided services
2. workforce health and well-being
3. inclusive leadership.

These outcomes were evaluated, scored, and rated using available evidence and insight. The report asked for Board approval before submission to NHS England on 29 February 2024. All three domains had been assessed against the Domain Outcomes and scored varying degrees of activity.

Domains 1 and 2 were assessed through engagement events involving internal and external stakeholders. Virginia described the stakeholder mapping and engagement around these domains. Domain 3 was assessed by Harrogate and District NHS Foundation Trust. Once assessment had taken place, the Trust was then expected to devise an improvement action plan.

In terms of domain 1, it was suggested that the EDS criteria was built into service reviews as a means of easier assessment of evidence. Domain 2 it was suggested that through EDI workstreams and Inclusion forum, these were used to assess the evidence. A recent calculation of the scoring was an outcome of 32 which demonstrated 'achieving activity'.

Domain 3, Mrs Brown had been involved as part of the evidence assessment and she described that there was a framework that supported the type of evidence needed to provide any achievement. This involved written communication to staff, board papers and examples of messaging around leadership with EDI. Having gone through the assessment of evidence, the type of evidence would be reviewed this year.

Before final submission to NHS England, Mr Barkley agreed to share some typo amendments with Mrs McMeekin following the meeting and also recommended to include a description for the mean and median comparison graph (on page 179 (29 of the EDS reporting template) to clarify that this was in relation to the gender pay gap.

The Board received and approved the assurance report.

137 23/24 CQC Compliance Update

Mrs Parkes presented the report which described progress with delivery of actions within the Trust's CQC Improvement Plan, overseen through the fortnightly Journey to

Excellence meeting. Progress was going well as detailed in the report and a strong process implemented to manage delivery dates. In answer to a question from Mr Barkley around the dates given beyond March 24, Mrs Parkes advised that CQC were well briefed and understand and agree through our engagement meetings if we have chosen to extend. There is not the desire to close actions down unless there is clear understanding of the sustained outcome required.

Mrs Parkes advised that the CQC engagement meeting for York site ED had been postponed by CQC for January and was to be rescheduled for the end of March.

The Board was reminded of the 2020 CQC's section 31 regarding the safety of patients with mental health needs in York and Scarborough emergency departments. The CQC requested updates on the new Mental Health Risk Assessment form, staff training, and monthly audit results. The developments are now complete, with positive results and ready for technical testing. However, there were delays in the roll-out of the electronic mental health risk assessment in the emergency departments, which was scheduled to commence at Scarborough on 15 January 2024, but launched on 6 February 2024 and was working well with a view to roll out to York. Mrs Parkes advised that she was in discussion with the CQC on how the Trust could work to close the section 31. There was a formal process and was recommended that once rolled out to York, there is an assessment on compliance and usage before any submission was made to close.

The Board noted that the CQC received information from various sources regarding the quality of care provided at the Trust, including known incidents, formal complaints, and concerns submitted by patients, staff, the public, or other organisations. The CQC shared these concerns with the Trust for review, investigation, and response. Mrs Parkes advised that two CQC cases had been received since the last report, one related to patient experience on Ward 26 at York Hospital and one for information about a patient discharged with a cannula in situ. The Trust currently had 12 open cases, most of which were awaiting submission of finalised Serious Incident Reports and CQC responses.

Mrs Parkes shared that the CQC had provided guidance for care homes, hospitals and hospices on helping people have visitors which advocated open visiting. Mrs Parkes advised that early discussions around this with Senior Nursing staff was encouraging however, it was acknowledged that this had to be balanced with IPC issues.

138 23/24 Trust Response – Letby Review Summary Report

The Board noted the report which outlined the findings of the commissioned internal review to investigate available methods for staff to escalate concerns regarding patient safety. This included a review of escalations to the Executive Directors regarding patient safety within the previous two years and any recommendations for improvements. A key stakeholder group convened, and the outcome measures and methodology were outlined in the report.

Mrs Parkes highlighted the number of actions included in the report (page 204) that had been taken to ensure that Executive were sighted, and have ongoing insight, into any safety issues or any concerns from members of staff.

Mr Barkley mentioned that he had received contact from a source who chaired the independent investigation who had indicated that he was willing to provide an online briefing for the Board to attend and would be in touch with further details. It was agreed that this should be arranged.

Action: Mr Barkley

Mrs McAleese highlighted that the report had also been presented and discussed at the Quality Committee but this had been omitted from the front sheet of the report.

The Board noted the findings of the commissioned review and supported the recommended actions.

