York Teaching Hospital NHS Foundation Trust

Scarborough Hospital

Quality Report

Woodlands Drive, Scarborough, YO12 6QL
Tel: 01723 368111
Website: www.yorkhospitals.nhs.uk

Date of inspection visit: 17 – 20, 30 – 31 March and 11 May 2015
Date of publication: 08/10/2015

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Scarborough Hospital was one of three main hospitals forming York Teaching Hospital NHS Foundation Trust. The trust provided acute hospital services to the local population. The trust also provided a range of other acute services from York and Bridlington hospitals to people in the wider York area, the north-eastern part of North Yorkshire and parts of the East Riding of Yorkshire. In total, the trust had approximately 1170 beds, over 8700 staff and a turnover of approximately £442,612m in 2013/14. Scarborough Hospital had approximately 300 beds.

Scarborough Hospital provided emergency and urgent care, medical care, surgery, maternity and gynaecology services, paediatrics services, outpatients and diagnostics and end of life care for people in the Scarborough, Whitby and Ryedale areas of North Yorkshire.

We inspected Scarborough Hospital as part of the comprehensive inspection of York Teaching Hospital NHS Foundation Trust, which includes this hospital, York and Bridlington hospitals and community services. We inspected Scarborough hospital on 17 – 20, 30 – 31 March and 11 May 2015.

Overall, we rated Scarborough Hospital as 'requires improvement'. We rated it 'good' for being caring but it requires improvement in providing safe, effective, responsive care and for being well-led.

We rated emergency and urgent care, medical care, surgery, critical care, maternity and gynaecological services, and outpatient and diagnostic services as 'requires improvement', and as 'good', for children & young people's services and end of life care.

Our key findings were as follows:

- Care and treatment was delivered with compassion and patients reported that they felt they were treated with dignity and respect.
- Patients were able to access suitable nutrition and hydration, including special diets. Patients were satisfied with their meals and said that they had a good choice of food and sufficient drinks throughout the day.
- We found the hospital was visibly clean, Hand-washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. The last episode of MRSA septicaemia was more than 500 days prior to the inspection.
- The trust had no mortality outliers. However, the Summary Hospital-level Mortality Indicator (SHMI) for Scarborough hospital of 107 was higher than both the Trust overall (102) the England average (100) in June 2014. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
- There were concerns that patients arriving in the A & E department did not receive a timely clinical assessment of their condition.
- At the time of the inspection, in the majority of services the Trust was below its own target of 75% for mandatory training including safeguarding training. The Trust's target was to achieve 75% minimum compliance for the year ending August 2015. We have since been informed by the Trust that the figures provided to the CQC only included the training provided for the period of six months prior to the inspection as this was the time the Trust implemented a new system to capture and record training carried out. We were told the compliance levels did not include any training staff may have had prior to the 1 September 2014 and we were not provided with evidence to reflect this in the overall training levels.
- Some areas had staff shortages: nursing staff on medical and surgical wards; consultant cover within A & E; and radiologists. The trust was actively trying to recruiting to the majority of these roles.

Summary of findings

- There were policies and guidelines on the intranet. However, there were some guidelines in maternity services relating separately to Scarborough Hospital and York Hospital, which were out of date and did not adhere to national guidance.
- Patients were not always protected from the risks of delayed treatment and care as the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets were not being achieved.
- The trust was half way through its five year plan to integrate services following the acquisition of Scarborough & North East Yorkshire NHS Trust in 2013.Services within all three of the acute hospitals were at differing stages of integration.
- Staff we spoke with had varying views about their engagement and involvement with the process of integration. A number of staff were concerns that Scarborough was seen as the "Poor relation".
- Pathways, policies and protocols were not always reviewed and some still had to be harmonised across the trust to avoid confusion among staff.
- Four of the eight core services we inspected had good local leadership within the service.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels, especially in A & E, on the medical and surgical wards, operating department practitioner (ODP) cover within theatres, radiology and senior medical cover in relation to cross-site working. Additionally within critical care the provider must ensure staffing levels are adequate to ensure clinical education, unit management, clinical coordination, continuity of care, and effective outreach.
- ensure that there is adequate access for patients to pain management and dietetic services within critical care
- ensure improvements are made in the 18 week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
- ensure that staff, especially within medicine, outpatients & diagnostics and critical care, complete their mandatory training, and have access to necessary training, especially basic life support, mental capacity and consent (Outpatients and diagnostic staff), safeguarding vulnerable adults and safeguarding children.
- ensure that pathways, policies and protocols are reviewed and harmonised across the trust, to avoid confusion among staff, and address any gaps identified.
- ensure that patient flow into and out of critical care is specifically in relation to delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.
- ensure that all equipment is tested in a timely manner and in line with the Trust's policy, especially checks on fridges and resuscitation equipment.
- ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service.

In addition there were areas where the trust should take action and these are reported as the end of the report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Overall we rated the safe domain as requiring improvement. The majority of patients were not clinically assessed when they first arrived in the department. Some patients waited up to two hours for a clinical assessment. The department was visibly clean and infection control precautions were adhered to. The emergency department had a separate children's treatment room which was spacious and well-equipped. However, it was not sufficient for all the children who attended and so some children had to be treated in adult areas. We found there were shortages in medical and nursing staff and not all staff had received up to date mandatory or safeguarding training. Overall we rated the effective domain as requiring improvement. Patients' care and treatment were planned and delivered in line with current evidence-based guidance, standards and best practice. There was participation in national clinical audits. Information about effectiveness was shared with, and understood by, staff working in the department. Overall we rated the caring domain as good. We spoke with patients and relatives who told us on the whole they were happy with the care they received. The majority of patients that we spoke with said that they had been involved in the planning of their care and had understood what had been said to them. Patients and relatives told us that they had been consulted about their treatment and felt involved in their care. Overall we rated the department as requiring improvement for being responsive. We found less than 50% of nurses had received training about the needs of people with dementia and only a third had received training about learning difficulties. The department had been unable to meet the national target of admitting or discharging 95% of patients within four hours and between 1 October 2014 and

Summary of findings

31 December 2014 there had been 349 recorded black breaches. Staff responded well to any complaints or concerns and used learning from these to improve future care and treatment.
Overall we rated the service as requiring improvement for being well-led. Although there was not a written strategy all staff that we spoke with understood the vision for the department. They wanted to rapidly assess and treat all patients presenting to the department in a safe and effective manner. Senior staff told us that there was a strategy for achieving the vision. However, it had proved difficult to implement. Monthly governance meetings were held and all staff were encouraged to attend, including junior members of staff.
Nursing and medical staff told us that the senior clinical and managerial staff had the knowledge, skills and personal integrity to effectively lead their department. Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.

Medical care

Requires improvement

Overall, we judged this service as requires improvement. In the main, patients were protected from avoidable harm and abuse. However, the provider was unable to consistently provide safe staffing levels. Mandatory training compliance needed to improve across medical services at both hospitals.
Following the acquisition of Scarborough hospital staff told us they were confused about which protocols and the lack of availability of some protocols. Results from the Sentinel Stroke National Audit Programme (SSNAP) showed no recent improvement, and there were a number of indicators from other national audits that were below the national average.
Patients were happy with the care they received, and found the service to be caring and compassionate.
There were concerns about the management of patient flow through the hospital including access to senior medical staff to make timely decisions, and delayed discharges.
Staff told us that they were well supported by their immediate line manager, but the executive and senior divisional leadership was reported to be

Summary of findings

lacking in visibility and effectiveness. Staff shortages impacted upon ward manager's ability to effectively lead their teams. Some staff did not feel that they were always actively engaged or consulted regarding service changes.

Surgery

Requires improvement

Nurse staffing levels were not always maintained as planned. Services were responsive to patients' individual needs, but there were breaches of waiting times, such as the 18-week referral-to-treatment time (RTT) target and the achievement of cancer waiting times. There had been one 'never event' in surgery in the last 12 months relating to wrong site surgery. Never events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken.

The service provided effective and evidence-based care and treatment. Patients received compassionate care and their privacy and dignity were maintained.

Senior leaders understood their roles and responsibilities to oversee the standards of service provision in surgical areas. However, work was continuing to integrate surgical services and to deliver common standards of care across the three hospital sites. There was innovative practice, including a new surgical ward and assessment unit.

Critical care

Requires improvement

Staff were caring and professional. Patients, their relatives and friends spoke highly of the care provided on the unit. There were positive comments from staff in relation to culture and teamwork. Some aspects of staffing did not meet national best practice guidance, particularly the medical on-call rota. Nurse staffing presented a mixed picture, with shortfalls particularly in relation to clinical education, unit management, clinical coordination, continuity of care and outreach. Staff could not be released for training frequently enough. Support from specialist teams was limited as there was no hospital-wide pain team and input from the dietetics service did not meet best practice recommendations.

There were suitable processes in place in relation to incident management, safeguarding and assessing and responding to patient risk. The environment and layout of the unit did not meet national best

Summary of findings

practice guidance. Space around the beds on the unit was limited and storage space was a problem. The environment was visibly clean and patient safety outcome data did not raise any concerns. The high number of patients who were non-clinical transfers out of the unit had a negative impact on patient safety, which was a concern. The services were part of the Case Mix Programme managed by ICNARC was positive, but there was limited evidence of other measures being taken to assess effectiveness. Service and strategic planning was at an early stage and there was a lack of certainty about the future design of the service and any immediate actions to mitigate delayed discharge, delayed admissions and high capacity. Ideas were in place for developing the service and improving safety but were not formalised or clearly mapped out.

Maternity and gynaecology

Requires improvement

Overall the maternity service at York hospital required improvement. The staff did not always receive feedback / lessons learnt from incidents and there were concerns about staffing of theatres out of hours. There were policies and guidelines on the intranet. However, there were guidelines relating separately to Scarborough Hospital or York Hospital in place, which were out of date and did not adhere to national guidance. There were policies and guidelines on the intranet. However, these were different for each hospital, some were out of date and did not adhere to national guidance. Monitoring of performance was difficult to review. Staff were caring and treated women with respect. The services were responsive and delivered in a way that met the needs of the women accessing them.

Services for children and young people

Good

There were enough nursing staff to meet the needs of children and families because some beds were closed. Children's services did not have all the necessary individual risk assessment tools in place so staff were not able to conduct a robust, individualised risk assessment when required. Training records submitted by the trust prior to the inspection showed varying levels of training uptake by members of staff, but not all were achieving the 75% compliance set by the Trust.
Children, young people and parents told us that they received compassionate care with good

Summary of findings

emotional support. Parents felt informed and involved in decisions relating to their child's treatment and care. Staff of all grades told us that children's services were offered very limited CAMHS (Child and Adolescent Mental Health Services) support for children with mental health needs by other providers; the children's directorate risk register also noted this.
The service was responsive to children's and young people's needs and was well led. The service had a clear vision and strategy.

End of life care

Good

We saw that end of life care services were safe, effective, caring and responsive, with elements of outstanding practice in terms of being well led. We observed specialist nurses and medical staff provided specialist support in a timely way that aimed to develop the skills of non-specialist staff and ensure the quality of end of life care. Staff were caring and compassionate and we saw the service was responsive to patients' needs. There was good use of auditing to identify and improve patient outcomes.
The trust had a clear vision and strategy for end of life care services. There was consistent leadership including the development of a number of initiatives, such as non-cancer end of life care and the development of training to improve advance care planning discussions, including those relating to DNA CPR.

Outpatients and diagnostic imaging

Requires improvement

Overall the care and treatment received by patients in Scarborough General Hospital outpatients and diagnostic imaging departments required improvement. Some policies and procedures were not being followed and staff were not attending mandatory training. There were also a significant number of a 27% vacancy rate for nurses in outpatients; a 12% vacancy rate for additional clinical services staff and a 43% vacancy rate for radiologists in some departments.
The managers told us that they reported any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether

Summary of findings

corrective action had been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).The morale of staff was low, especially within radiology, and staff felt that they only ever received negative feedback from managers. Many staff we spoke with felt the acquisition had not been handled sensitively and they felt excluded. Staff survey results had deteriorated from the previous year's results. Patients were very happy with the care they received and found it to be caring and compassionate. Services were on the whole responsive to patient needs and the care patients received was effective.

Scarborough Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Scarborough Hospital	11
Our inspection team	11
How we carried out this inspection	12
Facts and data about Scarborough Hospital	12
Our ratings for this hospital	12
Findings by main service	14
Action we have told the provider to take	121

Background to Scarborough Hospital

York Teaching Hospital NHS Foundation Trust provides a range of acute hospital and specialist healthcare services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles. The trust provides community-based services in Selby, York, Scarborough, Whitby and Ryedale. Trust-wide there are approximately 1,170 beds (with approximately 300 beds in Scarborough hospital), 7210 staff and a turnover of approximately £442,612m in 2013/14.

The Indices of Multiple Deprivation indicates that York is the third least deprived city (out of the 64 largest cities in the UK) and is the 87th least deprived borough out of the 326 boroughs in the UK. North Yorkshire is a relatively prosperous county compared to the rest of England, although there are pockets of deprivation. Eighteen Lower Super Output Areas (LSOAs) within North Yorkshire are amongst the 20% most deprived in England. Fourteen of these LSOAs are in the Scarborough district (around Scarborough and Whitby), two in the Craven district (around Skipton), one in the Selby district and one in the Harrogate district.

The trust acquired Scarborough & North East Yorkshire NHS Trust (which included Bridlington hospital) and community services for the wider York catchment and the north-eastern part of North Yorkshire in 2012. There is a five year integration plan in place: 2012 - 2017.

We inspected Scarborough hospital as part of the CQC comprehensive inspection programme.

Our inspection team

Our inspection team was led by:

Chair: Stephen Powis, Medical Director, Royal Free Hospital, London

Head of Hospital Inspections: Adam Brown, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical, paediatric and surgical consultants, junior doctors, senior managers, nurses, midwives, palliative care nurse specialist, a health visitor, allied health professionals, children's nurses and experts by experience who had experience of using services.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight core services at Scarborough hospital:

- Urgent and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatient services

Prior to the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held listening events in Scarborough on the 12 March 2015, where 12 people attended and in York on the 16 March 2015 where 17 people attended and shared their views and experiences of the Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone. We also attended additional local groups to hear people's views and experiences.

We held focus groups and drop-in sessions with a range of staff including nurses and midwives, junior doctors, consultants, allied health professionals including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out the announced inspection visit between 17 and 20 March 2015 and undertook an unannounced inspection in the evening on 30 March and the 31 March 2015 at York and Scarborough hospitals. A further unannounced to Scarborough was undertaken on the 11 May 2015.

Facts and data about Scarborough Hospital

Scarborough Hospital is the Trust's second largest hospital. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma and intensive care services to the population and visitors to the North East Yorkshire Coast. There are five operating theatres and approximately 300 beds.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1.We are currently not confident we are collecting sufficient evidence to rate the effectiveness of Outpatients & diagnostic imaging.

Urgent and emergency services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The accident and emergency department (A&E) at Scarborough Hospital is open twenty-four hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with minor injuries which need prompt treatment such as lacerations and suspected broken bones. The ED is a recognised trauma unit although major trauma cases go directly to Leeds. The department sees between 900-1100 patients each month.

The department has a three-bay resuscitation area, one bay is designated for children. There is major treatment area and an area for minors

We observed care and treatment and looked at treatment records. During our inspection, we spoke with approximately 19 members of staff including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We talked with 13 patients and seven relatives. We received comments from patients and the public at our listening events, and we reviewed performance information about the department

Summary of findings

Overall we rated the safe domain as requiring improvement. The majority of patients were not clinically assessed when they first arrived in the department. Some patients waited up to two hours for a clinical assessment. The department was visibly clean and infection control precautions were adhered to. The emergency department had a separate children's treatment room which was spacious and well-equipped. However, it was not sufficient for all the children who attended and so some children had to be treated in adult areas. We found there were shortages in medical and nursing staff and not all staff had received up to date mandatory or safeguarding training.

Overall we rated the effective domain as requiring improvement. Patients' care and treatment were planned and delivered in line with current evidence-based guidance, standards and best practice. There was participation in national clinical audits. Information about effectiveness was shared with, and understood by, staff working in the department.

Overall we rated the caring domain as good. We spoke with patients and relatives who told us on the whole they were happy with the care they received. The majority of patients that we spoke with said that they had been involved in the planning of their care and had understood what had been said to them.

Urgent and emergency services

Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.

Overall we rated the department as requiring improvement for being responsive. We found less than 50% of nurses had received training about the needs of people with dementia and only a third had received training about learning difficulties. The department had been unable to meet the national target of admitting or discharging 95% of patients within four hours and between 1 October 2014 and 31 December 2014 there had been 349 recorded black breaches. Staff responded well to any complaints or concerns and used learning from these to improve future care and treatment.

Overall we rated the service as requiring improvement for being well-led. Although there was not a written strategy all staff that we spoke with understood the vision for the department. They wanted to rapidly assess and treat all patients presenting to the department in a safe and effective manner. Senior staff told us that there was a strategy for achieving the vision. However, it had proved difficult to implement. Monthly governance meetings were held and all staff were encouraged to attend, including junior members of staff. Nursing and medical staff told us that the senior clinical and managerial staff had the knowledge, skills and personal integrity to effectively lead their department. Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.

Are urgent and emergency services safe?

Requires improvement

Overall we rated the safe domain as requiring improvement. The majority of patients were not clinically assessed when they first arrived in the department. Some patients waited up to two hours for a clinical assessment.

The department was visibly clean and infection control precautions were adhered to. The emergency department had a separate children's treatment room which was spacious and well-equipped. However, it was not sufficient for all the children who attended and so some children had to be treated in adult areas.

We found there were shortages in medical and nursing staff and not all staff had received up to date mandatory or safeguarding training.

Incidents

- Staff told us the trust was investigating ways to reduce the number of patients waiting in the department. However, it was thought to be a complex problem and progress in solving this had been slow.
- Several staff told us about the Patient Safety Casebook which gave them up-to-date information on the department's safety record as well as governance and quality topics.
- Learning from incidents and "near-misses" was clearly displayed on a noticeboard in the staff room

Duty of candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Doctors and nurses that we spoke with understood the responsibilities associated with the Duty of candour.
- Senior staff demonstrated detailed knowledge of the practical application of this new responsibility.

Cleanliness, infection control and hygiene

Urgent and emergency services

- The ED was visibly clean and tidy. We observed support staff cleaning the department throughout the day.
- Hand washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. This helped to prevent the spread of infection.
- We saw the results from audits of infection prevention and control practices from January 2014 to March 2015. We saw generally the department was achieving high levels of compliance with infection control audits however we saw for seven out of the 15 months only 83% compliance had been achieved in the storage room. The last three months showed 100% compliance had been achieved.
- We observed staff treating a patient in isolation in accordance with trust policies and procedures. This included the appropriate use of gloves and disposable aprons.

Environment and equipment

- The emergency department had a separate children's treatment room which was spacious and well-equipped. However, it was not sufficient for all the children who attended and so some children had to be treated in adult areas.
- Children and their parents had a small waiting area that contained a selection of toys suitable for different ages of children.
- There was a large waiting room for patient who brought themselves to the ED. It had sufficient numbers of comfortable seats and a supply of drinks and snacks via a vending machine.
- There was a small X-ray room that was shared with the adjacent orthopaedic clinic. The door used for staff access was held open with a doorstop during our inspection. This meant that anyone could walk in while an x-ray was being taken, therefore being exposed to unnecessary radiation.
- There were no designated facilities for people suffering from mental health problems
- There was sufficient resuscitation, monitoring and decontamination equipment. This was clean, well maintained, regularly checked and ready for use.
- We spoke with staff from the medical physics department who maintain clinical equipment. They had responded quickly when nurses reported a monitor working incorrectly. They showed us comprehensive maintenance records of the clinical equipment in the department.

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs were checked regularly and recorded accurately in a register.
- Fridge temperatures were not checked on a daily basis. In the resuscitation room they had only been checked nine times in February and eight times in March. In the main drugs fridge they had been checked six times in February and four times in March. During the unannounced inspection we also noted fridge temperatures had not been consistently recorded. This meant that drugs could have been stored at an incorrect temperature and therefore may not have been as effective as necessary.
- The lock on the drug fridge in the major treatment area was broken which meant that unauthorised personnel could remove drugs if they wished.
- Unused drugs were disposed of in accordance with hospital policy.

Records

- The department had a new computer system that showed how long people had been waiting for and what investigations they had received.
- The system produced a patient record in paper format which consisted of one sheet of A4 paper. This was often not big enough to record all of the information necessary. Doctors and nurses sometimes had to write in the margins and this made the information difficult to read. There were no body map diagrams to accurately record injuries and no sections for risk assessments.
- If further pages or documents were needed they were loosely filed in a plastic folder. Although this meant that patient details remained confidential, there was a risk that vital documents could fall out of the file and be lost.
- When a patient was admitted to a ward there A&E records would go with them and would be included in the main medical record file. Copies of the documents were placed on the A&E computer system via a scanner. However, the quality of the scanned copies was poor and we found that important information was sometimes missing.

- This meant that, if a patient returned to the department at a future date, important information about their health and treatment may not be available to clinical staff.