139 23/24 Maternity and Neonatal Reports **Maternity and Neonatal Quality and Safety Update**

Sascha Wells-Munro attended the meeting and presented the report. Mrs Wells-Munro described that a 'Whose Shoes' event had been held in Scarborough on 7 February, in partnership with MNVP (Maternity and neonatal voices partnerships) to listen to service users' experiences and shape improvements. The interactive board game presented scenarios for group discussion on maternity and neonatal services. Attendees included service users, local authority colleagues, LMNS (Local Maternity and Neonatal Systems), and the maternity team. Key themes aligned with the Maternity & Neonatal Improvement plan, which was to be shared with service users through quarterly meetings and further engagement events to understand user experience and feedback.

Mrs Wells-Munro further described the '15 steps' event held in Scarborough's maternity and neonatal unit, in collaboration with MNVP, following a successful project in York last year, which supported environmental improvement work on the site. The event involved service users to come in and walk the Trusts services and provide feedback about how they feel in the first 15 steps for walking through the door.

The latest CQC maternity survey results had now been published and related to those who gave birth between 1 and 28 February 2023. The results demonstrate further improvement from the 2022 data. What was encouraging was those areas of improvement as outcomes from the survey, were already in line of sight and included in the maternity improvement plan.

The Trust continued to have challenges around maternity staffing and the maternity workforce review was ongoing, with the final report regarding birthrate plus compliance expected by the end of March. A meeting with the ICB was held to discuss workforce requirements and future requirements. The Director of Midwifery and Chief Nurse were working closely with the ICB Chief Nurse to address workforce shortfalls. Work was ongoing with the University of York and Hull to increase student midwifery numbers and promote the profession through apprenticeships and shortened programs. Mrs Wells-Munro shared that there was interest from York St John University to establish a midwifery training programme. The delivery suite co-ordinator development framework launched by NHS England had been published, aligning with the final Ockendon report of immediate and essential actions. The service was working with the LMNS to achieve this collaboratively.

The maternity quality and safety framework was being reviewed in relation to Trust governance changes. Out of 170 clinical guidelines, 136 were required (34 were redundant), with 9 out of date. These had been completed and were currently undergoing a new approval process. A risk assessment plan was in place for the remaining documents over the next six months. The maternity safety champions pathway, Attain and Perinatal Mortality Review Tool processes were being tested, along with ward to Board reporting and incident reviews related to Patient Safety Incident Response Framework implementation.

The refurbishment of maternity theatres began in February but had been delayed to April due to manufacturing issues. Business cases for caesarean sections and scan requirements were being finalised and presented to the appropriate group for approval. A review of the maternity and neonatal estate was underway, including the provision of community midwifery clinics and exploring new care models for improved accessibility. A quality improvement project had been launched to standardise information provided to service users using a video, ensuring all users receive the same information and removing variation. This project was being undertaken in collaboration with the MNVP to ensure coproduction and design. The review and rationalisation of community midwives should consider areas of high deprivation and access to services, as the current community estate was impacting women's accessibility and engagement.

In response to a previous Board request, Mrs Wells-Munro reported that around 40% of uncompleted antenatal risk assessments were linked to telephone screening contacts without a risk assessment requirement, indicating non-compliance on BadgerNet. Having dug into the detail of this, there continued to be connectivity issues and issues for community midwives with the use of BadgerNet that were being addressed.

The Postpartum haemorrhage (PPH) improvement group were meeting fortnightly and focused on areas of improvement, including standardised risk assessment, blood loss measurement, proforma completion best practices, and uterotonic administration. Immediate actions had already been taken based on the thematic review which was around processes in theatre where it clearly articulated that the rate of PPH was greater for an elective section. Although there was a fall in December figures, it was still not a desired position and next steps for the group were reviewing care in maternity theatre, escalation, and maternal anaemia. Will continue to feedback on the progress of these actions.

Mrs Wells-Munro advised that work around Consultant attendance in clinical situations which was not yet recorded in BadgerNet. Work was underway to add a mandated field to the EPR to capture this, as the service needed a more formal approach. Currently, reporting was done through the clinical incident system, and no incidents reported for non-attendance in December, following the guidance. An interim measure was that consultant attendance were now captured in every handover whether a consultant had attended in the clinical situation. Manual audit would then be achievable until BadgerNet is accessible for this.

Dr Boyd acknowledged the progress made in the past year around maternity services, particularly in identifying challenges and making effective plans to address them. She also noted the significant change in public engagement over the past year, which had been a significant factor in the progress made in the past year. Mrs Parkes added that Mrs Wells-Munro had improved the Trust's structure around maternity safety champions, and Dr Boyd and herself had worked with her to improve the framework. There were regular meetings with Mrs Wells-Munro and the maternity operational safety champions, and this will be reported through the Quality Committee. This was an important element, as it has been missing in the data set. Mrs Parkes and Dr Boyd were now identified as maternity safety champions on agendas and minutes, making it clear who they were at Board level.