Safeguarding

- Staff that we spoke with were aware of their responsibilities to protect vulnerable adults and children. Most understood the safeguarding procedures that were in place for children and how to report concerns. There was limited awareness of adult safeguarding procedures.
- The Safeguarding children and young people: roles and competencies for healthcare staff: Intercollegiate document, March 2014 stated that all clinical staff working with children/young people and their parents and who contributed to assessing and planning to meet the child's needs, should undertake Level 3 safeguarding training. This includes staff working within accident and emergency departments.
- At the time of our inspection only 22% of staff had completed training in adult safeguarding and 46% had completed recent children's safeguarding training. Trust data showed only 11% of nursing staff and 21% of medical staff had received safeguarding training at level 3
- There was no clearly defined system for identifying children who may be at risk of abuse. Staff told us that they would use their professional judgement but this varied depending on the experience of the member of staff.
- Clinical records for children did not include a risk assessment tool aimed at quickly identifying any concerns regarding child welfare.
- In order to improve the safety of vulnerable children the hospital safeguarding lead reviewed all children's records once a week. In addition copies were sent to school nurses.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control and manual handling.
- Data supplied by the Trust indicated that in most staff groups statutory and mandatory training for the Scarborough hospital emergency department directorate were not achieving the 75% compliance levels required by the Trust. For example, information governance was at 68% for nursing staff and 18% for medical staff. Conflict resolution training was at 15% for nursing staff and 9% for medical staff.
- We were told staff hadn't attended training because of staff shortages.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient.
- Doctors and nurses in A&E were not trained or experienced in the resuscitation of children. They called a team from the children's unit to attend if a child needed resuscitating. We observed this in practice. The children's team arrived quickly and demonstrated effective clinical skills. However, they seldom worked in the resuscitation room and were not supported by a member of the A&E team. There was a risk that they would not know where to find vital equipment as soon as it was required.
- A national target has been set that states ambulance patients should be handed over to the care of A&E staff within 15 minutes. The hospital was failing to meet that target. Figures sent to NHS England by the ambulance service showed that in January 2015 79 ambulance patients waited more than an hour to be handed over to and assessed by a nurse or doctor. This was an improvement on previous months. Figures for February were not available at the time of inspection.
- Patients arriving by ambulance were meant to be rapidly assessed by a senior A&E doctor. We observed the assessment process and found that it took between ten and fifteen minutes. Meanwhile other ambulances were arriving and the doctor was not available to assess them.
- In order to maintain patient safety an experienced nurse was responsible for briefly assessing ambulance patients between 10am and 10 pm. There was no nurse at night to do this and hospital figures show that ambulance patients can sometimes wait for an hour and a half before being clinically assessed.

Urgent and emergency services

- Patients who walked into the department, or who were brought by friends or family were directed to a receptionist. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be assessed by a nurse.
- This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their on-going care. This is often known as triage.
- We observed the initial assessment of a patient (with their consent) and found it to be thorough and effective. The nurse had completed special training in triage and had been assessed as competent before undertaking the role.
- Guidance from the Royal College of Nursing (RCN) and Royal College of Emergency Medicine (RCEM) states that "Triage is a face to face encounter which should occur within 15 minutes of arrival." The A&E department at Scarborough Hospital was not meeting this standard
- During the morning of our inspection we observed that the there was no triage nurse available for over an hour. This was because the major treatment area was busy and she had been asked to help. This led to long delays in assessing patients.
- Attendance figures from the week before our inspection showed that some patients waited between two and three hours before being clinically assessed.
- Some patients were not triaged by a nurse at all. If the receptionist thought their injury or ailment was a minor one they would wait to see an emergency nurse practitioner. There was a list on the wall in reception describing the injuries and ailments that did not need rapid assessment. These included minor head injuries, knee injuries or pain, shoulder or elbow pain. The list applied to children over one year as well as adults.
- Data from the previous week showed that some patients waited one or two hours before seeing an emergency nurse practitioner.
- This meant that their condition could deteriorate because no-one had identified any risks that may be associated with it.
- Some of the reception staff that we spoke with expressed concern about deciding whether injuries were minor or not. They sometimes found this difficult as they did not have any clinical training.
- There was particular concern regarding children. We were told that a child would often stay with one parent while the other completed the registration process. This meant that receptionists sometimes did not see children before deciding whether their illness or injury was a minor one.
- A position statement issued by the RCN and RCEM states that "Staff undertaking this role (triage) should be registered healthcare professionals experienced in emergency/urgent care who have received specific training and can demonstrate developed interpersonal skills so that they are able to communicate effectively with patients and their families in what is often a stressful situation". Triage should not be carried out by a receptionist, however experienced.
- During the unannounced inspection we raised concerns regarding the triage and streaming process within the ED.
- The trust indicated in a letter dated 27 March 2015 that a revised Standard Operating Policy would be developed and that discussions within the directorate have begun already around this. The review would consider and develop a proposal to ensure that the department had enhanced 24 hour cover of nursing staff, appropriately skilled in the assessment and triage of children. The review would also assess the respective skills of those undertaking triage in both the ED and urgent care centre and would consider if further training and development would deliver improved flexibility and more efficient use of these highly skilled staff. This review was to be completed by the end of April 2015.
- Following feedback to the trust we visited the ED department unannounced twice to check improvements had been made. We found the trust had implemented a nurse led streaming service between 8am to 10pm each day.
- Both clinical and non-clinical staff told us it was no longer the responsibility of the reception staff to stream patients and felt this was much more efficient.
- Data received from the trust showed between 1 April 2015-10 May 2015 52% of patients had been seen within 15 minutes of arrival. 25% of patients were seen between 15-30 minutes, 19% 30-60 minutes, 3% 60-90 minutes, 1% 90-120 minutes and less than 1% waited over 2 hours. The maximum wait was 146 minutes.
- The national early warning scores (NEWS) were used throughout the department. This is a quick and systematic way of identifying patients who are at risk of deteriorating. Once a certain score is reached a clear escalation of treatment should be commenced.

- The scores were not used when requesting a bed on a ward when patients needed to be admitted. This meant that the manager trying to find a bed did not have an objective understanding of the seriousness of the patient's condition.

Nursing staffing

- Nurse staffing levels were based on historical establishments which had been reviewed over time to take account of changing demand. A specific staffing acuity tool was not used**.**
- We looked at the duty rota for the fortnight beginning 16th March 2015 and compared it to the A&E staffing recommendations issued by the National Institute for health and Clinical Excellence (NICE).
- Based on the size of the department and the number of patients cared for the NICE guidelines indicate that there should be at least ten nurses during the day and six or seven at night. The duty rota showed that there were between five and seven nurses during the day and three at night. There were one or two additional nurses in the evening but they left at midnight.
- The lead nurse for A&E told us that he tried to achieve the staffing levels recommended by NICE by employing temporary nurses from an agency. However, there were not always sufficient temporary nurses available who were able or wished to work in the A&E department.
- Although agency nurses are fully qualified they do not always have specialist experience needed in ED and have often not worked in the department before. This means that some patients will not be looked after by nurses with the experience required. Senior staff told us that agency nurses often did not have the clinical assessment skills required in an emergency setting and did not have up-to-date resuscitation skills.
- It was not possible to comply with NICE recommendation to have a Band 7 sister in charge of the department on each shift because the department did not employ sufficient nurses of this seniority. During the two weeks that we looked at there was never a band 7 sister on duty at night. The weekend of 28th and 29th March 2015 had no band 6 or band 7 nurses on duty at night. This meant that the nurse in charge of the department was an inexperienced band 5 staff nurse.
- The national Intercollegiate Standards for children and young people in emergency care settings state that there should be a registered sick children's nurse (RSCN) on duty at all times. The A&E department only employs one part-time RSCN and so there is rarely a properly qualified nurse to look after sick children.
- During the unannounced inspection we reviewed the off-duty and found the planned numbers of staff were either achieved or exceeded.
- We found there was always a nurse on streaming as per SLA with urgent care centre between the hours of 8am and 10pm.
- Staff told us told that staffing across the department in its entirety was an issue and although streaming would be covered the nurse would often have been planned to be on duty somewhere else within the department.

Medical staffing

- We found the department did not comply with RCEM guidelines for consultant staffing. This states that there should be a consultant in the department for sixteen hours a day.
- The consultant rota allowed a consultant presence from 8am until 8pm during the week and from 10am until 2pm at weekends. There was a consultant on-call at night.
- Junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive.
- We saw a consultant working clinically in the department. They lead the treatment of the sickest patients, advised more junior doctors and ensured a safe clinical handover of patient's treatment when shifts changed.

Major incident awareness and security.

- The hospital had a major incident plan (MIP), which was up-to-date and detailed. The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries, including those caused by burns or blasts and chemical contamination.
- Staff in the ED department were well-briefed and prepared for a major incident and could describe the

processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT).
- ED staff told us they felt there were insufficient security staff in the hospital.

Are urgent and emergency services effective?
(for example, treatment is effective)

Requires improvement

Overall we rated the effective domain as requiring improvement. Patients' care and treatment were planned and delivered in line with current evidence-based guidance, standards and best practice. There was participation in national clinical audits. Information about effectiveness was shared with, and understood by, staff working in the department.

Evidence-based care and treatment

- The ED department used a combination of NICE and College of Emergency Medicine (CEM) guidelines to determine the treatment that was provided. Guidance was regularly discussed at governance meetings, disseminated and acted upon as appropriate.
- A range of clinical care pathways and proformas had been developed in accordance with guidance produced by NICE.
- At monthly governance meetings any changes to guidance and the impact that it would have on their practice was discussed.
- The department did not satisfy the requirements of the national "Intercollegiate Standards for children and young people in Emergency Care settings".
- The ED participated in a number of national audits, including those carried out on behalf of the College of Emergency Medicine (CEM).

Pain relief

- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department. However, patients sometimes waited for over two hours to be assessed which delayed effective pain relief.
- Although formal pain scores were not always assessed, four of the five patients that we spoke with reported that they had been offered appropriate pain relief.

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed and administered and recorded when clinically indicated.
- A "comfort round" and was meant to take place hourly. However staff told us this was difficult to maintain when the department was busy.

.

Patient outcomes

- The CEM Consultant sign off audit measures a number of outcomes, including: whether a patient has been seen by an A&E consultant or senior doctor in emergency medicine prior to being discharged from A&E when they have presented with non-traumatic chest pain (17 years of age or older), children under one year of age presenting with a high temperature and patients who present back to the ED within 72 hours of previously being discharged by an ED. Results from the 2013 audit showed that A&E at Scarborough performed better than many other departments in the country.
- The CEM audit of fractured necks of femur (broken hips) showed that pain relief was poor but that patients were sent to X-ray and were admitted more quickly than most other departments.
- Audits for renal colic, sepsis and feverish children showed similar results to other A&E departments.

Competent staff

- Appraisals of both medical and nursing staff were being undertaken and staff spoke positively about the process.
- For the period July 2014 – November 2014 there was 82% of registered nurses who had a current appraisal; 28% of staff in additional clinical services and 90% of administrative and clerical staff.
- We spoke with junior doctors, who told us that they received regular supervision from the emergency department consultants but weekly teaching sessions were sometimes cancelled if the department was busy.

- We were given a list of nurses who had attended training in resuscitation and trauma skills. The list did not contain any dates so it was not possible to know whether the skills and knowledge required was up-to-date.
- New nurses underwent a two-week orientation programme that involved working with an experienced nurse. This was supported by an induction programme that set out the skills nurses needed to learn.
- A competency framework had been developed for band 5 nurses so that they could develop the skills required to be a competent A&E nurse. This also prepared them for more senior roles.

Multidisciplinary working

- There was effective multidisciplinary working within the A&E department. This included effective working relations with specialty doctors and nurses, mental health teams, social workers, therapists and GPs.
- Medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

Seven-day services

- The ED consultants were not present in the department 24 hours a day. They were however present seven days a week from 8am to 8pm and provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.
- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when indicated.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- The computer systems provided up-to-date information about patients' condition and progress within the ED. However previous information about patients who had previously been admitted was difficult to find.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Senior staff displayed a commitment to the use of new mental capacity assessment forms although they were not able to show us any examples during the inspection.

Are urgent and emergency services caring?

Good

Overall we rated the caring domain as good. We spoke with patients and relatives who told us on the whole they were happy with the care they received. The majority of patients that we spoke with said that they had been involved in the planning of their care and had understood what had been said to them.

Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.

Compassionate care

- We observed that care was sometimes rushed and that patients and their families were not always informed about their care.
- Staff rarely introduced themselves by name or sometimes did not explain treatment plans in terms that were easily understood.
- However,we spoke with 13 patients and a number of family members. On the whole, they were happy with the care that they had received. One said "The staff here are brilliant".
- In 2014, 85% or people who took part in the NHS Friends and Family test for A&E said they would recommend the department. This was slightly less than the national average of 87%.
- The trust scored similar to other trusts in the A&E Survey 2014. The questions covered on access to care,

safeguarding, cleanliness, nutrition and hydration, pain relief, compassionate care, patient understanding and involvement, emotional support and access and flow and meeting patient individual needs.

Understanding and involvement of patients and those close to them.

- The majority of patients that we spoke with said that they had been involved in the planning of their care and had understood what had been said to them.
- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.

Emotional support

- Support was poor for relatives of patients who needed to be in the resuscitation room. We observed the family of a very sick child who had been brought in by ambulance. They were separated from the child and were asked to wait in the relatives' room. This was in an isolated part of the department and there was no-one to support them while they waited. No-one in the resuscitation room took responsibility for updating them on their child's progress. After half an hour we saw that they looked upset and anxious and asked them if they knew what was happening. They said that no-one had been to see them.
- When we later asked staff about emotional support for relatives they told us that they tried to provide this but a lack of experienced staff meant that it was not always possible. They told us that hospital chaplains were always available if they were needed.

The relatives' room was large enough to accommodate several people and was appropriately equipped.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Overall we rated the department as requiring improvement for being responsive. We found less than 50% of nurses had received training about the needs of people with dementia and only a third had received training about learning difficulties.

The department had been unable to meet the national target of admitting or discharging 95% of patients within four hours and between 1 October 2014 and 31 December 2014 there had been 349 recorded black breaches.

Staff responded well to any complaints or concerns and used learning from these to improve future care and treatment.

Service planning and delivery to meet the needs of local people

- The staff told us the department had an escalation plan which described how it prepared in advance to deal with a range of foreseen and unforeseen circumstances where there was an unusually high demand for services.
- Senior staff told us that progress has been made in response to the CEM report "How to achieve safe, sustainable care in our Emergency Departments.

Meeting people's individual needs

- We found less than 50% of nurses had received training about the needs of people with dementia and only a third had received training about learning difficulties. When we discussed these issues with them their knowledge was vague although sympathetic.
- People with learning disabilities attended a listening event organised by CQC before the inspection. We were told that they had been treated with respect and consideration but their special needs were not fully understood. Their difficulties in describing symptoms had occasionally led to delayed diagnosis.
- Staff were able to describe the translation services that were available to the department. They were familiar with their use.

Access and flow

- All A&E departments in England are expected to receive and assess ambulance patients within 15 minutes of arrival. Scarborough Hospital had failed to meet this target over the last year. The latest average waiting time that we have been given (December 2014) was 25 minutes.
- Between 1 October 2014 and 31 December 2014 there had been 349 recorded black breaches. Black breaches are defined as the time between an ambulances arriving at a hospital to the patient being formally handed over to the trust which is longer than 60 minutes.

Urgent and emergency services

- The ED at Scarborough hospital had not achieved the national emergency access target to admit, transfer or discharge 95% of patients within four hours of arrival. This target had not been met since May 2014, 20% of patients waited between four and 12 hours to be admitted to a ward. The trust also had a number of patients that breached 12 hour waits
- There is an obvious awareness of the importance of the four hour target amongst admitting teams of clinicians and ward staff and there is evidence that they are committed to achieving it. We heard a number of conversations between admitting teams regarding how they could best admit a patient to a ward within four hours.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, who would formally log their complaint and would attempt to resolve their issue within a set period of time. PALS information was available within the main ED.
- Formal complaints were investigated by a consultant or the nurse manager and replies were sent to the complainant in an agreed timeframe. Learning points from complaints were discussed at ED governance meetings and at nursing staff meetings.

.

Are urgent and emergency services well-led?

Requires improvement

Overall we rated the service as requiring improvement for being well-led. Although there was not a written strategy all staff that we spoke with understood the vision for the department. They wanted to rapidly assess and treat all patients presenting to the department in a safe and effective manner. Senior staff told us that there was a strategy for achieving the vision. However, it had proved difficult to implement.

Monthly governance meetings were held and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed.

Nursing and medical staff told us that the senior clinical and managerial staff had the knowledge, skills and personal integrity to effectively lead their department. Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.

Vision and strategy for this service

- Although there was not a written strategy all staff that we spoke with understood the vision for the department. They wanted to rapidly assess and treat all patients presenting to the department in a safe and effective manner. They were clear about what the department did well and where it could improve.
- Senior staff told us that there was a strategy for achieving the vision. However, it had proved difficult to implement. This was mainly due to a lack of consultant medical staff and difficulties in admitting patients to wards leading to slow patient flow and a crowded department.

Governance, risk management and quality measurement

- Quarterly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed. Attendance was variable.
- The ED maintained a risk register which fed into the hospital risk register. We asked how departmental risks were included in the hospital risk register. The procedure was described to us but we were told that it did not always work in practice. This meant that there were difficulties escalating severe risks to senior staff within the trust.
- Monthly governance meetings were held and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed.
- At the time of the inspection we raised concerns regarding a possible theme for some of the incidents reported. The executive were aware of the incidents.

However, a themed review had not been completed to ascertain whether there were systematic failures in the streaming and clinical assessment of patients with headaches.

- Following the inspection the trust, in a letter dated 27 March 2015 informed us that the reports for the specific incidents had been completed and have been reviewed by the serious incident group. Some actions have already been implemented and none of the cases related to the process for streaming and clinical assessment.
- There was no evidence provided of an assessment of the staffing in the ED in relation to the recently developed NICE guidance.
- During the inspection we were informed that a new urgent care centre (run by another provider) was opening adjacent to the emergency department at Scarborough Hospital two weeks after the inspection. The service shared the same reception and initial screening staff with the ED. At the time of the inspection there were no formally agreed standard operating procedures or formally agreed contracts in place; training was proposed to take place during the week that the unit opened. In addition the agreed opening was during the Easter bank holiday. The trust's governance had not highlighted this to be a risk to the organisation, and there was no risk mitigation plans in place. We fed back to the Trust our concerns during the inspection and wrote to the trust requesting further assurances regarding the safety of service element run by the Trust which included evidence of training and additional staffing. Evidence from the trust and unannounced inspection indicated that most but not all staff had been trained and that during the day an ED nurse was allocated to deliver the initial screening of patients.

Leadership of service

- Leadership and management of ED were shared between a clinical lead, lead nurse and directorate manager.
- The directorate manager was shared with the A&E department at York and the lead nurse was on secondment from York.
- Nursing and medical staff told us that the senior clinical and managerial staff had the knowledge, skills and personal integrity to effectively lead their department.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.
- We were told that concerns were investigated in a sensitive and confidential manner and that lessons were shared and acted upon.
- The culture within the department was centred on the needs and experiences of people who used the service.

Public and staff engagement

- Staff felt actively engaged by the A&E leadership in the planning and delivery of services.
- The Friends and Family test indicated that the percentage of people who would recommend the department to others was variable. It ranged from 80% in December 2013 up to about 92% in July 2014. The trust had been actively encouraging patients to respond to the survey.

Innovation, improvement and sustainability

- The clinical lead told us of plans to open an urgent care centre next to the A&E department. This was due to happen in the next few weeks and it was anticipated that it would reduce waiting times for the sickest patients in the A&E department.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Scarborough Hospital forms part of the York Teaching Hospital NHS Foundation Trust. Medical care at Scarborough Hospital comprises eight medical wards, an acute medical unit (AMU), an ambulatory care provision (Haworth unit), and also a discharge lounge. The ambulatory care service provides planned treatments and ongoing monitoring for patients with long-term conditions, and accepts urgent referrals from GPs for assessment and diagnostic testing for conditions such as suspected deep vein thrombosis (DVT) and pulmonary embolism (PE). The medical directorate includes a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, stroke, gastroenterology, endocrinology and haematology.

During the inspection we visited all medical wards, including the AMU and the ambulatory care area. We spoke with 15 patients and relatives, and over 30 members of staff, including doctors, nursing staff, therapists, volunteers, non-clinical staff and managers.

We also observed care and treatment, and looked at patient electronic and paper records, including medical notes, nursing notes, and drug charts. We looked at the care records of 12 patients. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Overall, we judged this service as requires improvement. In the main, patients were protected from avoidable harm and abuse. However, the provider was unable to consistently provide safe staffing levels. Mandatory training compliance needed to improve across medical services.

Following the acquisition of Scarborough hospital staff told us they were confused about which protocols and the lack of availability of some protocols. Results from the Sentinel Stroke National Audit Programme (SSNAP) showed no recent improvement, and there were a number of indicators from other national audits that were below the national average.

Patients were happy with the care they received, and found the service to be caring and compassionate.

There were concerns about the management of patient flow through the hospital including access to senior medical staff to make timely decisions, and delayed discharges.

Staff told us that they were well supported by their immediate line manager, but the executive and senior divisional leadership was reported to be lacking in visibility and effectiveness. Staff shortages impacted upon ward manager's ability to effectively lead their teams. Some staff did not feel that they were always actively engaged or consulted regarding service changes.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Medical services provided at Scarborough Hospital were rated as requires improvement for safety. In the main, patients were protected from avoidable harm and abuse. However, the provider was unable to consistently provide safe staffing levels. There was poor compliance with mandatory training requirements. Although staff we spoke with at Scarborough indicated that they were up to date with mandatory training, and training was easily accessible, data showed that compliance rates for some elements of training were low. For some of the staff groups in the medical or elderly directorates, completion rates of children's and adult safeguarding were as low as 21% and 29% respectively. Incidents were reported by staff, and learning fed back to staff. The trust was aware of areas in which it needed to improve (such as falls), and there was an established falls panel which evaluated the investigation, findings and learning from falls incidents. The medical wards were clean and tidy, and there were regular cleaning schedules in place. The trust used the National Early Warning Score (NEWS), and staff could easily escalate deteriorating patients to medical staff.

Incidents

- There had been 756 incidents reported in the medical care service at Scarborough and Bridlington hospitals, during the period from October to December 2014. Thirteen of these were classified as resulting in moderate harm or above. The largest category of incidents were those relating to slips, trips and falls.
- All incidents graded as moderate or above were investigated using root cause analysis (RCA) methodology.
- Incidents were reported using 'Datix', the trusts electronic incident reporting system. Managers told us that they encouraged staff to report incidents.
- Incidents were investigated in line with trust incident management policies and procedures, and the senior sister aimed to have responses for patients and families ready within a two week time frame.
- A ward manager in one area showed us the ward communication folder, which was kept at the nurses' station for all staff to access and read. The communication file held quality and safety information, which included compliance against a number of key quality indicators, including information regarding incidents. The incident summary report for January 2014 to February 2015 showed all of the incidents reported across the medicines directorate by type, and gave the details of the actions taken as a result of each incident. The outcome of the RCA investigation of serious incidents (SIs), together with their associated action plans, were also held in this file to be shared with staff.
- In addition to the communication file, safety briefings occurred each morning, at handover. Incidents were discussed there to identify whether an incident could have been avoided, and what actions were needed to reduce the likelihood of future incidents occurring.
- Staff were aware that the number of falls was an issue for the trust, and the investigation of falls incidents were reviewed by a falls panel to ensure robustness of investigation, and that key messages were shared, and improvements made in all relevant areas of the trust.
- Actions taken by the trust to reduce the number of falls included the use of red non-slip socks to highlight patients at risk of falling; movement sensors were also used, and patients were nursed in cohorts when one-to-one nursing levels were unavailable.
- We were told that regular safety incident bulletins were made available to staff, and incidents were reviewed and discussed at shift handovers.
- Staff we spoke with were familiar with the incident reporting system, and told us that they regularly reported incidents and near misses.
- We saw that the Duty of Candour information was publicly displayed, and the duty was included as a mandatory field for completion within the incident reporting and management system.
- Staff understood the principles of Duty of Candour and when this should be implemented.
- Consultant mortality reviews were undertaken on every death, and there was a monthly summary discussion of all cases.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms, and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.

Medical care (including older people's care)

- We were shown the Safety Thermometer information, which was held electronically on the 'signal system', the trusts electronic safety report system. This was held with the matrons' reports library, which allowed the matron to monitor the wards' overall performance data.
- Oak Ward was identified as a ward that required support to improve, and plans were in place to improve ward safety indicators, such as falls, complaints and pressure ulcers. We saw on Oak Ward that indicators were improving, and for March 2015, 87.07% of routine observations were completed within the one hour goal, against a target of 90%.
- We saw that the system included a range of safety information, recorded monthly for the past 12 months. Safety incidence information included falls, pressure ulcers, catheter-associated urinary tract infections (CAUTIs), deteriorating patient, venous thromboembolism (VTE), hand hygiene and infections.
- The information held on the 'signal system' was used to populate the ward governance and assurance chart, which was on display for staff to review.
- Over the previous year, the medical directorate had maintained a consistently low rate for pressure ulcers, except for one peak in May 2014. Falls and CaUTIs remained low throughout the year.

Cleanliness, infection control and hygiene

- The wards were visibly clean and mostly tidy, although some wards had limited storage space and appeared cluttered.
- Single sex accommodation was maintained, and bathroom and toilets clearly labelled male and/or female.
- All of the patients appeared comfortable and well cared for.
- We saw staff washing their hands prior to, and in between, providing care to patients, and wearing PPE appropriately. Posters giving information about hand-washing techniques were clearly displayed. Gels and soaps were in sufficient supply around the ward.
- Coronary care staff told us that their last infection prevention and control audit had achieved a score of above 90%.

Environment and equipment

- The environment in the ward areas appeared clean and well maintained. Daily cleaning checks were displayed and up to date. Clean stickers were attached to equipment in readiness for the next use.
- Staff said that in the main, equipment to meet patients' needs was available. We observed that a request for a pressure-relieving mattress was not actioned immediately on the AMU, as the equipment library was out of stock. The member of staff told us that this did not happen very often, and that the ward could hire a bed directly when this did happen.
- Resuscitation trolleys were available, along with portable oxygen and suction. On most wards, daily and weekly checks of this equipment were up to date. Emergency drug boxes were sealed, with an expiry date visible and in date. On the coronary care unit (CCU), Oak and Graham Wards, we saw that the equipment was not consistently checked in accordance with trust policy and guidance.
- The layout of the Haworth Unit was not ideal for its purpose. There was nowhere to store medicines within the main treatment area, and they needed to be kept in a treatment room used by the specialist nurses. This meant that on occasions, patients had to wait for medications when the second room was in use, or patients had to be disturbed. A second concern raised by staff was that there was no lock on the door to the main treatment area, and this meant that staff had to move all equipment from this room into a lockable area each evening.
- We looked at other equipment and refrigeration, and found they were appropriately checked, cleaned and maintained.

Medicines

- On the wards we found that medicines were stored, prescribed and administered safely.
- We reviewed a sample of medication administration records, and we saw that most of the medication had been administered as prescribed, and medicines had been administered at appropriate times.
- Pharmacy staff carried out a full clinical check of all prescription and administration records daily, Monday to Friday.
- Omissions of critical medicines were monitored monthly, and the results were shared with ward staff to identify areas for improvement.

- Nursing staff told us that they had easy access to medicines information, and that a pharmacist would discuss medicines with individual patients if this was requested.
- An additional pharmacy discharge team had recently been established, which had improved medicines reconciliation on admission, speeded up responses to discharge prescriptions, and helped to reduce critical medicine omissions.
- Medicines were stored safely, and pharmacy staff audited medicines security and the management of controlled drugs on a regular basis.
- Fridge temperatures were monitored daily and recorded appropriately.
- We observed nurses administering controlled drugs, and checking that documentation and administration were carried out safely and correctly.
- The pharmacy team undertook analysis of medication errors.
- Nursing staff on Beech Ward told us that patients were sometimes discharged without their medicines, because discharge prescriptions were not always available in a timely manner. This led to medicines being taxied to a patient's home, or the patient/relative returning to the hospital to collect them.

Records

- Patient's records were a combination of both electronic and paper records.
- A range of risk assessments were included within the electronic records: such as falls, manual handling, Waterlow scores, nutrition and body mass index (BMI), bed rails, early warning scores, and neurological observations to manage the deteriorating patient.
- We did note from one set of records we reviewed on the stroke unit that a social worker had not made an entry on the day of their visit. This had been identified by the ward staff, and an entry of a follow-up call with the social worker was recorded. The sister agreed to follow-up on this issue. Apart from this one omission, we saw the patient record was comprehensively completed and up to date.
- The bedside records were completed and up to date for blood glucose level monitoring, fluid intake and food intake, and the patients overall comfort observations.
- The electronic risk assessment records were completed and up to date, and included the use of bed rails, falls, nutrition, daily blood sugar levels, manual handling and EWS observations.

Safeguarding

- Staff we spoke with were aware of their roles and responsibilities in safeguarding adults, and they were able to explain safeguarding referral processes.
- Staff told us that there was a safeguarding team, who were accessible for advice and guidance when needed.
- There was a safeguarding e-learning programme available.
- We saw a range of safeguarding information displayed on notice boards for staff reference.
- Despite staff indicating that they were up to date with safeguarding training, data indicated that uptake against the trust's targets was low, for both nursing and medical staff in the medical directorate.
- Aggregated Scarborough and Bridlington data for the elderly medical care wards showed 61% compliance with adult safeguarding training for nursing staff, and 29% compliance for medical staff, against a target of 75%. Children's safeguarding training compliance was 61% for nursing staff, and 21% for medical staff, against a target of 75%.

Mandatory training

- Most of the staff we spoke with told us that they were up to date with their mandatory training and appraisals; however, trust data indicated poor compliance in a number of areas.
- On the stroke ward we were told that staff statutory and mandatory training, such as fire, manual handling, nutrition, and infection prevention and control, were up to date. Medicines management, dementia and end of life care were not as up to date, and 50% of staff appraisals were not completed, as staffing challenges had impacted on progress. The ward manager told us that there was a plan in place to address completion.
- Data reported for Scarborough also includes the elderly medical wards on the Bridlington site. At the time of the inspection the trust target for compliance was 75% for all categories. Compliance rates with mandatory training for Scarborough and Bridlington acute and elderly medical directorates varied. From the data provided medical staff had only achieved the 75% for one of the categories: 75% for blood safety by the acute

medical doctors, it was 58% for the elderly medicine doctors. All other medical staff training was non-compliant with the 75% target. Other medical training ranged from dementia awareness 15% for elderly medicine doctors, infection prevention and control 42% for elderly medicine doctors and 72% for acute medicine doctors and person with a learning disability awareness training was at 25% for elderly medicine and 48% for acute medicine doctors. For nursing staff in elderly medicine there were only four of 18 areas of mandatory training that were above 75%. Areas below included: Moving & Handling Training (practical) 14%; Person with a learning disability awareness 23% and infection prevention and control 64%. For nursing staff in acute medicine five of the 18 areas of mandatory training that were above 75%. Areas below included: Moving & Handling Training (practical) 24%; Person with a learning disability awareness 43% and nutrition 34%.

Assessing and responding to patient risk

- All wards used the National Early Warning Score (NEWS) system to identify patients' whose condition was deteriorating. Patient observations were recorded appropriately, and concerns were escalated in accordance with the guidance.
- Basic observations, such as blood pressure, pulse and respirations were recorded electronically, and these were up to date. We saw that there were standard operating procedures and escalation procedures displayed for managing the deteriorating patient. The staff we spoke with were able to explain the procedures for managing the deteriorating patient.
- Frequency of observations was set by the registered nurses (RNs), based on NEWS scores and clinical judgement.
- Risk assessments were also recorded electronically, and a risk scoring system was in use.
- Training was being rolled out to aid the recognition of the deteriorating patient and sepsis.
- Risks associated with falls, pressure ulcers, VTE, and catheter and urinary infections were assessed on a monthly basis using the NHS Safety Thermometer assessment tool.
- Multidisciplinary meetings occurred daily to discuss patient's progress and goals, and any patient safety issues.
- Medical staff told us that GP referrals to the acute medical unit were triaged by the bed managers, which meant that the specialist registrar (SpR) on duty did not always know the how ill the patient was, or the patient's medical diagnosis, until they arrived on the unit. We were told that sometimes the bed manager would contact the SpR with information, but that this did not always happen.

Nursing staffing

- Information on planned and actual staffing numbers was reported to the trust board monthly, and submitted nationally in accordance with requirements.
- The hospital had told us that recruitment to nursing vacancies was extremely difficult, and that this was particularly an issue for the medical care service. We observed from staffing data available that nurse staffing issues were most acute during the day.
- It was also reported that it was sometimes difficult to fill healthcare assistant (HCA) shifts.
- The registered nurse vacancy rate for the medical service at Scarborough Hospital was 30.86%.
- In January 2015, none of the wards within the medical directorate filled over 90% of the required shifts for registered nurses (RNs), and only two of the wards filled over 80% of RN day shifts. Only two wards achieved more than a 90% fill rate for support staff on day shift, and four wards fill rate for support staff on days was less than 80%. Night shifts on five of the wards achieved a 90% or better fill rate for RNs; the remaining three wards had less than an 80% fill rate for RN night shifts. Two wards had less than a 90% fill rate for support staff on night duty.
- Where low numbers of RNs were evident, the hospital tried to provide greater numbers of healthcare assistants, but this had only been possible on some of the wards during January 2015.
- The shortage of RNs was particularly acute on Oak and Graham Wards during January, with fill rates of 66.7% and 68.8% respectively for day duty. Oak Ward had achieved a RN fill rate of 90% on night duty during January, but Graham Ward had only 62.1% of RN shifts filled on night duty for the same time period. Oak Ward had 2 RN vacancies, and had recently appointed a band 6 deputy sister not yet in post.
- Staff in a number of areas told us that they were frequently moved to other areas to support staff shortfalls. With the exception of the stroke ward, there

were no records of staff movement available. Staff reported that moves were so frequent that they had an adverse effect on staff morale, and in some areas staff felt very strongly that this situation had directly increased staff turnover.

- Staff on the stroke unit told us that their actual figures were often down by one RN due to movement of staff to other areas of the hospital. The stroke specialists (band 6 and 7 staff) were also included within the daily RN numbers and could often be dispatched to support the emergency department. Staff felt that movement, and the stroke nurses commitment to support A&E, meant that staffing on the ward could become unsafe. A written record of the daily staff movement was maintained. Staff movement records indicated that an average of 20 staff were moved each month between November 2014 and February 2015. to cover other areas of the hospital.
- Nursing staff on the wards told us that they felt they could not always deliver the standard of care they would like to, due to insufficient numbers. There were processes in place to escalate staffing concerns should they arise.
- Nursing staff told us that security staff regularly needed to be called to assist with patients with challenging behaviour.
- A staffing acuity/dependency tool was used twice yearly, which determined staffing establishment.

Medical staffing

- Medical staffing was made up of a higher proportion of consultants than the England average; the proportion of middle career doctors was the same as the England average, and registrars were lower than the England average. The proportion of junior doctors was slightly higher than the England average.
- There was 24 hour, seven days a week consultant cover and junior doctor availability. Out-of-hours cover was provided at nights and weekends.
- The 'hospital at night' consisted of two senior house officers (SHO) and one specialist registrar (SpR) to cover AMU and the wards. Medical staff we spoke with felt that this was inadequate.
- Foundation year 1 (FY1) doctors did not do night time on–call duties, but covered normal working hours, and when on-call, covered weekdays 5pm to 10pm, and weekends 9am to 10pm.
- Junior doctors reported good supervision and support from senior doctors and consultants, and that they could easily escalate patient concerns to a SpR out of hours.
- Medical staff reported good communication and handover of patients, and attended daily board rounds as part of the multidisciplinary teamwork activities. One doctor told us how a formal handover sheet had been introduced to improve effectiveness of handover at weekends.
- Junior medical staff were ward-based, and nursing staff reported that this had made a huge, positive difference to the ward, and to the availability of medical staff and work time available.
- The AMU was covered by two consultants each day, 8.30am to 7pm, Monday to Friday. Overnight consultant cover was provided by the general medical consultant on-call. At weekends, general medical consultants were on-site. There was a team of three AMU doctors at SHO level who covered Monday to Friday, with out-of-hours cover provided by the medical on-call team.
- A consultant told us that the standard of care provided by the SHOs on AMU was excellent. Other medical staff told us that medical cover on AMU was sufficient to meet demand and patient needs almost all of the time.
- Staff told us that shortages of acute medical consultants and specialist consultants adversely affected patient flow and length of stay, as there was no daily senior decision-making in some areas. Consultant ward rounds tended to be two or three times a week.
- Ambulatory care was, in the main, a nurse-led service, with treatments provided under consultant direction or according to strict protocols or pathways. Senior medical staff were accessible to nursing staff when the need arose.
- Junior medical staff had some concerns regarding staffing and junior medical cover. We were told that patients were allocated to specialist consultants, and could be on any medical ward, or potentially outlying on a non-medical ward. This meant that it was difficult to keep track of all patients needing to be seen, and it also took longer to review patients who were spread over a number of wards. We were told that there was an inconsistent approach to allocating patients to consultants, which made providing safe, effective care more difficult.

Medical care (including older people's care)

- There were a number of consultant vacancies, which had been difficult to recruit to and remained unfilled. Vacancies were apparent in A&E, respiratory medicine, cardiology, neurology and gastroenterology.
- The trust was supporting the development of 16 advanced care practitioners (ACPs) to help address some of the medical staffing shortfalls.
- Stroke priority nurses could request scans, and out-of-hours telemedicine was available for consultants to review scans at home.
- Doctors at all levels told us that medical shift patterns, ways of working, and on-call and cover arrangements, including consultant cover, were too varied to be efficient, and impacted upon patient safety and effectiveness, and access and flow of patients throughout the hospital.

Major incident awareness and training

- The trust had a major incident plan, which provided guidance on the actions to be taken.
- There was a business continuity plan for the trust, and site-specific plans were also available.

Are medical care services effective?

Good

Medical services at Scarborough were rated as good for delivering effective care. Policies and pathways were based on NICE and Royal College of Physicians guidelines, and were available to staff, and accessible on the trust intranet site. The trust participated in national clinical audits. The results from the Sentinel Stroke National Audit Programme (SSNAP) showed no recent improvement, and there were a number of indicators from other national audits that were below the national average. The stroke pathway was being reviewed to facilitate improvements in effectiveness and patient safety.

Not all pathways and protocols had been harmonised following the merger of the York and Scarborough trusts, and this had led to some confusion among staff, and a lack of availability of some protocols.

We witnessed good multidisciplinary team working during our inspection, and this was corroborated by feedback from all disciplines spoken with. Overall, Scarborough Hospital had a shorter length of stay than the England average for elective admissions, but a longer stay than the England average for non-elective admissions. The re-admission rate for non-elective patients was better overall than the England average.

Evidence-based care and treatment

- Not all pathways and documentation had been harmonised following the merger of the Scarborough and York trusts, and there was some uncertainty on occasions regarding the correct paperwork or protocol to use.
- On the cardiology ward there were clear care pathways for angiography; however, there was no clear protocol regarding permanent pacemakers and anticoagulation, and staff reported that this was confusing.
- Policies and pathways were based on NICE and Royal College of Physicians guidelines, and were available to staff, and accessible on the trust intranet site.
- The Haworth Unit had care plans and pathways for a number of presenting conditions, which included DVT, cellulitis and PE, as well as a number of care plans for regular planned treatments.
- Ward managers had an audit day every month (and used a tool called QUEST) to monitor compliance with guidance and key quality indicators, such as staffing, sickness, appraisals, capacity, the Friends and Family Test, patient harm and MDT effectiveness.
- We saw that this information was held in staff communication files, so that staff could access their results and progress, and that any issues were easily visible. Ward managers would address any issues highlighted by these reports with their staff, and implement action plans as appropriate.
- The stroke unit had a number of specialist nurses at band 6 and 7, who were part of the ward establishment, and available to provide specialist support to the emergency department.
- The stroke pathway and supporting documentation had been developed in line with national and NICE guidance. The pathway was a multidisciplinary record of the patients care and treatment.
- The stroke pathway for the York Teaching Hospital NHS Foundation Trust was under review, to improve effectiveness of treatment across the trust. The on-call stroke consultant also provided support to the Scarborough Hospital through the use of telemedicine

outside of normal working hours, to ensure thrombolysis was given appropriately, and within the critical time window, before patients were transferred to York for further treatment.
- The nurse in charge on the cardiology ward was trained to advanced life support (ALS) standards, and updated their skills six monthly. All other staff were trained to at least intermediate life support standard (ILS).
- We saw that Sepsis Six cards were in use, and there were posters on display to alert staff, and remind them of the actions they need to take.
- The York Teaching Hospital NHS Foundation Trust had its own service improvement team, which assisted clinicians with work to improve pathways. Senior clinicians told us that there were ongoing projects around developing a mobile chemotherapy service, fast track dermatology services, and improved neurology support.

Pain relief

- We saw that a 0 – 10 pain assessment score was available on the trust's electronic system. There was not an alternative pain assessment tool in use that prompted staff to make a full assessment of a patient's pain incorporating the assessment of body language or facial expressions when patients were unable to score their pain. We did not see clearly documented evaluations of pain in relation to the effectiveness of medication given.
- Regular comfort rounds were carried out, and these included asking patients regularly about their level of comfort or pain.
- Pain was assessed routinely as part of the checks made when undertaking other observations.
- The palliative care and end of life team had on-call staff that were available to provide support regarding pain control, outside of office hours.

Nutrition and hydration

- A nutritional screening and assessment tool was incorporated into the patient admission record to assess patients on admission.
- Nutrition and hydration risks were assessed and monitored via the electronic records. Fluid balance and nutritional intake charts were held and completed at the patient's bedside.
- We looked at patient menus and saw a range of food choices were available to the patient. The menus also highlighted choices such as healthy, gluten free, diabetic and soft consistency options.
- A red mat system was in use on some wards, to identify the patients whose food and fluid intake required recording and monitoring; however, this was not used on Chestnut Ward.
- We saw from the food and fluid intake charts we looked at that these were completed and up to date.
- Four hourly comfort rounds included offering the patient oral fluids and nutrition as appropriate.
- Meal times on wards were displayed as protected times. AMU staff told us that patients' mealtimes were not protected as they should be.
- Patients stated that the food overall was good.