In answer to a question Mrs Wells-Munro described that discharge delays were multifactorial but primarily caused by medical cover issues, including the inability to perform neonatal checks and administer medications. The delay in discharge was exacerbated by a shortage of midwives, which was linked to the staffing shortages in services and delivery suites.

CQC Section 31 Update

The response to Mr Barkley's question to whether feedback was ever received from the CQC, was that there was no indication of any concern and overall positive about the progress being made. What would further improve the position enough to consider removing the section 31 was demonstrating that the Trust has sustainable on the improvement.

140 23/24 Q2 Mortality Review – Learning From Deaths Report

Dr Stone presented the report which described the mortality rates, including crude mortality, SHMI (Summary Hospital Mortality Index), and HSMR (Hospital Summary Mortality Indicator). It also highlighted the diagnostic groups contributing to these rates. The report used data from nationally and locally mandated data, quality account data, and themes from SJCRs (structured judgement case note review) considered by the Learning from Deaths Group in Q4.

Dr Stone had clarified that SHMI referred to the death rate that includes the people in the 30 days after they've been discharged from hospital and includes palliative care deaths. HSMR referred to hospital death rates that are not adjusted for palliative care, and there were fewer diagnostic groups included in it.

Dr Stone confirmed that there was no concern in the level of SHMI and investigation continues in understanding the deviations in HSMR rates. She shared her confidence that coding was good. Alerts were triggered for very specific conditions to ensure that these deaths are investigated.

In terms of the medical examiners Medical deaths reviewed, last month there were issues with sickness and cover and consequently the numbers dropped but generally they were on top of workload. The examiner reviews were becoming much more consistent across York and Scarborough following the disparity across the two sites last year.

Datix has a modular on it where we can keep abreast of deaths and pull data required and the report would continue to evolve as further data would become accessible.

Dr Stone responded to a question around the divergence between the SHMI and HSMR and confirmed that this was influenced by the number of patients that were dying in hospital who would ordinarily have passed away elsewhere. This was attributed to the longer lengths of stay due to difficulties in discharging patients when they no longer needed hospital-based care. Mr Barkley asked Dr Stone to pass on the Boards thanks for an excellent report.

141 23/24 Quality Improvement Update

Dr Stone presented the report describing that the Board had approved the Quality Improvement Strategy in August 2021, highlighting progress in delivering objectives. Key highlights included the design of an educational dosing model, an increasing number of staff trained in QI, the appointment of an Associate Medical Director in 2022, QI becoming an awards category, successful bid for three Health Education England Future Leaders Fellows to support quality improvement projects, and completion of the NHS Impact assessment in October 2023.

The strategy for 2021-2025 was included in the report but this was to need some revision later in the year. With the quality improvement methodology, the Trust was using Quality,

Service Improvement & Redesign Practitioner Programme (QSIR P) training but QI (Quality Improvement) training was also captured through other methods. It was noted that the position for training was not ideal but the pressures that the Trust had faced over the last few months had been challenging to accommodate any training on QI.

Dr Stone stressed that there now needed to be an improved plan for a consistent approach. The impact assessment approach was to be shared across colleagues to actually work out what the priorities needed to be and will work with care groups and corporate teams to establish who those colleagues will be. This will then go through Executive Committee to support the planning of the QI priorities. Adele Coulthard was supporting the team to get to this position.

Mr Hawkins highlighted that, as part of the wider strategy, there was a need to understand whether it was overall continuous improvement or more QI in the traditional sense.

Mr Barkley shared that for QI to be truly transformative there was a need for the Trust to have a systemic QI approach. This was about something that impacts the whole organisation and emphasised the note in the report around closer working between the various functions in the Trust. The Board noted that the NHS released the NHS Impact Framework in April 2023 which articulated the importance of taking an aligned and integrated approach to continuous improvement delivery and capability building. NHS Impact's five components, taken from evidence based improvement methods, underpinned a systematic approach to continuous improvement:

- Building a shared purpose and vision
- Building improvement capability
- Developing leadership behaviours for improvement
- Investing in culture and people
- Embedding a quality management system

The Board received and noted the report.

142 23/24 Questions from the public

No questions from members of the public.

143 23/24 Time and Date of next meeting

The next meeting days if the Board of Directors held in public will be on 27 March 2024.