Patient outcomes

- During 2013/14 York Teaching Hospital NHS Foundation Trust participated in national clinical audits and national confidential enquiries, as well as undertaking a programme of local clinical and quality audits.
- In the Sentinel Stroke National Audit Programme (SSNAP) 2014, Scarborough had improved its rating since October 2013, but had remained at a D rating since January 2014. The scale used is A – E, with E being the worst. The sister on the stroke unit acknowledged that the hospital was not performing as well in the SSNAP audit as it would like, and that this was mainly due to not meeting the speech and language, physiotherapy and occupational therapy indicators. The stroke pathway across the trust was being reviewed, to facilitate improvements to effectiveness and patient safety.
- Results from the National Diabetes Inpatient Audit (NaDIA) in September 2013 indicated that Scarborough was performing worse than the national average in 14 of the 19 measures of the Audit. Of the indicators that performed below the national average, these predominantly related to staff knowledge, visit by specialist diabetes team, medication errors, meals, and foot risk assessment. No data was available for whether or not patients were involved in their treatment plans.
- Overall, Scarborough Hospital had a shorter length of stay than the England average for elective admissions, and a longer stay than the England average for non-elective admissions. Non-elective geriatric medicine patients had an average stay of 12.6 days,

against a national average of 9.8 days. Non-elective cardiology patients had an average stay of 6.9 days, against the England average of 5.5 days. Elective gastroenterology patients had an average stay of 5.6 days, against an England average of 3.3 days.

- Emergency re-admissions to Scarborough Hospital within 28 days of discharge from medical wards was better than the England average for all of the top three categories of non-elective admissions. The re-admission rate for elective admissions to gastroenterology was worse than the England average. Overall, elective re-admission rates were better than the England average.

Competent staff

- Nursing annual appraisal rates for the Scarborough medical departments for the period July to November 2014 were: Acute Medicine 80%, Stroke 30%, Respiratory Medicine 75%, Medical Wards 93%.
- Training records could be accessed by the ward manager online, and the IT hub within the training and development department alerted managers when training updates were needed.
- Staff reported good team work and told us that preceptorship programmes for qualified staff and HCAs were in place to support new staff. A newly appointed matron told us that she was receiving a 10 week period of mentoring from a more experienced colleague.
- Staff also told us that they were up to date with their statutory and mandatory training and appraisals, and there were opportunities available to develop clinical practice.
- A trainee HCA on the Haworth Unit told us that there was good access to learning resources and computers in the workplace, and that she was being supported to achieve an NVQ qualification.
- FY1 doctors told us that an hour of teaching was provided for them every week, and that it was usually possible to get to the sessions. The quality of the sessions was usually very good, and a variety of topics were covered, but sometimes sessions were cancelled without notice and people were left waiting.
- Training for ACPs was a two year university training course, to enable them to take on some duties that have been traditionally undertaken by doctors. We spoke to a practitioner who confirmed that the trust was fully supporting and sponsoring this training. As part of the course, practitioners were assigned to support and undertake weekly clinical practice with named clinicians.

Multidisciplinary working

- All medical wards held a multidisciplinary team (MDT) morning board round meeting, which included ward nursing staff, physiotherapist, occupational therapist, consultant and junior medical staff.
- During the inspection, we observed a number of board rounds, and they were seen to include reviews on all of the inpatients care, treatment and daily progress. Key agreed outcomes, goals or tasks were logged onto a white board located within the staffroom for all staff to refer to.
- Some of the key events included medication reviews, referral for assessments by social services, mental health services, clinical diagnostic tests, and review of any results. Moving and occupational therapy progress assessments, family involvement and discharge planning were also discussed.
- We spoke with staff from all professional groups, and they told us that the ward MDT board rounds worked well and promoted effective MDT working.
- The board rounds were a positive way of capturing and communicating a holistic, clinical and social progression of the patients care and treatment.
- The MDT also met weekly to discuss patient's care and treatment progress. The discharge liaison team and community therapy team work closely with social services, and we were told that there had been a picture of improvement since January 2015.
- Nursing staff from the Haworth unit reported good working relationships with GPs, A&E, community nursing teams, consultants and social care, and described how many of their regular patients were supported by multi-agency teams in order to manage their long-term conditions.

Seven-day services

- Physiotherapy and occupational therapy were provided mainly within normal working hours, Monday to Friday, 8.30am-5pm. If patients needed ongoing support at the weekend, they could be referred to be seen by the on duty respiratory physiotherapy team.
- Therapy staff were aware of the trust undertaking a review of the provision of seven-day services.

Medical care (including older people's care)

- Pharmacy inpatient services were available Monday to Friday, 8am to 5pm. There was also a pharmacist and technician on duty on a Saturday morning, and a pharmacy technician on duty on a Sunday morning for dispensing. Night times and weekend afternoons were covered by an on-call pharmacist. Pharmacy staff told us that they would be recruiting additional staff to provide weekend cover from April 2015.
- The Haworth Unit was open Monday to Friday, 8.30am to 4.30pm, for urgent and planned treatments.
- There was a transient ischaemic attack (TIA) service available at Scarborough Hospital, Monday to Friday, and at the York Hospital, Saturday and Sunday.
- The trust was actively moving towards a seven-day working scheme, and were developing a number of business cases across a number of services.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information, such as x-rays, medical records and physiotherapy records, appropriately through electronic and paper records.
- Not all pathways and documentation had been harmonised following the merger of the Scarborough and York trusts, and there was some uncertainty on occasions, regarding the correct paperwork to use.
- Patient records were almost always available for clinic and ambulatory care attendances.
- Specialist nurses, such as the safeguarding team, learning disability lead, and medical staff, were available and easy to access when nurses needed specialist advice or support.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff demonstrated a good understanding of consent, mental capacity and best interest decisions, and accessed training through an e-learning platform.
- Staff had readily accessible guidance and information, and knew who to contact for advice and support if needed.
- Stroke occupational therapists undertook Oxford cognitive assessments on patients, and then if required, referred for a full mental capacity assessment involving social services.
- We reviewed the MDT records for one patient whose mental capacity had been assessed due to a vulnerable adult concern. We saw that a range of hospital assessments had been completed, which included the use of the hospital anxiety and depression scale (HADS), and Oxford cognitive and speech assessments. The team had also requested that the social worker carry out a further mental capacity assessment. It was confirmed that the patient had capacity to make their own decisions and choices. As a result, a case review with the hospital MDT and social services was arranged for the following day, to plan and arrange the patients discharge from hospital.
- Not all staff we spoke to on Graham Ward had a good understanding of deprivation of liberty safeguards (DoLS), and we noticed from a patient's notes that although they had a community DoLS in place, there was no mention of this in the current medical or nursing notes. When discussed with the sister, this was to be discussed with the safeguarding team.

Are medical care services caring?

Good

We rated the medical services good for caring. Throughout our inspection we witnessed good care being given. Interactions between staff and patients appeared natural and easy-going - communication was kind and caring. Patients were happy with the care they received, and found the service to be caring and compassionate. Most patients spoke very highly of staff, and told us that they, or their relatives, had been treated with dignity and respect.

Friends and Family Test (FFT) information for Scarborough Hospital, during February 2015, showed a higher response rate (52.42%) than the England average (39.8%). The percentage of patients who would recommend the services was 93%, against a national average of 95%.

The trust performed in the top 20% of all trusts taking part in the cancer patient experience survey 2013/14 for 18 of the questions, and around the same as other trusts for the remaining 16. The trust performed around the same as other trusts in relevant questions in the national inpatient survey 2014.

Compassionate care

Medical care (including older people's care)

- Throughout our visit, we saw staff interacting with patients in a courteous and professional manner. Curtains were drawn and side room doors closed to maintain patient's dignity and privacy. Staff were seen to provide reassurance when responding to patient enquiries, and whilst performing care interventions, such as moving and handling, and baseline observations.
- The patients appeared comfortable; we also saw that relatives were accommodated if they wished to stay at their relative's bedside.
- Patients we spoke with on the coronary care unit told us that staff were excellent; they were courteous, kind and considerate.
- We saw that regular comfort rounds were in place, and records indicated that these were adhered to in a timely manner.
- Pressure-relieving aids were used to support patients whilst on bed rest or sitting at the bedside. The patients appeared comfortable and well cared for at the time of our visit.
- One confused patient on AMU was distressed by a blood-stained dressing wound site, and told us that the nurse said she had seen it but had walked away. The nurse told us she had not wanted to change the dressing too soon in case of causing further bleeding, but accepted that the sight of the blood might make a confused patient more distressed.
- One patient on Graham Ward complained of rough moving and handling one night, but overall, most staff were excellent, friendly and came when called by patients.
- We saw that staff on the wards actively encouraged patients to leave feedback on their experience. During February 2015, all but one ward achieved a response rate of over 30%. Most of the wards had over 90% of patients who would recommend their ward to others.
- We spoke with 15 patients and relatives throughout the inspection. Most patients and relatives told us that they or their relatives had been treated with compassion, and that staff were caring and responsive to needs.
- The trust performed around the same as other trusts in relevant questions in the national inpatient survey for 2014.

Understanding and involvement of patients and those close to them

- Patients on the coronary care unit told us that staff involved them, and provided sufficient information for them to make care and treatment choices. They were clear about their care and treatment plans, and they told us they saw their doctors on a daily basis.
- One patient on the stroke unit asked to see us. They told us they had been an inpatient for two weeks and the ward was excellent. They also told us how the nurses do their job efficiently; they kept them involved and informed about their care and treatment. They recorded what they drank and ate, and patients understood why thickening additives were required in their drinks. Patients saw the doctor at least twice a week. Asked if the care overall was good, their reply was "better than good top notch".
- We saw that the ward staff actively encouraged patient and family feedback through the Friends and Family Test (FFT), and results and actions from surveys such as the Friends and Family Test were displayed for patients and visitors to see.
- Posters were visible advising patients and relatives what to do if they had any concerns or complaints.
- One patient on Graham Ward told us that they did not really know what was going on, but felt that doctors were approachable to ask.

Emotional support

- Staff were seen to provide reassurance and emotional support to patients when responding to patient enquiries and whilst performing care.
- Staff on the Haworth Unit told us that they had access to private areas, where they could take patients who became distressed and needed additional support, or somewhere to speak in private.
- There was a range of material around the hospital offering information, advice and signposting to people with mental health problems.

Are medical care services responsive?

Requires improvement 

Medical services provided at Scarborough Hospital were rated as requires improvement regarding responsiveness to patients' needs. Scarborough Hospital struggled with the management of flow through the hospital and delayed

discharges. If the AMU did not have available beds, patients referred from GPs waited in A&E. Between July and November 2014, there were 302 medical outliers at Scarborough Hospital.

Ambulatory care services were available, and were being further developed to alleviate patient flow pressures, by working closely with the acute medical unit and A&E staff, to proactively initiate the transfer of appropriate patients into their area for treatment.

Although overall Scarborough Hospital had a shorter length of stay than the England average for elective admissions, patients experienced a longer stay than the England average for non-elective admissions.

Referral-to-treatment (RTT) times for the trust had exceeded standards for all speciality groupings, with the exception of rheumatology, which had achieved 83.3% of patients meeting the 18 week wait standard against a target of 90%. RTT had been consistently better than the England average since June 2013.

The trust was on a par with the England average for national cancer waiting times.

Service planning and delivery to meet the needs of local people

- The services provided by York Teaching Hospital NHS Foundation Trust were predominantly commissioned by the clinical commissioning groups of East Riding, Vale of York and Scarborough, Whitby and Ryedale) to meet the needs of the local people.
- The major challenge for the trust was to provide medical care services for an increasing elderly population, which was expected to increase significantly over the next five years. There was also expected to be a significant service requirement for the management of dementia and other long-term conditions.
- The trust had identified that reconfiguration, particularly of the acute medical beds, was required to meet patient needs. The reconfiguration was in progress, and some changes had already been implemented.
- Ambulatory care services were available, and were being further developed to alleviate patient flow pressures by working closely with the acute medical unit and A&E staff, to proactively initiate the transfer of appropriate patients into their area for rapid treatment, diagnostic testing and discharge.

Access and flow

- Routine / elective admissions and outpatients were admitted directly to the relevant base ward.
- Non-elective / emergency patients were predominantly admitted from A&E to the AMU.
- The AMU accepted patients from A&E and by GP referral. Patients were triaged for admission by the bed managers, using protocols for different conditions, such as chest pain or suspected deep vein thrombosis (DVT). If the AMU did not have available beds, patients referred from GPs waited in A&E.
- AMU staff told us that flow through the hospital was poor, and several times a week medical patients were sent from AMU to surgical wards to then have surgical outliers back-up on AMU. We were also told that staff felt under pressure at times from the bed managers to move patients inappropriately and against clinical judgement. They felt that some patients were put into lower acuity areas before they should.
- We were told that generally, patients on the AMU were seen by a junior doctor within four hours and by a consultant within 12 hours. We observed in a patient record that the patient had been clerked within four hours, and seen by a consultant within 12 hours.
- Following "Perfect week" where staff from across the hospital and also stakeholders worked to achieve the ideal access and flow through the hospital. Learning from this this was developed into "Operation Fresh Start" which commenced in January 2015. It included ward discharge liaison officers to support discharge. The service covered all inpatient areas, and assisted ward staff with planning and co-ordinating of complex discharges.
- Feedback from staff was that effectiveness and timeliness of discharge had improved, and workload pressures for other members of staff had also been alleviated to some extent by the discharge team's assistance.
- The trust had a much lower proportion of delayed discharges caused by either completion of assessment or from waiting further NHS non-acute care compared to the national average. There is a high proportion of delayed transfer of care due to patients awaiting care packages in their own home (37%) or waiting for nursing home placement or availability (22.1%). and the trust needs to consider how this could be improved.

Medical care (including older people's care)

- Bed occupancy across the trust, for quarters one and two 2014/15, was just under 90% for general and acute beds.
- The hospital had opened Graham Ward in October 2014, to alleviate Winter bed pressures, and this was planned to close in April 2015.
- Ward staff told us that due to demand for beds, it was sometimes necessary to board patients out onto non-medical wards. We were told that this usually affected patients who were medically fit for discharge, but were awaiting social care input at home, or a nursing home placement.
- Between July and November 2014, there were 302 medical outliers at Scarborough Hospital. The outlying patients were from the following specialities: geriatric medicine (131), gastroenterology (75), endocrinology (51), and respiratory medicine (45).
- Data regarding inpatient moves for April to November 2014, showed that 36% of patients were not moved to another ward during their hospital stay; 47% of patients had one ward move, while the remaining 17% had two or more ward moves during their stay.
- Non-elective geriatric medicine patients had an average stay of 12.6 days, against a national average of 9.8 days. Non-elective cardiology patients had an average stay of 6.9 days, against the England average of 5.5 days. Elective gastroenterology patients had an average stay of 5.6 days, against an England average of 3.3 days.
- We were told that patients were allocated to specialist consultants, and could be on any medical ward, or potentially outlying on a non-medical ward. This meant that it was difficult to keep track of all patients needing to be seen, and it also took longer to review patients who were spread over a number of wards. We were told that there was an inconsistent approach to allocating patients to consultants, which made providing safe, effective care more difficult. Junior doctors surmised that shortages of acute medical consultants and specialist consultants adversely affected patient flow and length of stay, as there was no daily senior decision-making in some areas. Consultant ward rounds tended to take place two or three times a week.
- The trust was on a par with the England average for national cancer waiting times.
- General medicine, gastroenterology, geriatric medicine and neurology all achieved 100%, against the 18-week RTT target.
- On the stroke ward, 95% of staff had completed 'perfect week access and flow training', which tracks the patients care and treatment journey, and promotes timely MDT intervention to improve patient care and discharge plans. This initiative was to go live on the ward within the next couple of weeks.
- On the stroke unit, the MDT met weekly to discuss patients' care and treatment progress, and the discharge liaison team and community therapy team worked closely with social services. We were told that there had been a picture of improvement since January 2015.
- Board rounds were held in the early morning, to facilitate discharges on a morning if possible, and to improve patient flow, as the majority of admissions and GP referrals were during the afternoon and evening.
- Staff told us that sometimes patients were moved to the discharge lounge before discharge prescriptions were ready, to free-up beds for admissions. This situation was reported as having improved with the discharge liaison team and their interventions.
- Access to neurology services was limited due to consultant vacancies.
- Doctors told us that the trust's referral system was an old-fashioned paper-based system, which varied between specialities, and which could cause confusion and delays, as items needed to be handed to the relevant secretary or administrator.
- It was reported that the procedure room on the cardiology ward was sometimes used as an escalation ward bed space, and this had led to the cancellation of elective procedures.
- Coronary patients for primary angioplasty accessed services mainly provided by the Leeds Teaching Hospitals NHS Trust, with some patients going to Hull and East Yorkshire Hospitals NHS Trust. Ambulance paramedic crews were requested for transferring patients to both trusts, and relatives were provided with information regarding these transfer services.
- Patients had good access to therapy services, Monday to Friday. Physiotherapy and occupational therapy staff were allocated to certain wards, and covered these on an ongoing basis.

Meeting people's individual needs

- We saw a wide range of information publicly displayed, to provide patients and families with information relating to different services and aspects of care.

Medical care (including older people's care)

- Some staff were aware of 'This is me' and 'forget me not' approaches to caring for dementia patients; however, not all staff had accessed dementia awareness training, or were aware of initiatives and practices to improve the care of patients with dementia.
- Staff had access to information about different cultural, religious and spiritual needs and beliefs, and interpreting services were available for patients who did not speak English, or who had other communication difficulties.
- Translation services were available, and staff were aware of how to arrange these services.
- Telephones had a long-line hearing loop for patients who were hard of hearing, and other communication aids were available through occupational therapy.
- One patient told us that he was frustrated that he could not keep and administer his own analgesia, although he had received an explanation for this, and understood his medicine was a controlled drug.
- Patients on Graham Ward told us that staff came when called, and answered buzzers promptly even though they were busy.
- One patient on Graham Ward told us that he knew it was a temporary ward, and that it showed in that there was nothing to do and no TV; however, the quality of care was good.
- Staff were aware of an in reach service provided by the Alzheimer's Society.
- Two patients on coronary care told us that they had been referred to another provider for further cardiac interventional treatment, and that they had to wait until an appointment became available. They told us that the nursing sister on the unit had spent time discussing and explaining their individual treatment plans, and why there was a delay. The team were following this up on a daily basis. (The sister confirmed to us that the delays had been escalated in accordance with the agreed treatment pathway protocols.)

Learning from complaints and concerns

- The trust had a Patient Advice and Liaison Service (PALS), which was available to all patients. Patient Advice and Liaison Service information, on how people can raise concerns and/or complain, was publicly displayed and available.
- Responses to formal complaints received by the medical directorate were shared with ward staff by the matron, and action plans were developed and implemented with ward staff where appropriate.
- Safety briefings were carried out each day, and we were told that these included learning and action points from complaints and incidents. The information from complaints was held in ward communication files, which were accessible to all staff.
- Staff we spoke with told us that they would try and resolve concerns and complaints at ward level wherever possible; on occasions, they would escalate the complaint to the ward manager or matron, who would resolve it if possible, and refer on to the Patient Advice and Liaison Service when necessary. We spoke with the relatives of a patient who wished to make a complaint regarding the care and treatment of their loved one and ineffective communication with themselves. The hospital responded appropriately, to proactively contact the family to try and resolve their concerns as soon as possible.

Are medical care services well-led?

Requires improvement

We rated medical services as requires improvement for well-led. Staff shortages impacted upon ward managers' ability to effectively lead their teams. There were mixed reports regarding support from line managers and inter-team relationships. Most of the staff told us that they were well supported by their immediate line manager, but more senior leadership was reported to be lacking in visibility and effectiveness.

Staff did not always feel that they were actively engaged or consulted regarding service changes, or that their concerns were listened to or acted upon. Some medical staff felt that the services at Scarborough were attributed secondary status to those provided at York, and that not enough was done at a senior level to ensure cross-site working and cover.

Managers and senior clinicians had a vision for the future of their services, and were aware of the risks and challenges faced by the service. There were a number of business

plans with the trust board for strategic development of services. Long-term strategies were in place for the medical and elderly medical departments. Most staff were clear about the vision and strategy for the service.

There were a number of examples of innovation and service improvements.

Vision and strategy for this service

- Ward managers and sisters were aware of the trust vision and strategy, and that key messages were on the intranet and emailed out periodically to senior staff to share with their teams.
- Staff we spoke with were aware of the trusts vision, and knew how to access trust-wide information from the intranet.
- The senior sister for ambulatory care was aware of plans to develop ambulatory care at Bridlington, and across the Scarborough and York sites, to alleviate pressures on A&E. She was also aware that consideration was being given to whether urgent and planned treatments should be separated in some way.
- Most of the staff we spoke with were aware of 'Operation Fresh Start', a trust-wide initiative to improve patient flow by making the discharge process more effective. Improvements included a discharge liaison team, and access to on-site social worker and mental health liaison support.
- There were longer-term plans to develop and increase the number of medical trainees coming through the trust, to promote York and Scarborough as a place to work for their future career. Emphasis was being given to training, retention and talent management of junior medical staff.
- Plans for addressing staffing and recruitment problems across the York teaching hospitals included the development of a local staff bank, development of a career structure for nursing, sponsorship for HCAs wanting to undertake nurse training, and development of new roles for non-registered practitioners.
- There was an information technology strategy in place, which would improve cross-site working and integration with primary care systems, to facilitate more effective communication and patient care.
- There were five year strategies in place for the medical care service.

Governance, risk management and quality measurement

- Governance structures were in place to facilitate analysis of information from incidents and complaints, identify themes, and ensure communication from ward to board. Key messages from incidents and complaints were communicated across the trust via staff meetings, training and newsletters.
- Ward managers attended a professional forum every month, where governance issues were discussed and disseminated for action. The group looked at information from patients, including complaints and incidents, to identify learning and areas for improvement.
- Staff told us that incidents were discussed at handovers, with complaints and other patient safety information, to ensure that staff were aware of any key messages or changes to practice they needed to implement.
- Risk registers were in place for the medical and elderly medical directorates.
- Leaders and managers were aware of the risks and challenges faced by the wards, such as staffing and shift patterns, and had a number of plans to address these, such as working closely with the University of York, taking part in recruitment fairs, and holding one-stop-shops for the recruitment of nurses and healthcare assistants.
- Weekly mortality reviews were carried out, involving the chief executive, the director of nursing, and the medical director.
- There were internal quality assurance systems and processes in place to investigate and review any clinical concerns or issues, and to make recommendations and improvements.

Leadership of service

- Ward managers told us that they had one or two days a week allocated to management time. However, they often needed to give up dedicated management time, due to staff shortages. This impacted on their capacity to lead their teams effectively.
- Ward staff stated that local leadership was supportive; ward managers and matrons were visible and provided clear leadership.
- Oak Ward had been identified by the Trust as a ward needing improvement. Action had been taken by the Trust and progress was demonstrated through the quality and safety audit (QUEST) results.

Medical care (including older people's care)

- It was reported that more senior managers were visible when a crisis arose, but tangible support or contribution was difficult to recognise.
- AMU staff told us that frequent staff moves were causing poor staff morale and increased turnover.
- We were told that ambulatory care staff from Scarborough and Bridlington were invited to a full team meeting four times a year, but staff reported that it was difficult to get to these meetings. Although the senior sister was aware of planned developments for ambulatory care, there had been little in the way of staff consultation and involvement. Staff from Scarborough and Bridlington did not seem to have been involved with the pilot of ambulatory care at York.
- The percentage of staff able to contribute towards improvements at work had been a negative finding in the trust staff survey (2013).
- Although some staff said that they were proud to work at Scarborough Hospital, and felt ward and multidisciplinary team work were good, others said that they sometimes did not want to come to work, as they did not know where they would be working.
- An initiative at the trust "Blue Thursday" meant that matrons worked on a ward for one day each month, which increased their accessibility, visibility and credibility with staff.
- Ward managers were encouraged to undertake a leadership programme, which was also to be rolled out to junior sisters.
- The staff did not feel that the executive team were visible at ward level. Although the chief executive held surgeries for staff to drop in to, and the dates of these meetings were advertised in the staff bulletin, Staff matters, staff seemed largely unaware of them.
- Some medical staff felt that the services at Scarborough were attributed secondary status to those provided at York, and that not enough was done at a senior level to ensure cross-site working and cover.
- Support and training for medical staff was reported as being good.

Culture within the service

- Trust-wide data from the 2013 staff survey reported a negative finding regarding fairness and effectiveness of procedures for reporting errors, near misses and incidents.
- Staff told us that they would, and did, regularly raise concerns when necessary, but were not always sure that their concerns had been listened to or acted upon.
- Staff told us that they regularly reported incidents and near misses, and received feedback.
- Some medical staff felt that some teams did not engage well with others, and were unaware of other people's roles, and that a culture of 'tribalism' existed.
- However, in the main, there was a good ethos of multidisciplinary working, and respect and value for multiprofessional skills and knowledge.

Public and staff engagement

- The trust had a well subscribed foundation trust membership, and actively sought their views on various topics.
- The public were encouraged to nominate staff for annual awards, and the trust and its staff proactively sought feedback through the Friends and Family Test (FFT) and other patient surveys.
- The wards displayed the FFT results on 'You said, we did' boards, so that patients and the public could see changes made as a result of their feedback.
- Staff were not always engaged with service changes, or feel that their views had been heard or acted upon. For example, staff on ambulatory care did not appear to have been involved with informing the ambulatory care pilot on the York site.

Innovation, improvement and sustainability

- There were a number of examples of innovation, improvement and sustainability, such as 'Operation Fresh Start. This was a multiagency approach to facilitate rapid discharge especially for elderly patients, together with the establishment of a discharge liaison team. It was implemented following the learning from "Perfect week" – A multiagency pilot to trial the perfect system to facilitate timely access and flow of patients.
- An early warning trigger tool had also been developed to identify wards where problems were occurring.
- Senior clinicians and managers told us that there was work needed to improve cross-site working at consultant level, to improve the clinical sustainability of some services.

Surgery

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Surgical services at Scarborough Hospital included general surgery, urology, orthopaedic surgery, ear, nose and throat (ENT), ophthalmology, maxillofacial surgery and theatres. There were 106 surgical inpatient beds and five operating theatres.

We visited pre-assessment, operating theatres, the discharge lounge and the post-anaesthetic care unit (PACU). We also visited the surgical wards: Haldane, Maple, Ash and Holly.

We spoke with 20 patients and 28 members of staff, including matrons, ward managers, nursing staff (qualified and unqualified) and medical staff. We observed care and treatment. We received comments from people who contacted us to tell us about their experiences.

Before the inspection, we reviewed performance information about the trust.

Summary of findings

Nurse staffing levels were not always maintained as planned. Services were responsive to patients' individual needs, but there were concerns over waiting times, such as the 18-week referral-to-treatment time (RTT) target and the achievement of cancer waiting times. There had been one 'never event' in surgery in the last 12 months relating to wrong site surgery. Never events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken.

The service provided effective and evidence-based care and treatment. Patients received compassionate care and their privacy and dignity were maintained.

Senior leaders understood their roles and responsibilities to oversee the standards of service provision in surgical areas. However, work was continuing to integrate surgical services and to deliver common standards of care across the three hospital sites. There was innovative practice, including a new surgical ward and assessment unit.

Surgery

Are surgery services safe?

Requires improvement

Staffing establishments and skill mix were reviewed regularly. However, optimum staffing levels and skill mix across surgical services were not being sustained at all times of the day and night.

Effective handovers took place between shifts and included daily safety briefings to ensure continuity and safety of care.

There were effective arrangements in place to minimise the risk of infection to patients and staff. Medicines were managed appropriately. However, patients were sometimes discharged without their medicines or had long waits for take-home medicines because doctors did not always write up electronic discharge notes in a timely way. There were some concerns regarding the management of medicines.

Staff were encouraged to report incidents and most received feedback on what had happened as a result.

There were processes in place for staff to recognise and respond to changing risks to patients. These included processes for responding to the warning signs of rapid deterioration of a patient's health.

Incidents

- Staff were aware of the process for reporting incidents and were confident in their explanations of the reporting mechanisms and categories of incidents to report. Most staff said that they received feedback and learning from incidents to improve patient care.
- There was one never event relating to wrong site surgery in 2014/15. A root cause analysis had been undertaken and an action plan developed. This included the recommendation that a consultant surgeon who did not have other clinical commitments should always be allocated to the operating list and that they should check the marking of the surgical site with the patient's consent form and medical records. The action plan showed that these recommendations had been implemented.
- In the surgery directorate, there had been 30 serious incidents reported between January and December 2014 that required investigation. These included 11 falls and 11 pressure ulcers. The directorate recognised the concerns relating to harm occurring from patient falls and pressure ulcers and improvements included a revision of risk assessments and intervention processes. Fall reduction plans showed that the prevalence of harm from falls had decreased.
- A monthly safety publication, 'Nevermore', included key learning from serious incidents, complaints and claims. All serious incidents were reviewed and learning discussed at clinical governance meetings; these were held each month.
- There was good awareness among staff about the principles of the Duty of Candour, and the specific requirements of the new regulations that had come into force in November 2014. The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. We saw that the regulations were displayed in ward areas.

Safety thermometer

- The trust used the NHS Safety Thermometer. This is a local implementation tool for measuring, monitoring and analysing harm to patients and 'harm-free' care. Monthly data was collected on pressure ulcers, falls, urinary tract infections for people with catheters and venous thromboembolism (VTE or blood clots).
- Trust data showed that 93.9% of patients had received care 'free from harm' in January 2015.

Cleanliness, infection control and hygiene

- Ward areas we inspected were clean. We saw that staff regularly washed their hands between patient appointments and interventions. Staff were 'bare below the elbows' in line with trust policy and national guidelines for hygiene best practice.
- There had been no methicillin-resistant Staphylococcus aureus (MRSA) infections within surgery over the last 12 months. There had been five reported cases of Clostridium difficile (C. difficile) for the surgical directorate between April and November 2014.
- Elective patients undergoing orthopaedic surgery were screened at pre-assessment for MRSA and patients were isolated in accordance with infection control policies.
- We observed staff in all surgical areas following guidance for the safe disposal of different types of clinical and domestic waste and used needles (sharps).

- Ward and equipment cleaning frequency schedules were in place and were in accordance with NHS national cleaning standards.
- Effective processes were in place for the flow of endoscopy equipment from preparation to cleaning.
- The unit participated in ongoing surgical site infection audits run by Public Health England. The last published results, for April 2013 to March 2014, showed that there were no surgical site infections for the trust relating to total knee replacements.
- There were no surgical wound infections reported for elective orthopaedic surgery between April 2014 and January 2015.
- Infection control and environmental audits were carried out regularly in clinical areas. Overall results were compliant with trust targets in most surgical areas and action plans were in place where improvements were needed.

Environment and equipment

- Ward-based staff reported having sufficient equipment to enable them to carry out their duties.
- There were effective systems to ensure that resuscitation equipment, including emergency drugs, was readily available in surgical areas, including theatres. Records showed that daily checks had been carried out on this equipment.
- Theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedure.
- Full tracking and traceability of surgical instruments was provided. This offered a full audit trail, ensuring that each decontamination process was followed correctly and according to international standards. There was a four-hour turnaround time for urgent theatre trays.
- Technical equipment used for monitoring patients had been safety tested and labels indicated the next date when checks were to be made. Equipment was serviced in a timely way.

Medicines

- Pharmacy staff visited the wards each day and carried out a full clinical check of all prescription and medicine administration records. A pharmacy technician checked medicine stock levels and patients' own medicines, recoding any missing medicines.
- New patients had medicines written up immediately; all medicines were signed for and patients' allergies recorded.
- We saw that a number of patients were receiving oxygen but sometimes a prescription had not been written to authorise this.
- Medicines were stored securely and pharmacy staff audited medicines security and the management of controlled drugs on a regular basis. However, medicine fridges on some wards were not monitored fully in line with trust policy.
- The preparation and administration of controlled drugs were subject to a second independent check. Records showed that the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Wards kept supplies of commonly used pre-labelled medicines to facilitate faster discharge of patients. A full audit trail was maintained to account for all medicines supplied.
- Nursing staff told us that patients were sometimes discharged without their medicines because of delays in doctors completing electronic discharge notifications. We observed that patients were waiting between two and three hours in the discharge lounge for their take-home medicines.

Records

- Care pathways were used for patients undergoing elective surgery. The pathway incorporated the patient journey from pre-assessment to admission, surgery, recovery and discharge. Records we looked at were completed accurately.
- There was access to electronic patient records on the wards, and these listed the essential patient care requirements. This included completion of the early warning tool for adult inpatients and of the risk assessments for falls, pressure ulcers and malnutrition.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Dementia screening tools were in place and completed for patients over the age of 65. Records showed that, where a diagnosis of dementia had been made, patients received further investigations.

Safeguarding

Surgery

- There were safeguarding policies and guidelines in place for the protection of vulnerable adults and children. The trust had a designated safeguarding lead who provided advice and training for staff and linked into the multi-agency safeguarding networks.
- Nursing and medical staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and they were aware of the hospital safeguarding systems and processes.
- Figures showed that 65% of medical staff and 34% of nursing staff had completed level one training for safeguarding adults and children against a trust target of 75%.

Mandatory training

- Overall completion of statutory and mandatory training for surgery and theatres was 62% across all staff groups and hospital sites.
- The trust had launched a learning hub which enabled staff to understand their training requirements and how these could be delivered. Management teams could also see which staff had not refreshed their training.

Assessing and responding to patient risk

- The surgical wards used the National Early Warning Score (NEWS), a recognised early warning tool for the management of deteriorating patients.
- Escalation processes were in place to obtain a medical review or response within 30 minutes. Staff confirmed that there was good access to a patient's consultant or to the on-call consultant out of hours when urgent medical input was required.
- We saw guidance to theatre staff on following the 'five steps to safer surgery' (part of the World Health Organization (WHO) surgical safety checklist). This included team brief, sign in, time out, sign out and debrief. An audit conducted between April 2014 and February 2015 showed good compliance with the checklist in the trust of between 98% and 100% across all surgical specialties.
- There was a 12-bed high observation unit on Maple ward for patients who needed more intensive observation, treatment and nursing care. This unit had experienced trained staff and good input from the critical care outreach team.
- Surgical staff used a sepsis screening tool as part of the assessment that was part of the early warning score. This enabled them to alert medical staff to patients with clinical indicators of possible infection.
- There was a daily theatre team meeting attended by the surgeon, anaesthetist and theatre co-ordinator to discuss all patients and any risks before listing them for theatre.
- There was access to an emergency acute theatre; the theatre co-ordinator prioritised the most appropriate urgent cases.

Nursing staffing

- There was a number of nursing vacancies within the surgical directorate at Scarborough. For example, in November 2014 the directorate was short by 11.56 whole-time equivalent (WTE) staff in general surgery and 5.42 WTE in anaesthetics. Information provided by the Trust indicated that for general surgery in Scarborough there was a 10.5% vacancy rate for nurses, 29% for medical staff and 12.7% for additional clinical services staff.
- Wards and departments had planned and actual staff numbers on display.
- Staff on the surgical step-down unit told us that there should be one registered nurse to three patients. However, the staffing numbers on each shift were regularly one registered nurse to six patients.
- Theatre staff told us that they were seconded to the wards to care for medical patients when theatre lists were cancelled. Staff said that they were expected to undertake duties which they were not confident about or trained to do. A policy had recently been developed to clarify the roles and responsibilities expected of staff covering staff shortages.
- An acuity and dependency audit had commenced in January 2015 using the Safer Nursing Care Tool; this was ongoing.
- There was a safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed roster. Daily staffing meetings took place to deploy staff to high-risk areas. If there were areas of low activity, these staff were moved to other wards in order to improve staffing levels.
- During periods of high patient activity, matrons and assistant directors of nursing met twice daily to ensure the safe deployment of staff.

- Work had been undertaken by the trust to reassess staffing levels on wards. The trust was in the process of increasing staffing levels, including by recruiting staff from abroad.
- Recruitment was ongoing in most surgical areas and a number of vacancies had been filled or interviews were scheduled during the coming months. This was to ensure that staffing establishments reflected the acuity and dependency of patients.
- The average proportion of bank staff used to cover general surgery shifts between April and November 2014 was 11.61%.
- When a patient became acutely unwell and required escalation to medical staff or to the critical care outreach team, the registered nurse and medical staff communicated using the Situation, Background, Assessment Recommendation (SBAR) tool to ensure a consistent approach.

Surgical staffing

- Surgical services were overseen and led by consultants for each 24-hour period.
- Arrangements were in place to ensure that the surgical directorate had access to and the support of consultant surgeons and anaesthetists during normal working hours and out of hours, with on-call access for staff if needed.
- There was a consultant ward round each day; this ensured that all patients were reviewed within 12 hours of admission.
- The orthopaedic consultants worked in both Scarborough and Bridlington.
- Staff told us that the orthopaedic consultants would see all patients each morning in Scarborough before they went to do their elective lists at Bridlington Hospital. Staff could contact the on-call registrar or consultant at Bridlington in an emergency. An orthopaedic registrar was also available in the clinic at Scarborough for advice and support.
- The directorate's locum usage was around 5%.
- Medical staff shift lengths were in line with the European Working Time Directive. The General Medical Council National Training Survey 2014 identified no risks with regard to doctors' workloads.

Major incident awareness and training

- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who could be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency. Staff were familiar with their role in an emergency response.
- There was a business continuity management plan that provided a clearly defined framework to ensure the resilience and continuation of the trust's critical activities.

Are surgery services effective?

Good

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. There was effective communication and collaboration between multidisciplinary teams.

Patients were able to access suitable nutrition and hydration and pain management. Patients' surgical outcomes were monitored and reviewed through formal national and local audits.

Staff had the right qualifications, skills and knowledge to do their job. Staff undertook competency-based assessments to show that they met the requirements of their role.

Evidence-based care and treatment

- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.
- The directorate took part in all the national clinical audits for which it was eligible. There was also a formal clinical audit programme in which national guidance was audited and local priorities for audit were identified. For example, results from the National Bowel Cancer Audit Programme (NBCAP) 2014 identified no cause for concern with regard to the key indicators. The 90-day mortality rate was slightly higher than average, but this was still within acceptable limits.

- A fractured neck of femur audit assessing the level at which the targets for best practice were being met for patients at discharge showed 100% compliance. This was better than the standard set by the British Geriatrics Society.
- Patients receiving post-surgical care were nursed in accordance with NICE guideline CG50: 'Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital'.
- The directorate followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- Patients followed an enhanced recovery programme for hip replacement surgery. This was an evidenced-based approach that allowed patients to play an active role in their care and helped them to recover more quickly following major surgery and return to a normal life as soon as possible.

Pain relief

- Patients were asked regularly about their pain levels, particularly immediately after surgery, and these were recorded using a pain scoring tool. We reviewed a number of care pathway records and saw that the pain relief given to patients undergoing a variety of procedures was documented.
- The trust had a dedicated pain team that provided daily advice and support to the wards. Out of hours, ward staff could access the on-call anaesthetist for advice if required.
- The majority of patients who spoke with us said that their pain was assessed by nurses and they had been given pain relief promptly when it was required.
- An enhanced recovery pathway was in place for patients admitted for orthopaedic procedures. Patients who underwent surgery followed a pathway developed to ensure that they were provided with defined pre-operative, peri-operative and post-operative analgesia, which facilitated early patient mobilisation and independence and earlier hospital discharge.
- Patients recovering from surgery were provided with patient-controlled analgesia to enable them to control their own pain.

Nutrition and hydration

- Fluid input and output records were used appropriately to monitor patients' hydration. We looked at a sample of records on the surgical wards and saw that they were completed to a good standard.
- A nutritional screening tool for inpatients was in place. This was completed within the first 24 hours after admission and repeated weekly, with action taken where required. Dietary boards were used on the orthopaedic wards to identify patients who were diabetic or required special diets.
- Staff followed guidance from the Royal College of Anaesthetists regarding pre-operative fasting. A post-operative nausea and vomiting protocol was also completed.
- We observed that mealtimes were not protected on some wards. For example, plates and crockery were still being cleared away during visiting times.
- Patients were satisfied with their meals and said that they had a good choice of food and sufficient drinks throughout the day.

Patient outcomes

- There were no current CQC mortality outliers relevant to surgery. This indicated that there had been no more deaths than expected for patients undergoing surgery at the hospital.
- Scarborough Hospital had performed better than the England average in nine out of 10 measures in the National Hip Fracture Audit 2014.
- The trust was slightly worse than the England average for patients being admitted for surgery on the day of or the day after admission. For example, 71.9% of fractured necks of femur were seen within 48 hours, compared with the England average of 73.8%.
- The relative risk of readmissions was lower than the national average for both elective and non-elective procedures.
- The hospital outcomes for Patient Reported Outcome Measures (PROMS) between April 2013 and December 2014 for hips, knees and groin hernia repair showed that the percentage of patients who had improved following each procedure was in line with the figures reported nationally.
- The average length of stay was slightly shorter than the national average for elective procedures and slightly longer for non-elective procedures.

- The National Emergency Laparotomy Audit 2014 showed that 13 of the 31 indicators being audited were rated as 'not available'.
- The average length of stay was in line with the national trend in most specialties, although it was higher than the national average for some specialties (such as non-elective gastrointestinal surgery).

Competent staff

- Staff had the right qualifications, skills and knowledge to do their job. Nursing staff undertook competency-based assessments to show that they met the requirements of their role.
- Out of 11 staff groups associated with surgery in Scarborough, only two had percentages of appraisals completed for July and November 2014. All other staff groups had no figures. The average percentage based on the two staff groups was 68%. This was below the trust target of 95%.
- Junior doctors told us that they attended teaching sessions and participated in clinical audits. The General Medical Council National Training Survey 2014 identified no risks in these areas.
- Theatres had a well-equipped resource room with computer terminals for staff to complete their e-learning and to access protocols and guidelines**.**

Multidisciplinary working

- There was effective multidisciplinary team working on the wards. Daily ward rounds were carried out in which the clinical care of every patient was reviewed by members of the multidisciplinary team; this was led by the consultant managing the patient's care.
- Staff told us that there was effective communication and collaboration between teams, and that teams met regularly to identify patients who required visits and to discuss any changes to the care of patients.
- Discharge letters were sent to the patient's GP and a copy of the letter provided to the patient.
- There was evidence of multidisciplinary working for patients on the enhanced recovery programme, with input from dieticians, occupational therapists and physiotherapists.

Seven-day services

- Out of hours, consultants were available on call and would attend when required to see patients at weekends.
- Pharmacy support was available between designated hours on a Saturday and via on-call arrangements out of hours.
- There was access to the critical care outreach team and the endoscopy team 24 hours a day, seven days a week.
- Referrals for radiology could be made 24 hours a day, seven days a week.

Access to information

- All local policies and guidelines could be accessed electronically on the trust systems. For example, there were local guidelines for pre-operative assessments; these were in line with best practice.
- The Clinical Patient Database (CPD) was in place in all clinical areas so that staff could update clinical records in real time.
- Acute surgical patients were booked for theatres using a paper admission form completed by the surgeon. Once the acute theatre list was agreed, the theatre co-ordinator transferred this information onto the CPD.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- The elective surgery care pathway incorporated formal consent forms and supporting information for both staff and the patient. These consent forms were in line with current Department of Health guidance.
- Consent forms identified the procedure to be undertaken and its associated risks. There were documented records of the healthcare professional responsible for consulting the patient, and the forms also included patient signatures to indicate that they were providing consent to undergo any proposed procedure.
- All patients we spoke with told us that they had been asked for their consent before surgery. They said that the risks and benefits had been explained to them and they had received sufficient information about what to expect from their surgery.
- Staff were aware of their responsibilities relating to the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DOLS), although more training and reinforcement were necessary.
- Patient records showed that best interest meetings had taken place for patients lacking capacity. The meetings included involvement from the multidisciplinary team, social services and the patient's family.

Surgery

Are surgery services caring?

Good

The surgical service was caring. We observed positive, kind and caring interactions on the wards between staff and patients. Patients spoke positively about the standard of care they had received.

Patients felt that they understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.

Compassionate care

- We observed positive, kind and caring interactions on the wards between staff and patients. Staff introduced themselves appropriately to patients.
- Call bells on the wards were mostly answered promptly and were in reach of patients who needed them.
- Patients told us that, although staff were very busy, the standard of care they had received was good and all their clinical needs had been met.
- Patient-led assessments of the care environment (known as PLACE) for 2014 showed that the trust was better than the England average for cleanliness, privacy, dignity and well-being and slightly below average for food and facilities.
- Hourly comfort rounds (checks to make sure that patients were comfortable and had what they needed) took place to ensure that staff were aware of any emerging needs patients might have.
- The response rate for the NHS Friends and Family Test at Scarborough was 30.1%, which was the same as the England average. Figures for April to July 2014 showed that 75% of patients would recommend the trust to their family and friends.
- The CQC Adult Inpatient Survey 2013 did not identify any evidence of risk and the trust was rated 'about the same' as other trusts.
- There were no mixed-sex accommodation breaches in the wards we visited during our inspection.

Understanding and involvement of patients and those close to them

- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers for specialist nurses to ensure that they had adequate support after their discharge.
- Patients on the enhanced orthopaedic recovery programme were given a patient data booklet that they completed daily. This provided details of the goals achieved by the patient each day and provided staff with information to further support the patient. Additional information was available on DVD, on the internet and in an information leaflet.

Emotional support

- There was information within the care plans to identify whether patients had emotional or mental health problems. Assessments for anxiety and depression were done at the pre-assessment stage. Nursing staff provided extra emotional support for patients both pre- and post-operatively.
- We observed staff recognising the emotional support needs of two patients with learning disabilities. A person-centred care plan that had been developed with the patient, primary carers and family was reviewed and updated. The care plan was communicated and shared with ward teams at each handover.

Are surgery services responsive?

Requires improvement

We found that staff were responsive to people's individual needs. However, the trust was failing to meet the national waiting time targets, such as the 18-week referral to treatment time (RTT) target and the achievement of cancer waiting times.

Surgery had systems in place to plan and deliver services to meet the needs of local people, including the provision of a newly designed surgical ward and assessment unit. There were effective processes in place to support patients with learning disabilities.

Information about the trust's complaints procedure was available for patients and their relatives.

Surgery

Service planning and delivery to meet the needs of local people

- Surgical services were available 24 hours a day, seven days a week, with emergency access to operating theatres outside normal working hours.
- A new surgical ward and assessment unit had been built to improve, and help streamline, the care pathway for patients requiring surgery.
- To meet the needs of local people, the directorate was in the process of moving all orthopaedic elective work to Bridlington Hospital during 2015. This move was supported by a programme to develop a service providing outpatients, treatment and rehabilitation, all of which were to be co-located for ease of access.
- The trust had an escalation policy and procedure to deal with busy times. This gave guidance to staff on how to proceed when bed availability was an issue.

Access and flow

- The trust had introduced 'Operation Fresh Start' at Scarborough, an initiative to improve patient flow and allow managers to make decisions about the number of patients requiring beds who were admitted to the hospital. Ward-level discharge liaison officers were in post to facilitate the process of patient discharge and a patient flow manager had recently been appointed. Staff told us that the system was making a difference.
- The directorate was not meeting its targets for the 18-week RTT pathway in five of the eight surgical specialties. Operational standards are that 90% of admitted patients should start consultant-led treatment within 18-weeks of referral. The directorate was continuing work to populate a capacity and demand model in order to deliver the 18-week target. In January 2015 , 234 elective procedures were cancelled at a time of national demand on NHS acute services. The organisation responded to this by moving some elective orthopaedic activity to the Bridlington site and by organising additional lists when pressures eased and patients were offered surgery at other NHS providers.
- The trust had agreed a recovery plan with the local clinical commissioning group (CCG) to achieve this target. However, it was not expected to achieve this until July 2015.
- The directorate had outlier guidelines for managing patients from non-surgical specialties; these included criteria for whether patients were suitable for transfer. Staff reported that it was common for medical patients to be cared for on surgical wards. Trust data showed that, between July and October 2014, there had been 302 medical outliers at Scarborough Hospital. Staff said that patients were reviewed by the medical teams and the process had become more efficient since the introduction of 'Operation Fresh Start'.
- Discharge planning began at pre-operative assessment stage for elective patients and on admission to the unit for trauma or emergency patients.
- Maple Ward had 12 high observation beds for patients admitted from critical care or for post-operative patients who needed higher levels of observation. This helped to relieve some pressures on the wards by admitting patients requiring extra monitoring (for example, epidural management).
- Two bays in the post-anaesthetic day unit were used for eye surgery for patients having local anaesthesia. This supported patient access and flow.
- Theatre utilisation in September 2014 was 82.43% and it averaged 76.9% in October and November 2014 across six theatres. (The national average in England was 86%.)

Meeting people's individual needs

- Support was available for patients with learning disabilities. Staff had access to a learning disability specialist nurse at the trust. A 'This is me' form was completed so that staff were aware of the patient's health and their personal and social needs.
- We observed a patient with learning disabilities being cared for in theatre. A multidisciplinary care plan had been completed effectively and shared with relevant clinical teams. All the requirements to care for the patient's health and social and personal needs were met.
- Staff were able to access and refer patients living with dementia to the specialist dementia nurse, who was supported by two mental health liaison nurses. The trust had introduced 'Forget me not' stickers on case notes; these reminded staff that patients with dementia may have memory problems.
- As part of the enhanced recovery programme in orthopaedics, patients were involved in the preparation and planning before admission, pre-operative assessment, recovery and early mobilisation. Patients were better prepared to manage when they were back at home.

Surgery

- There were two stoma nurses and an upper gastrointestinal specialist nurse who provided advice and support for patients during their pathway of care. Nurses saw patients in a clinic and provided follow-up care at home.
- A physiotherapist and an occupational therapist were based on the elective orthopaedic ward to provide patients with support and advice for early mobilisation.
- Discharge planning commenced at the pre-assessment stage. Planning for discharge continued during admission. Delays to discharges were said to be mainly related to the completion of discharge letters and external factors such as community-based needs and referrals for social services assessments.
- All staff wore name badges with yellow backgrounds; these helped patients with dementia to identify staff easily.
- A translation telephone service was available for patients who did not speak English as their first language. There were multiple information leaflets available for different conditions and procedures. These could be made available in different languages.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes for dealing with complaints at ward level and through the trust's patient experience department.
- There had been 77 complaints relating to the surgical directorate since January 2014. The majority of these related to care and treatment, communication and staff attitude.
- A 'Your experience matters' booklet was given to patients during their admission. The booklet explained how patients could provide different types of feedback to the trust.
- Complaint officers met regularly with the management team to review current complaints, identify any problems and offer support and advice.
- Staff from surgery attended the patient experience steering group on a quarterly basis. The key focus of the group was to consider complaints referred to the Health Service Ombudsman, NHS Friends and Family Test feedback, national patient surveys, complaints and Patient Advice and Liaison Service feedback.

Are surgery services well-led?

Requires improvement

The leadership in surgical services required improvement. Senior leaders understood their roles and responsibilities to oversee the standards of service provision in all surgical areas. However, work was continuing to integrate surgical services and to deliver common standards of care across the three hospital sites. Leadership at a local level was visible however members of the trust board were not very visible on the Scarborough site.

The culture within the service was mainly positive and open. Most staff wanted to work more closely with York Hospital however; some staff did not understand the new management structure or their roles and responsibilities. Because of time pressures on the wards senior ward staff did not have sufficient protected management time for areas such as undertaking personal development reviews and monitoring staff training.

Although directorate-level governance arrangements were in place, the use of standardised protocols, guidelines and pathways of care across the three sites was variable and not yet fully established.

There were aspects of innovation; for example, Scarborough had the first surgical ward nationally that had been built using an evidence-based, best practice design solution.

Vision and strategy for this service

- A five-year strategic plan was in place for orthopaedics and the general surgery strategic plan was under development. The plans were aligned with the trust's vision and values. There was evidence of staff consultation and that they could comment on the development of the strategy and any future reviews.

Governance, risk management and quality measurement

- Clinical quality in the directorate was managed through the performance management process. Performance improvement quality and safety meetings were held in the directorate. These meetings were used to monitor and drive forward clinical practice.

- Although directorate-level governance arrangements were in place, the directorate was in the process of developing standardised protocols, guidelines and pathways of care across the three sites. However, these were variable and not yet fully integrated. For example, theatres were using different documentation and induction packages compared with those used by staff working in York.
- We saw that risk registers were in place for orthopaedics. The level of risk was identified, and actions were described to manage gaps in controls and assurance, with associated review dates and executive leads identified.
- Directorate risk registers were discussed at the performance management meetings and locally in the directorate. Areas of risk included staffing levels and achievement of the 18-week RTT targets and waiting times. Significant risks identified from the directorate risk registers were added to the corporate risk register and considered by the board of directors.
- The directorate held joint governance meetings across the three hospital sites every quarter. The meeting minutes showed that patient experience, complaints, incidents, audits and quality improvement projects were discussed and action taken where required, including feedback to staff about their individual practice.

Leadership of service

- Each surgical specialty was led by a clinical director, directorate chief nurse and general manager.
- Members of the senior leadership team had a good understanding of their roles and were aware of the risks and developments required to improve the quality of patient care.
- Matrons and ward managers were in post within the directorate to oversee operational issues and to assist with daily workforce planning to ensure that staff were distributed according to clinical needs. Staff said that matrons and the directorate chief nurse were visible and attended the wards on a regular basis.
- Some staff said that the trust executive team was not very visible on the site.

Culture within the service

- Most staff reported an open and transparent culture on the surgical wards. They reported good engagement at ward level, and they felt that they were able to raise concerns and these would be acted on.
- Some staff felt that joining York felt like a “takeover”. They said that they did not understand the new management structure or their roles and responsibilities. However, other staff said that being one trust was a positive move: staff across the sites could share, update and improve clinical practice.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.
- Staff in most surgical areas said that they attended staff meetings. However, some staff said that they had not had a staff meeting for a few months. Ward manager meetings were mainly held with colleagues at Bridlington Hospital.
- Ward sisters said that they had no protected management time because of pressures on the wards. This meant that areas such as staff training and personal development reviews were not being kept up to date.
- There was evidence of positive cross-site working among staff in the endoscopy unit. Staff, equipment and some protocols were integrated in both units.
- Sickness levels for medical and nursing staff in surgery between April and November 2014 were at 4.84% which was higher than both the overall trust rate and the national rate.

Public and staff engagement

- Data from the NHS staff survey for 2013 showed that the trust scored as expected in 23 out of 29 areas. There were negative findings in areas such as job satisfaction, training, staff being able to contribute to improvements at work, and the fairness and effectiveness of procedures for reporting incidents.
- The wards were starting to receive quarterly laminated patient experience information, which was displayed at ward level. This informed patients, relatives and staff about the Friends and Family Test results and ‘You said, we did’. The trust’s patient experience team worked closely with the ward sisters to ensure that information reflected the actions the wards had taken when improvements were required.

Innovation, improvement and sustainability

Surgery

- The trust had commissioned the development of a new 31-bed surgical ward and assessment unit – Lilac Ward. This was the first ward nationally to have been built using an evidence-based, best practice design solution called 'repeatable rooms'. The design of the four-bedded bays made efficient use of space while maximising the distance between bed heads. It also maximised the visibility of external landscaping to patients and the visibility of patients to nursing staff.
- Staff told us that the York IT systems were not compatible with the system in place in Scarborough. The Scarborough system could link to SystmOne in GP surgeries, which made it easier for consultants to get information.

Critical care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The critical care unit (CCU) at Scarborough had approximately 400 admissions per year, of which around 65% were level 2 patients.

The CCU at Scarborough Hospital had seven bed spaces and was funded to staff five beds (for level 3 patients). There was one relatively new negative pressure isolation room, a two-bedded bay and a four-bedded bay. There was flexibility when accommodating level 2 and level 3 patients and a sixth bed was occasionally opened; this was only ever on a temporary basis.

We inspected the unit over the course of a day and spoke with a range of staff, patients and relatives. We spoke with the Director of Theatres, Anaesthetics and Critical Care (York and Scarborough). We spoke with, as a group, the Deputy Director of Theatres, Anaesthetics and Critical Care (York and Scarborough), the Directorate Manager for Theatres, Anaesthetics and Critical Care (York and Scarborough), the Lead Clinician for Critical Care (York and Scarborough) and matrons for theatres, anaesthetics and critical care from both York and Scarborough Hospitals.

Summary of findings

Staff were caring and professional. Patients, their relatives and friends spoke highly of the care provided on the unit. There were positive comments from staff in relation to culture and teamwork. Some aspects of staffing did not meet national best practice guidance, particularly the medical on-call rota. Nurse staffing presented a mixed picture, with shortfalls particularly in relation to clinical education, unit management, clinical coordination, continuity of care and outreach. Staff could not be released for training frequently enough. Support from specialist teams was limited as there was no hospital-wide pain team and input from the dietetics service did not meet best practice recommendations.

There were suitable processes in place in relation to incident management, safeguarding and assessing and responding to patient risk. The environment and layout of the unit did not meet national best practice guidance. Space around the beds on the unit was limited and storage space was a problem. The environment was visibly clean and patient safety outcome data did not raise any concerns.

The high number of patients who were non-clinical transfers out of the unit had a negative impact on patient safety, which was a concern. The services were part of the Case Mix Programme managed by ICNARC was positive, but there was limited evidence of other measures being taken to assess effectiveness. Service and strategic planning was at an early stage and there was a lack of certainty about the future design of the

Critical care

service and any immediate actions to mitigate delayed discharge, delayed admissions and high capacity. Ideas were in place for developing the service and improving safety but were not formalised or clearly mapped out.

Are critical care services safe?

Requires improvement

Safeguarding processes were in place and staff were aware of how to raise concerns. Safeguarding training figures for the unit, at all levels of training, were under the target of 75%. Mandatory training figures for the directorate were variable, but, overall, compliance levels were well below the target of 75%.

Staffing levels presented a mixed picture. The number of band 5 nurses matched the prescribed numbers, but staffing was clearly a challenge and the overall use and management of staff were having a negative impact in several areas, including clinical education, unit management, clinical coordination, continuity of care, outreach and morale.

Medical staffing, including out-of-hours support, was managed well. Over half of medical staff were specialists in intensive care medicine. This meant that about 50% of out-of-hours consultant cover was by an intensivist. The fact that some on-call duties were covered by non-intensivist consultant anaesthetists meant that best practice guidelines were not being met.

There was an open incident-reporting culture and incidents of concern, particularly serious incidents, were investigated and lessons learned were implemented where necessary. Safety data was collected and the way in which some of the data was displayed for the public was under review.

The environment of the intensive care unit (ICU)/high dependency unit (HDU) was clean but the design and layout did not meet best practice building guidelines. Working space was very limited and storage space for equipment was also limited. Data showed that infection control was within expected ranges and infection control practices were generally good.

There were suitable processes in place for assessing patient risk and escalating concerns, with a clear escalation policy.

Incidents

Critical care

- There had been no 'never events' requiring investigation between January 2014 and March 2015. A 'never event' is a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken.
- There had been two serious incidents between April 2014 and March 2015; both related to pressure area care and pressure sores. One patient developed a sore from wearing a specialised breathing mask and another patient developed a sore from a tracheostomy tube (a tube inserted in a surgically created opening in a patient's windpipe).
- A root cause analysis had been conducted for both incidents and learning or changes to practice had been implemented.
- For the specialised breathing masks, new face pads and gel-padded masks had been introduced. In relation to the tracheostomy sore, lessons learned were disseminated to unit staff in order to raise awareness and re-emphasise best practice with a view to preventing similar incidents.
- An incident had occurred at the York Hospital CCU involving a tracheostomy, and changes to practice had occurred as a result. These included revision of the tracheostomy competency pack, revision of the tracheostomy policy and inclusion of scenarios involving tracheostomy tubes to scenario-based training sessions. Discussions with the CCU sister in Scarborough showed that the lessons had not been shared. However, the two units had officially merged only six weeks prior to the inspection.
- The unit sister stated that all incidents were discussed at 'all staff' meetings and there was an incident log for each month.
- The incident log was also reviewed at 'all staff' meetings and lessons learned and changes required to practice were also highlighted.
- Nursing staff we spoke with were able to describe how they reported incidents; this was via a computer system known as Datix.
- We asked the unit sister how staff knew what to report on the Datix system and they stated that if staff were uncertain they asked a more senior member of staff.
- We reviewed incident data provided by the trust. This related to theatres, anaesthetics and critical care, including the CCU at Scarborough Hospital; the data was not specific to critical care only.
- For the Theatres, Anaesthetics and Critical Care Directorate, there was a total of 409 recorded incidents between April 2014 and December 2014. The majority of recorded incidents (298) were 'no harm'. There were 72 minor or low harm incidents, six moderate harm and two severe harm. The severe harm incidents had been fully investigated and lessons learned had been implemented. The data showed that 30 incidents were not classified ('blank'). We were not able to establish whether these figures were comparable to those for other similar-sized directorates in other hospital trusts.
- Of the 409 recorded incidents, there were 28 falls (21 no harm, five minor/low harm, one moderate and one severe), 23 medication errors (none involving controlled drugs) and 134 pressure ulcer incidents, 19 of which were newly developed sores (113 no harm, 16 minor/low harm, four moderate and one severe). The number of recorded pressure ulcers seemed comparatively high and comprised around 32% of all recorded incidents.
- In relation to pressure ulcers, we were not informed of any specific initiatives or focused work to tackle the problem within the directorate. It was acknowledged that 85% of pressure sore incidents were defined as resulting in no harm but just under 3% were moderate harm and 0.75% severe harm.
- We asked the unit sister if there were any formal meetings where mortality and morbidity were discussed and were told that such meetings had started relatively recently. We reviewed the meeting minutes for February 2015 where ICU mortality and morbidity were agenda items.

NHS Safety Thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring, and analysing patient harm and 'harm-free' care. The NHS Safety Thermometer records the presence or absence of four harms: pressure ulcers, falls, urinary tract infections (UTIs) in patients with a catheter and new venous thromboembolisms (VTEs).
- While on the unit we did not observe any publicly displayed patient safety data. The unit sister informed us that displaying such information had recently stopped and was under review; there were plans to display patient safety data again in the near future but in a different format.

- The unit provided NHS Safety Thermometer data to the Health and Social Care Information Centre (HSCIC) on a monthly basis.
- We asked about some key safety data and found that the unit had had 170 days without a ventilator-associated pneumonia (VAP) infection and, in November 2014, there had been one central line infection, which had been the first in three years.
- The NHS Safety Thermometer data for 'harms' occurring between June 2014 and March 2015 showed only one recorded harm; this was for a pressure ulcer in August 2014.
- There were no recorded 'harms' for falls, UTIs or VTEs between June 2014 and March 2015.
- This meant that the 28 falls and 133 of the 134 pressure ulcers mentioned above did not occur in critical care but in other areas that came under the Theatres, Anaesthetics and Critical Care Directorate, although we were not clear about where these 28 falls and 133 pressure ulcers had occurred.

Cleanliness, infection control and hygiene

- Some infection control data formed part of the quality indicator and outcome data presented in the ICNARC report. The report provided by the trust for Scarborough Hospital CCU was for the period from 1 January 2014 to 30 June 2014. However, we were able to speak with the clinical lead and unit sister about more up-to-date information and the main trends of concern for the unit.
- Trends in unit-acquired infections, for methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) for the period 1 January 2014 to 30 June 2014 were within expected limits and not above the figures for similar units; this included MRSA bloodstream infection.
- The last MRSA bacteraemia had occurred 2,200 days previously and the last C. difficile infection 400 days previously. There had been one methicillin-sensitive Staphylococcus aureus (MSSA) bloodstream infection in the previous 12 months.
- We observed the physical environment of the unit and found that surfaces, particularly commonly touched surfaces, were visibly clean and there were suitable cleaning schedules in place.
- Equipment was also visibly clean and nursing staff we spoke with understood their role in ensuring that the environment and equipment were clean.
- We noted that there were designated hand-washing basins within every bed bay area and that these were easily accessible.
- There was one hand-washing basin or scrub sink situated opposite the nurses' station in the main corridor area. The sink was set into the worktop and was not free-standing; this did not meet best practice standards.
- Alcohol hand rub was available for staff and visitors to use and was accessible near the point of care.
- We were informed that hand hygiene audits were conducted on a monthly basis and compliance results were acceptable.
- We observed nursing and medical staff providing care and support to patients and, in the majority of cases, staff used alcohol hand rub before patient contact.
- Personal protective equipment (PPE), including gloves and aprons, was easily accessible. We observed staff using PPE when required.
- Use of PPE was also audited and the unit sister described how the overuse of gloves had been an ongoing issue or challenge.
- To address this problem, the infection control team for the trust had designed a poster to encourage staff to think more carefully about glove use and to discourage the wearing of gloves for common tasks such as bed making, administration work and carrying meal trays.
- There was a designated isolation room and staff could use the bay with two beds to isolate a second patient if necessary.

Environment and equipment

- There were known challenges with the environment of the unit and these had been noted at the CCU multidisciplinary team (MDT) meeting in February 2015. The main issues noted were lack of capacity and storage and the fact that the unit was non-compliant with building regulations.
- The unit was not purpose-built; in practical terms, the CCU had been put into what was a hospital ward.
- The patient environment was comfortable but working space for staff was limited and the unit fell short of national new-build specifications for CCUs.
- The working space around the beds did not meet best practice guidance and space became particularly tight when specialised equipment was used on some patients.

- Storage space was an issue for the unit. Some changes had occurred prior to our inspection to improve this, including optimising the space available.
- Physical space for storing larger items was limited but staff attempted to use the space available the best they could.
- There was one side room that had been refurbished relatively recently to include an automated sliding door and the ability to provide negative pressure if required.
- In relation to equipment, there was a rolling equipment replacement programme in place and several items of equipment had been replaced relatively recently. For example, patient monitors, ventilators and volumetric pumps were all relatively new.
- There were 12 mattresses for a total of seven beds; this meant that there was an adequate number of mattresses to allow them to be sent for cleaning. Mattresses were cleaned in-house at the equipment library facility.
- The unit had a blood gas machine and there was technical support provided remotely for the machine during weekday office hours. We were told that the machine regularly required technical support but that this service was not available out of hours. This was causing difficulties for staff and they were often required to use blood gas machines in other departments, including A&E and the acute medical unit.
- The unit did not have tracking on the ceiling to enable patients to be hoisted, so a portable hoist was used. The unit had its own slings but not a portable hoist; this had to be borrowed from a nearby ward. Resuscitation equipment was easily accessible and there were separate trolleys used in emergency situations; resuscitation equipment was checked daily.
- We were informed that equipment on the resuscitation trolley was all single patient use and items in packets were not opened until they were to be used.

Medicines

- We were unable to speak with the unit pharmacist during the inspection. The unit sister confirmed that the unit pharmacist was a senior pharmacist and was on the unit each weekday during school terms. During school holidays a pharmacist continued to visit the unit but was a more generic pharmacist.
- Most of the time, the unit was covered by a pharmacist who had suitable critical care pharmaceutical knowledge and, for the size of the unit, input from the pharmacy service was seen as sufficient.
- We were unable to establish whether the pharmacy service had benchmarked itself against all aspects of the guidance for pharmacy as set out in the Core Standards for Intensive Care Units (2013).
- We reviewed two drug charts and found that they were completed accurately and clearly set out.
- We were informed that pharmacists working on the unit closely monitored the standards of prescribing via their day-to-day activities and the unit was part of the annual trust-wide pharmacy audit.
- We observed the one drug fridge and found that the door was appropriately locked, temperature checks were recorded daily, and the temperatures, on the day, were within the correct range of +2°C to +8°C.

Records

- We reviewed both medical and nursing records. A key document used by the nursing team was the observation chart. We observed three charts and saw that the nursing observations and interventions had been documented accurately.
- There were separate medical and nursing files; the contents were standardised and information was easy to locate. There was a third file for the physiotherapy team.
- Many of the interventions and risk assessments were managed using specific care bundles. We reviewed the use of some care bundles, for example for skin integrity, and found them to be completed accurately.
- We reviewed two sets of medical notes and found that documentation was of a good standard and included admission details and assessments, daily reviews and multidisciplinary input.

Safeguarding

- There was a lead nurse for safeguarding who was a key point of contact for safeguarding matters, support and advice. The lead nurse was easily accessible.
- Safeguarding incidents were often discussed at an MDT involving medical staff, senior nursing staff, including the matron, and members of the safeguarding team.
- Safeguarding was part of the mandatory training programme; all qualified nursing staff and allied

healthcare staff were required to complete level 2 training on safeguarding adults and children and healthcare support workers were required to complete level 1 training for adults and children.

- Safeguarding training was recorded for the Scarborough site and within that the group of theatre, anaesthetics and critical care staff. Safeguarding adults level 1 training for nursing was 93% compliant against a trust requirement of 75% and 36% for medical staff. Safeguarding adults level 2 for nursing was down as being both 19% and 100% compliant with no data provided for medical staff. Safeguarding children level 2 for nursing was recorded as both 64% and 31% for medical staff. Safeguarding children level 3 training data were not provided for theatres, anaesthetics and critical care.
- Some other staff groups had low rates of compliance with safe guarding training. For example, additional clinical service staff was 48% for Safeguarding children level 2 training and 54% for safeguarding adults level 1 training.
- Staff told us about situations where safeguarding processes had needed to be initiated. We were informed by the unit sister that the processes were effective and staff escalated concerns appropriately.
- Nursing staff we spoke with were clear about how to escalate safeguarding concerns and what might be seen as a safeguarding issue. Staff were also clear about how to access the trust's safeguarding policy and the safeguarding team.

Mandatory training

- The training information provided centrally from the trust was for the Scarborough hospital site but not specific to critical care. It included staff from the theatres, anaesthetics and critical care directorate. The trust stated that the training data presented was 'averages of averages' so the figures were indicative.
- Some aspects of the training data provided were for statutory training, which included fire safety awareness and health and safety.
- The target for all mandatory and statutory training was 75%. Training was split into five staff groups: 'additional professional, technical and scientific', 'nursing and midwifery registered', additional clinical services', 'administrative and clerical' and 'medical and dental'.
- The training data we reviewed covered 26 different topics, including the two different levels of training for infection prevention and control and safeguarding for adults and children. There were 133 separate items on the list that should have had compliance figures of 75% or above (green). Some subjects were repeated and had different compliance figures, which made the data difficult to understand. The reason for the wide range was not clear or explained in the data presented. See the safeguarding figures above as an example.
- Of the 133 items, 49 items were green and the remainder were red (less than 75% compliance);
- Seven areas had 0%, including 'care of the patient with diabetes' for 'nursing and midwifery registered'. It was acknowledged by the unit sister that the mandatory and statutory training figures for the unit could have been better. There was a newly introduced 'learning hub' that aimed to improve access and monitoring of training.
- Mandatory and statutory training was provided in day block sessions, which meant that staff could complete their training in one day.

Assessing and responding to patient risk

- There was a critical care outreach service that played a key role in supporting the unit, and other wards and departments, in assessing and responding to patient risk.
- The critical care outreach service generally provided support on weekdays between 8am and 6pm.
- All wards had a list of patients whom outreach needed to be informed about.
- The hospital had a 'hospital at night' team that provided support to wards and units overnight, including flagging up and managing deteriorating patients.
- When the outreach service was not available due to a lack of staffing, staff on the CCU held the outreach pager. Concerns were raised in relation to the availability of the outreach service.
- Outreach played a key role in managing the deteriorating patient and, when possible, visited every ward or department twice a day. Outreach also provided training to nurses across the hospital; this included training in relation to sepsis, blood pressure, tracheostomy care and interpreting clinical observations.
- The outreach team also delivered a specific training course on managing the deteriorating patient.
- The unit sister was part of the deteriorating patient working group that covered both main trust sites: York and Scarborough.

Critical care

- We spoke with one of the two band 6 critical care outreach nurses and we were informed that the outreach nurses were regularly used to cover nursing shifts on the CCU and in other wards and departments, including the A&E resuscitation area; this happened on at least one shift per week.
- This was not seen as ideal as it disrupted the continuity of the outreach service. It affected the continuity of care for patients who had been reviewed the previous day and it also meant that patients were not able to benefit from the service during certain periods of the week. This, in turn, arguably increased risk to patients on the days the service was not running.
- The critical care outreach nurses were enthusiastic about their role, a key part of which was educating staff, not only on the CCU but across the hospital. However, time for teaching was limited because of resource limitation and the priority of managing patients. Lunchtimes provided the main opportunity for teaching but these were usually only 20-minute sessions.
- We reviewed some work that had been developed to support the management of the deteriorating patient; this included a critical care outreach assessment using the SBAR communication approach (Situation, Background, Assessment, Recommendation).
- There was also a separate form, using SBAR, for follow-up by the critical care outreach team. The outreach team followed up all patients who had been discharged to a ward or department within the hospital; this was a positive aspect of the service. However, this was affected if the team was not available.
- The hospital had implemented the use of an early warning score (EWS) system; this is a way of standardising the assessment of acute illness severity in the NHS. The system is used to support staff in determining the urgency of a clinical response. A low score prompted an assessment, a medium score prompted an urgent review, and a high score prompted an emergency assessment.
- There was an escalation process and the outreach team was easily accessible and could be paged during usual working hours.
- We were told that, because the unit was split into two separate bays and a separate side room, line of sight to the patients was not ideal; it was not possible to observe patients all of the time. To mitigate this, staffing skill mix was managed as well as possible; it was ensured that one of the two nurses working within the bays was experienced. Two comparatively inexperienced nurses were not put together if at all possible.

Nursing staffing

- The unit had a total of 31 registered nurses (RNs): these included one band 7 nursing sister and 5.2 whole-time equivalent (WTE) band 6 nurses. The planned number of band 6 nurses was 6.2, but the unit was down by one band 6 nurse.
- There was a full complement of band 5 nurses.
- With the size of the unit, national guidance suggests that there should be a 0.5 WTE clinical educator. There was no designated clinical educator and the role was being partly fulfilled by the band 7 sister.
- The unit sister was the identified lead for the unit; at the time of our inspection, the role was mainly a management role. This enabled them to perform duties as described within national guidance such as quality improvement and staff management.
- The band 7 sister was soon to become part of the unit nursing numbers, which would drastically reduce their available time to perform management duties. This would also affect the time available for clinical education.
- The unit should have had a supernumerary clinical coordinator to, at a minimum, coordinate activity at peak periods.
- We were informed that, as soon as the unit had adequate numbers of staff to ensure the safe care of patients, any staff seen as not being required were sent to support other wards or departments; this included outreach nurses and band 6 nurses.
- Nurse staffing levels on the unit were not meeting the recommendations made in national guidance. This was particularly apparent in terms of the nurse educator role, supernumerary clinical coordinator and outreach team.
- It also appeared that the imminent changes to the band 7 sister's role would affect the time available for management and leadership tasks.
- The staffing issues and the fact that staff were being called upon to support other areas on a frequent basis were affecting morale; the 'good will' of staff was running short, according to staff we spoke with.

Critical care

- The unit used external agency nurses and bank nurses where necessary. We were told that external agency nurses covered between two to three shifts per week and band nurses covered around five shifts per week.
- It was stated that covering shifts with agency nurses was a challenge because of the location of the hospital; not many agency nurses were available locally.
- Nurse staffing was clearly a challenge and the overall use and management of staff were having a negative impact in several areas, including clinical education, unit management, clinical coordination, continuity of care, outreach and morale.
- We were unable to sit in on a nurse handover but we spoke with junior and senior nursing staff about the process. The handover process had been changed relatively recently as part of the 'productive ward' process. This was specifically aimed at making the process more patient-focused and using handovers to drive safety and quality for patients and staff.
- Staff explained that handovers used very specific handover sheets that included information from the doctor's ward round.
- It was felt that the handovers worked well and no concerns about them were raised with us.

Medical staffing

- Six weeks prior to our inspection, critical care at York Hospital and Scarborough Hospital merged. Part of this involved considering staffing arrangements, especially in terms of medical clinical leadership.
- There was a Clinical Director of Theatres, Anaesthetics and Critical Care covering the two sites. Under the director, there were two clinical leads, one based at York Hospital and the second (deputy clinical lead) based at Scarborough Hospital.
- At Scarborough Hospital, there were six consultant intensivists for critical care and five consultant anaesthetists; between them, they rotated shifts on the unit and provided on-call cover.
- Shifts on the unit were 8am to 6pm Monday to Friday and were staffed by a consultant intensivist with a trainee or locum registrar.
- Outside these hours, consultant cover (non-resident unless living more than 20 minutes away) was provided by the on-call consultant anaesthetist. There were 12 consultants taking part in the on-call rota, of whom six were intensivists.
- This meant that about 50% of out-of-hours consultant cover was provided by an intensivist; the rest of the cover was provided by a consultant anaesthetist which was not in line with national best practice guidance.
- When there was a non-intensivist consultant on call there was a policy in place whereby the non-intensivist called an intensivist (either the Scarborough intensivist of the week or the on-call intensivist in York) to discuss new admissions.
- The unit also tried to ensure that weekends were split between a consultant intensivist and a non-intensivist so that all patients were seen by an intensivist at some point during the weekend, as well as being reviewed by the non-intensivist.
- There was always a resident doctor covering the unit; this could be an anaesthetic trainee, a locum registrar or a resident consultant.
- Within the last six months, the unit had started to increase the use of the resident consultant to cover the hospital at night; this included covering the unit.
- The consultant-to-patient ratio was 1:5 which was as specified in best practice for patients requiring level 3 care.
- The split of anaesthetists and intensivists meant that elements of national best practice guidelines could not be met, particularly relating to the on-call rota. However, cover was managed in a practical way and cross-site support was available from an intensivist.
- To some extent, the staff mix also affected the ability of all patients to be assessed by a consultant intensivist within 12 hours of admission.
- The challenges with consultant staffing were recognised and the Clinical Director of Theatres, Anaesthetics and Critical Care stated how there was a trust-wide review of critical care, including medical staffing.
- Scarborough had taken on four new consultant intensivists in recent months and was due to take on two more. Plans were to split some consultant job plans to include both Scarborough and York in order to provide cross-cover and broader consultant intensivist support.
- All consultants did one-week block shifts; this met best practice guidance and supported continuity of care and patient safety.
- We observed a medical handover, which was decisive and proactive. There were no concerns.
- We were informed that medical locums were used infrequently on the unit.

Critical care

Major incident awareness and training

- There was a major incident policy in place. All major incident and business continuity plans were available on the intranet.
- Staff we spoke with were aware of the procedures to follow if there was a major incident. They knew where the policies and procedures could be found for reference.
- Consultants on the unit had attended Emergo training. The Emergo Train System was developed in Sweden in the 1990s and is a disaster simulation exercise and training system.
- There were plans in place for major incidents, for example an influenza pandemic or Ebola.
- Business continuity plans were also in place, for example if there was a power shortage. All ventilators had back-up power supplies and there was a back-up generator that was tested regularly.

Are critical care services effective?

Requires improvement

In-house training was varied. Staff felt well supported in their role but were restricted in developing their skills and knowledge in some instances because of staffing pressures; staff could not be released for training frequently enough. The lack of a clinical educator also had a negative impact on the development of staff.

The services were part of the Case Mix Programme managed by ICNARC which was positive, but there was limited evidence of other measures being taken to assess effectiveness. There were no concerns with regard to outcome data presented in the latest ICNARC report. Medical and nursing practice was based on up-to-date evidence and followed best practice guidance. Support from specialist teams was limited as there was no hospital-wide pain team and input from the dietetics service did not meet best practice recommendations.

There were effective processes in place to ensure that new members of staff were supported; these included induction, competency-based training, peer support, supervision and appraisal. Staff, both nursing and medical, had a good understanding of consent and best interest decisions and, in the majority of cases, discussions with patients or friends and family were well documented.

Evidence-based care and treatment

- Some nursing staff on the unit had been to a research training day that had provided the nurses with skills and insight into research and implementing best practice.
- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of the nursing care provided were based on the use of care bundles, for example the ventilator care bundle and skin care bundle. Such bundles were evidence-based and aligned to best practice guidance.
- In terms of medical interventions, from our observations and discussions with medical staff, the approaches taken followed up-to-date medical practice.
- Policies we reviewed were based on best practice guidelines and were up to date and easily accessible via the intranet.
- There was a trust-wide research nurse who provided support with critical care-specific audits.
- A sepsis drug trial and a ventilated patient weaning study were under way. In total, there were seven trials being undertaken.
- The unit sister stated that VAP documentation was audited every month and central venous catheter CVC lines had been audited since January 2015; these were examples of audits that linked to local policy.
- However, there was limited evidence in terms of local assurance that staff adhered to local policies and procedures for either nursing or medical practice; this included audit activity.
- In relation to nursing, we requested a list of audit activity and the impact audits had made on clinical practice but no information was provided. From speaking with nursing staff, we felt that audit activity and results of audits were not clearly understood.
- High-impact intervention (HHI) audits had been conducted trust-wide on a regular basis but these had stopped. The HHI audits were aimed at ensuring high-quality care and they provided a way of measuring procedures and practice against key policies.

- The Intensive care/high dependency unit operational framework for Scarborough hospital dated February 2015 included reference to the Intensive Care Society (2006) Detection, prevention and treatment of delirium in critical ill patients.

Pain relief

- There was no hospital-wide pain team; the unit staff supported patients requiring pain management in-house. We were told that staff, including the consultant intensivists, were experienced and able to competently manage work relating to pain management.
- There had previously been a nurse pain specialist within the hospital who provided support to the wards and departments, but the post had become vacant and had not been filled. The position was still vacant at the time of our inspection.
- Staff within the unit managed all patients, including surgical patients, with pain control and pain assessments; this included patients with epidurals and patient-controlled analgesia (PCA) pumps. Support was also provided by outreach nurses.
- The unit used a critical care pain observation tool (CPOT).
- We reviewed patient records and observed the appropriate use of pain scores and support for patients requiring pain relief.
- All pain relief medication was stored and managed appropriately by staff.

Nutrition and hydration

- The British Dietetic Association recommends that there should be 0.05 to 0.1 WTE dieticians per bed. This recommendation was not being met at the unit.
- The dietician for the unit confirmed that they, or a colleague, visited the unit three times a week, on Monday, Wednesday and Friday.
- They were not aware that the existing service provision had been benchmarked against the national core standards for CCUs.
- The unit sister described how they used to have dietetic support five days a week and that the drop to three had impacted on nursing workload and had diluted the specialist support for patients.
- The dieticians worked as part of the MDT and attended the MDT ward rounds when possible.
- There was a protocol in place for initiating nutritional support out of hours. With the support of medical staff, nursing staff were able to initiate this.

Patient outcomes

- We reviewed ICNARC data for the period 1 January 2014 to 30 June 2014. Unit mortality data for ventilated admissions was within normal ranges. Unit mortality for admissions with severe sepsis was more variable but numbers were not excessive and followed the averages of similar units.
- The other unit mortality outcome measures, including for elective surgical admissions, emergency surgical admissions and admissions with trauma, perforation or rupture, were all within normal ranges compared with those for other, similar-sized units. Mortality for admissions with pneumonia had risen slightly in early 2014 but not excessively.
- Other quality and patient outcome data, including on early readmissions, early deaths, late deaths, late readmissions and post-unit hospital deaths, was all within expected ranges compared with data from other, similar-sized units.
- For the past few years, early reported discharges had seen a pattern of inconsistency. As of quarter 1 of 2014, early reported discharges were only slightly above the average compared with those of similar units.
- Data relating to non-clinical transfers out was the most negative. More recent data, for the end of 2014 and early 2015, showed the unit as being the greatest outlier for non-clinical transfers out in the whole country. Approximately 300 admissions (about 4.5%) had been transferred to other CCUs because the unit was full; such transfers did not occur for any clinical reason.
- We were informed that many transfers were to York Hospital's CCU, which was about 43 miles away – a one-hour drive in ideal traffic conditions. Some transfers were to hospitals outside Scarborough Hospital's critical care network; these included Wakefield, which was 80 miles away or just under a two-hour drive.
- In January 2015, for example, there were seven non-clinical transfers out, three of which were outside the network.
- Between April 2013 and March 2014 there had been 20 non-clinical transfers out. Between April 2014 and the middle of March 2015 there had been 28.

- It is recognised that transferring unwell patients for no clinical reason increases morbidity risk and is not ideal. In addition, staffing resource was taken from the unit as each transfer required a doctor and a nurse to escort the patient in the ambulance.
- Early readmissions and late readmissions to the unit were within expected ranges compared with those in similar units.
- Mortality ratios and trends in mortality were within expected ranges compared with those in other units and similar units.
- There were no reported CQC instances of the hospital being an outlier in any clinical areas.
- We were unable to establish the full extent to which the unit participated in other audits, including national audits. We requested information, a list of clinical audits and details of any critical care network peer audits, but no information or data was received.

Competent staff

- The unit sister stated that the unit's compliance rate for staff appraisals was around 50% and that this was an area that required improvement.
- However, the data provided centrally from the trust provided a more positive picture, as shown below.
- There were processes in place for managing appraisals; a band 6 nurse conducted these for the more junior nurses and the unit sister had their appraisal completed by the matron. Administrative and clerical staff had achieved 100% of appraisals. Nursing staff appraisals had deteriorated slightly and were at 77 % in November 2014.
- Medical staff told us that suitable processes were in place for managing revalidation and all consultants were up to date.
- We asked about guidelines for newly appointed consultants. There were no guidelines specific to critical care but there was a hospital-wide policy that provided suitable information in relation to the processes that should be followed.
- All medical staff were required to attend corporate induction and follow local induction protocols.
- In relation to nursing staff, a key best practice recommendation (Core Standards for Intensive Care Units 2013) is for a minimum of 50% of registered nurses to have been awarded a post-registration award in critical care nursing. At the Scarborough unit, around 20% of nurses had completed the award.
- All staff attended corporate induction and then a period of unit-level induction; this varied depending on the job role.
- All new band 5 nurses worked through a specific induction package and an eight-week preceptorship programme.
- Induction as a whole included three days of corporate induction and a few days of local induction on the unit; this included specific critical care competencies.
- There was access to additional training provided in-house, for example in advanced life support.
- Simulation training was also provided using a training manikin; this was done at the education centre.
- A fundamental issue was the lack of a dedicated clinical nurse educator. Best practice guidance states that each CCU should have a dedicated clinical nurse educator and the role should be supernumerary; the post was being covered as part of the unit sister's role.
- All the nurses we spoke with on the unit said that they felt well supported and that study was available in specific circumstances to support education. However, the ability to release staff for training was limited because of staffing pressures.

Multidisciplinary working

- We attended ward rounds and observed medical practice. The care provided involved the full MDT and we found that different staff teams worked constructively together.
- The MDT approach enabled care to be delivered in a coordinated way. Services such as pharmacy, physiotherapy, pain management and dietetics worked well with the nursing and medical team.
- External MDT working in relation to critical services, particularly with York Hospital, was steadily increasing. As discussed, the York and Scarborough CCUs had merged only six weeks before our inspection.
- Partnership working for critical care between the two sites was being developed and there were monthly directorate meetings that included staff from both York and Scarborough Hospitals.

Critical care

- The outreach team worked closely with the critical care team and wards or departments across the hospital. However, the fact that staff were released to support staffing gaps across the trust was affecting the delivery of the service.
- The outreach team followed up each unit discharge to the ward to ensure that ongoing care was appropriate and to provide support to ward staff. However, again, the staffing issues affected the continuity of service provision.
- Physiotherapy attended ward rounds on a regular basis and microbiology attended at least three times a week.
- Occupational therapy and speech and language therapy (SALT) were accessible and provided support to specific patients.

Seven-day services

- X-ray and computerised tomography (CT) were accessible 24 hours a day, seven days a week. Out of hours, medical staff were able to liaise with the on-call radiologist if necessary.
- Pharmacy services were available between 8am and 6pm on weekdays and via telephone at weekends and out of hours. At night, there was an on-call pharmacy service.
- Physiotherapy services were available Monday to Friday, 8am to 6pm, and there was a weekend and out-of-hours on-call service.
- Occupational therapy services were available during the week from 8am to 6pm.
- Medical consultants provided on-call support for critical care at weekends and out of hours.
- Magnetic resonance imaging (MRI) was available but not for patients who were intubated and under a general anaesthetic (GA). This was not ideal and patients who needed an MRI who were under a GA were transferred to York.

Access to information

- Nursing staff we spoke with felt that information they required was straightforward to access.
- All policies and procedures were easily accessible via the intranet.
- Documents were easy to locate, including all care pathways, care bundles and infection control paperwork.
- Staff were able to easily access blood results and x-rays via computer.
- Some information was also on laptop computers near the bedside and certain forms could be completed electronically, including falls and nutritional assessments.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We spoke with nursing staff about consent to treatment. They recognised that this was a challenge in the critical care environment due to the acute nature of the care provided.
- The nurses we spoke with described how consent was gained, where possible, from patients prior to certain procedures. For example, some patients required additional sedation and this was something that was discussed with patients beforehand and documented.
- We observed a situation in which staff gained verbal consent from patients before proceeding with a medical intervention and information was suitably delivered and documented by the staff.
- In relation to mental capacity and deprivation of liberty safeguards, staff provided examples of situations in which certain safeguards were required with patients. The examples included situations in which best interest decisions needed to be made, and where the MDT, safeguarding lead and family or friends were involved.
- The unit had a specific care plan for restraint, a risk assessment tool, a decision flowchart and information for relatives.
- Training on mental capacity and deprivation of liberty was provided as part of the mandatory training programme.
- The hospital safeguarding lead was easily accessible for advice and support and attended the unit if specific mental capacity or deprivation of liberty guidance was required.
- A flowchart had been introduced for the weekly ward round, as used at York Hospital. This helped prompt staff on best practice and deprivation of liberty assessments. There was also a specific critical care mental capacity assessment form.

Critical care

Are critical care services caring?

Good

We found that, overall, critical care services were caring. The patients, relatives and friends of patients we spoke with gave positive comments about the care provided. Patients and other people felt that staff were supportive and respectful. Patients and other people also felt that they were adequately involved in decisions about their care and their views were listened to.

In terms of emotional support, there was positive feedback from patients and their families and positive comments were received about the support provided by healthcare staff. Support was also available from other services, such as chaplaincy, but there were no formal processes in place in terms of counselling and/or psychological support for patients and/or families.

Compassionate care

- We spoke with two patients on the unit including a long-term patient.
- It was felt that the medical and nursing care provided was good and patients felt well looked after.
- Staff were described as supportive and listened to any comments or questions patients had about their care.
- Patients also felt that things were clearly explained to them and they were provided, where possible, with choices in relation to their treatment.
- We spoke with one relative who had no concerns about the care provided and felt well informed about the care being provided.
- We observed nursing and medical staff interact with patients and with relatives and friends. Staff were compassionate and caring in their approach and manner.
- The unit had participated in the Friends and Family Test but had not completed the test for a significant length of time because patients were very infrequently discharged from the unit to home.
- The unit did not conduct patient surveys. We were not told of any plans to implement these.
- A key way in which feedback about the service was provided was via thank you cards and letters; these provided positive feedback.
- Complaints were a way in which negative feedback was captured. Complaints were reviewed closely.
- There were limited activities undertaken to actively gain the views of patients and/or their families and friends.

Understanding and involvement of patients and those close to them

- All the patients we spoke with felt that they had been suitably involved, informed and consulted in the care and medical interventions being provided.
- One patient who had been on the unit for a relatively long period felt that they had been fully informed throughout their care in the CCU.
- Another patient we spoke with felt involved in their care and felt that any questions they asked were answered in full.

Emotional support

- There was a chaplaincy service available within the trust. However, the chaplain at York Hospital had retired and the Scarborough Hospital chaplain re-located to the York site. This had affected access to the service because of the distances between the two hospitals.
- There was a bereavement service which was easily accessible.
- We were informed that the safeguarding team was accessible and was able to provide advice in relation to the provision of emotional support.
- Specific services, such as counselling, were not available. Access to such services had to be gained via people's GP.
- We were not informed of any formal assessments used to assess anxiety and depression. Staff described how aspects of this would be noticed during day-to-day care and in observations or discussions about patients' overall well-being.
- In addition, the medical and nursing teams were seen as instrumental in providing ongoing emotional support on a day-to-day basis during a patient's hospital admission.
- It is recognised that some people can be emotionally affected after having been a patient on a CCU and post discharge clinics are seen nationally as an important part of patient follow-up. However, due to the lack of funding, this service was not provided at Scarborough.

Are critical care services responsive?

Critical care

Requires improvement

Overall, we found that the critical care service required improvement in this domain. As part of the Theatres and Anaesthetics Directorate, the Critical Care Units of York Hospital and Scarborough Hospital were officially merged in April 2013. We were informed that the more practical aspects of the merger, particularly in terms of joint working, did not start until September 2014. Key decisions and the clinical model design were yet to be finalised; this affected how full integration was to be achieved. The Trust was engaged with its CCGs in undertaking an external review to identify the model of critical care to be delivered and how this was to be financed. The timescales as stated on the headline directorate service plan did not reflect the existing levels of integration. At the time of the inspection, the Trust were key participants in the early stages of planning and scoping the external review and are working with external strategic partners to identify the model of critical care of the future , what is to be commissioned and how it was to be financed and delivered.

The key decisions and the design of the clinical model to meet people's needs was yet to be finalised.

Quality indicator information regarding patient flow presented a mixed picture; key challenges related to delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out. These areas were recognised as risks, and a solution had been put forward to increase staffing on the unit to enable an additional bed to be made available. However, such plans were not formally set out and decision processes were not clear. The mitigating steps being taken to tackle the patient flow issues were not explicit.

The services provided generally met people's needs. We found care to be person-centred and staff were supportive and responsive to patients' needs. Staff also provided support, where necessary, to patients' family and/or friends.

Formal complaints about the service provided were few. Where there had been issues raised about the service, these were addressed appropriately and changes were implemented if necessary.

Service planning and delivery to meet the needs of local people

- From our discussions, it seemed that key decisions and the design of the clinical model were yet to be finalised, which affected how full integration was to be achieved. The timescales as stated on the headline directorate service plan did not reflect the existing levels of integration.
- The organisation was working with its commissioning partners in the scoping of an external review of critical care services, the outcome of which would inform the development of service plans
- The documents we reviewed considered the needs of the local population to a certain extent but there was no detailed analysis. We were provided with meeting minutes, dated 21 November 2013, from a 'time-out' session for theatres, anaesthetics and critical care. Key issues were touched upon, including which services would be best placed in which locations and how services could meet the needs of people while ensuring value for money.
- The meeting minutes were from 2013 and no other documentation was provided highlighting the key issues and planned solutions for critical care service moving in to 2015/2016.
- The Director of Theatres, Anaesthetics and Critical Care (York and Scarborough) was able to describe the plans for critical care as an integrated service. Apparently, the plans had been approved by senior management.
- We were not presented with final plans for integrated critical care services, and senior directorate-level staff were uncertain about the future plans for the service.
- The Trust was not in a position to provide any finalised plans until agreement with key stakeholders around service provision and financing were agreed.

Meeting people's individual needs

- From our observations, from speaking with staff and from speaking with patients and family or friends, we found that care was centred on meeting people's individual needs. These needs tended to be acute medical needs but other needs were also addressed, for example emotional needs.
- The unit had experience of caring for and supporting patients with complex health needs and staff described the importance of MDT working and care planning.

- In many cases, people with complex health needs received close support from family members or carers. Staff on the unit worked closely with family members and carers in such instances and were flexible about the times people could visit the unit. f patients had their own carers, staff worked closely with the carers to ensure that optimum care was provided for the patients concerned.
- Translation services were available and staff could arrange these via the main reception.
- There were no specific resources available for extra support or advice in relation to supporting patients with learning difficulties or dementia.
- We were not informed of specialist staff who could be approached for advice or support or link workers who specialised in learning difficulties and/or dementia care. Such care was provided via the MDT and utilising the skills of the team.

Access and flow

- We reviewed the ICNARC data for the period 1 January 2014 to 30 June 2014. Data 'at admission' showed that 'non-clinical transfers in' for early 2014 were starting to rise above the average for similar units.
- Other patient flow data showed that out-of-hours discharges to the ward fluctuated. They had been steadily increasing and had consistently been above the averages for similar units.
- Delayed discharges (four-hour delay) for early 2014 were within acceptable limits but they had been increasing over time. Increased levels of delayed discharges (four-hour delay) are a national pattern and the numbers for the unit were within comparable limits. However, delayed discharges (four-hour delay) were seen as an issue for the unit.
- We spoke with the management of Anaesthetics and Critical Care (York and Scarborough), who recognised these issues. The short-term plan was to increase the number of beds on the unit by one and to increase nurse staffing levels.
- The unit was a significant outlier in terms of non-clinical transfers out which was at 4.6% during January – June 2014. The high number of non-clinical transfers out had a negative impact on patient safety. We were informed that a business case had been submitted relatively recently to increase the bed capacity on the unit to deal with delayed discharges, delayed admissions, high running capacity and non-clinical transfers out.
- The review of the business case had been put on hold until the planned service review had been completed. We were not informed when the service review would be completed, but, in the interim, risks remained in terms of the issues described above.
- Information provided to CQC prior to the inspection indicated that between June and November 2014 the bed occupancy of both the level three beds and the high dependency beds varied between 60% and 73%.
- Information provided during the inspection indicated that the unit was running at a consistently high occupancy rate of 100% and above. For example, over the New Year of 2014, the unit had run at between 100% and 104% capacity. At high capacity, some patients were transferred and managed by a member of the outreach team on the post-anaesthetic care unit (PACU). Ideally, according to national guidance, occupancy rates should be between 80% and 85%.
- Information provided before and during the inspection did not correlate. These discrepancies may have affected planning and monitoring of the service if the actual level of usage and availability of critical care beds was not known.
- The lead clinician acknowledged the challenges with patient flow and said that the issues were multifaceted. One main issue was the fact that the hospital was running at high capacity so there were often not enough ward beds to which patients could be discharged.
- The high occupancy rates were not listed on the risk register and interim mitigating actions to help relieve the pressures were not listed either.
- Two years before the inspection, the Scarborough unit had seen bed numbers decrease by one. At that time, there was a 50/50 split between medical and surgical patients.
- A six-bedded high observation bay (HOB) or surgical level 1 facility had been opened to benefit patients who needed closer monitoring after surgery or who were 'stepping down' from more intensive care. The staffing ratio was one nurse to three patients.
- The HOB was intended to reduce the number of surgical patients being admitted to the CCU in order to reduce high capacity levels.
- Over a short period, medical patient numbers had started to increase. In the past the unit had about 45% of days with patients requiring level 3 care. At the time of the inspection this had increased to about 75%.

Therefore, the unit had started to run at high capacity again. The bed that had been closed was reopened but capacity has remained high, which has increased the number of non-clinical transfers out.

Learning from complaints and concerns

- According to the data provided by the trust, there had been one complaint relating to the CCU within the previous 12 months.
- The sister for the unit was aware of all complaints and the outcomes of any investigations.
- We were informed that any concerns raised by patients, and/or visitors, would be managed in an informal way at an early stage to prevent matters escalating. However, staff knew how to register formal complaints.
- Learning from complaints was disseminated to staff via team meetings and/or at handovers.

Are critical care services well-led?

Requires improvement

At unit level, leadership was effective and nursing staff spoke positively about nurse leadership and the open and supportive culture. At a higher level, there had been relatively recent governance structure changes and some personnel were relatively new in their job role. The working arrangements were being embedded but there was progress to be made in terms of joined-up working within the York and Scarborough CCUs.

There were limited mechanisms in place for gaining feedback from patients and relatives. There were ambitions for the service and it was evident that changes were imminent in terms of service delivery. However, medical staff we spoke with did not seem aware of the plans for the future or of the strategic direction of the service, including how the Scarborough and York services would operate together in the short and longer term.

According to what staff told us, the overall culture within the service was supportive and staff felt that people in leadership roles were approachable. However, in some cases staff were not clear about the future and they said that they did not feel involved in the decision-making processes about the future of the service.

Vision and strategy for this service

- York Teaching Hospital NHS Foundation Trust had acquired Scarborough, North East Yorkshire Healthcare Trust (SNEY) in July 2012. According to discussions with the staff listed above, different directorates had merged at different times in a phased approach.
- The CCU at Scarborough and the unit at York had officially merged six weeks prior to our inspection. It was evident that the changes were relatively new and were still being embedded.
- In discussions with the leadership team, there was a mixed level of certainty in relation to the future service design, vision and strategy for the trust's critical care services as a whole. Considering the timescales involved, there was a lack of shared vision and structured strategic direction.
- We reviewed documentation in relation to the work that had been conducted on strategy, including the headline directorate service plan. The documents appeared to relate to early discussions during and/or just after the merger of SNEY with York Teaching Hospital NHS Foundation Trust. We were not presented with any specific or up-to-date strategy documents that clearly laid out the future plans for the critical care services at Scarborough and York Hospitals.
- The headline directorate service plan again made reference to SNEY. The directorate service plan covered the years 2012/13, 2013/14, 2014/15 and 2015/16. The plan for 2012/13 included a full merger of the critical service to offer level 2 and 3 care on both main hospital sites; 2013/2014 included considering all integrated service models; 2014/15 included agreeing on the clinical model design; and 2015/16 included implementation of the integrated service.
- The Directorate Manager for Theatres, Anaesthetics and Critical Care (York and Scarborough) confirmed that work on a new strategy document had started and there was an agreement to increase bed capacity at York and Scarborough.
- The Director of Theatres, Anaesthetics and Critical Care (York and Scarborough) had plans for the service which had, apparently, been approved by senior management. However, when speaking with the lead clinician and other members of the leadership team, there was distinct uncertainty about the future plans and structure of the service.
- Definitive decisions in relation to the future design of the two units, but particularly of the Scarborough unit,

seemed dependent on the imminent service review. However, there were known patient risks and the timescales for the start and completion of the review were not made explicit.
- The Director of Theatres, Anaesthetics and Critical Care (York and Scarborough) stated that, in the short term, there was to be a trust-wide review into critical care with a short-term plan to increase level 3 beds at York Hospital by one and at Scarborough Hospital by one.
- Additional anaesthetic consultant posts had been recruited to at Scarborough and York and a new operational director post had been applied for; this was a post intended to improve patient flow.
- Some changes had occurred with the merger of SNEY and York Teaching Hospital NHS Foundation Trust: for example, the York unit was now receiving more vascular and renal patients. Much of this was a result of Scarborough Hospital transferring such patients to York for treatment; this had an impact on both CCUs. However, the plans and strategic thinking behind such changes were not set out in the documentation we were provided.
- In light of the merger of the two units six weeks previously, changes were picking up pace. However, the implementation of changes and the thought processes behind them were not well established.

Governance, risk management and quality measurement

- There had been recent changes to governance structures within the directorate. The clinical leadership posts were relatively new and the Directorate Manager for Theatres, Anaesthetics and Critical Care (York and Scarborough) had not been in post long.
- We reviewed the governance structure chart for the Directorate of Theatres, Anaesthetics and Critical Care; this reflected some of the changes in terms of the recent merger. For example, Scarborough and York Hospitals had joint corporate-level meetings attended by anaesthetists. However, that was the only part of the framework that showed joint working.
- The Director of Theatres, Anaesthetics and Critical Care (York and Scarborough) stated that some cross-site working had started and one of the nine consultant intensivists from York worked one day a week at Scarborough and always went onto the CCU and into the operating theatres. The existing cross-site working structure was acknowledged as being ad hoc until firmer plans and additional staff were in place.
- The intention was that the new consultant-grade posts would split their work between the two hospital sites; this would help strengthen governance and shared working and learning.
- The Director of Theatres, Anaesthetics and Critical Care (York and Scarborough) had recently set up governance meetings with consultants and monthly directorate-level meetings via video link with Scarborough.
- Changes were happening steadily, but, again, there was no overarching plan and governance arrangements seemed in their infancy considering the length of time the merger had been known about.
- The involvement of staff in consultation processes for the intended changes was not clear and members of the Scarborough leadership team told us they had not seen some of the plans being discussed for critical care services.
- In relation to risk management, we spoke with the unit sister at Scarborough about the processes for monitoring risk and escalating concerns. If something was deemed a risk, a risk assessment was conducted and a judgement made about its severity and impact. Risk assessments were stored electronically on a shared drive. High-level risks were escalated to the divisional risk register and monitored at divisional level; there was the potential for these to be escalated to the corporate risk register if necessary.
- We were forwarded the divisional risk register and saw that items listed relating to critical care at Scarborough included the failure to comply with building regulations, the lack of capacity required to meet demand, being a significant outlier with non-clinical transfers out, and patients being cared for in recovery or PACU.
- Also on the register was the lack of storage space and the fact that temperatures were too high for patients and staff in summer because there was no air conditioning.
- From discussions with the unit sister, it was clear that key risks were understood and escalation processes were in place.

Leadership of service

Critical care

- In terms of nursing, and after having spoken with members of the nursing team, we found that people felt well led and that the senior nursing team was approachable and supportive.
- There was a good sense of teamwork and people felt supported by colleagues at both matron and directorate manager level.
- We spoke with a consultant trainee on the medical staff who said that they felt well supported.
- We realised that some aspects of leadership, especially in terms of cross-site working, were at an early stage and therefore focus is needed to make effective progress.
- At clinical director level, there were ambitions for the service and a focus on delivering high standards of care. However, medical staff we spoke with did not seem aware of the plans for the future or of the strategic direction of the service, including how the Scarborough and York services would work together in the short and longer term.
- The clinical director was aware of the challenges ahead and could identify the key actions that were required to improve the service, especially in terms of patient flow. They were also knowledgeable and had suitable experience to perform their role.

Culture within the service

- We spoke with a range of staff and observed several day-to-day activities such as ward rounds, handovers and staff conversations. The culture felt, and was described as being, open and supportive.
- A matron we spoke with described the culture as open and transparent with a strong sense of teamwork and a desire to improve standards.
- Junior staff we spoke with enjoyed their work and felt that staff in leadership positions were visible and approachable.
- Nurses we spoke with also felt that there was a positive culture around safety and patient-centred care.

Public and staff engagement

- It was felt that engagement with the public could have been better and the lack of follow-up clinics was a missed opportunity to engage with discharged patients and their relatives and friends.
- There were limited mechanisms in place for gaining feedback from patients and relatives; for example, there had been no recent patient surveys and there were no patient follow-up clinics. These were recognised as areas for improvement but it was unclear what improvements were to be made.
- Staff we spoke with described how senior staff were approachable and said that they felt listened to.
- Messages and updates were communicated in a number of ways, including via team meetings, at handovers and in message bulletins.
- Staff did not describe any formal processes in place for involving staff or gaining people's views in the planning of services. There was a sense that gaining the views of staff during service planning and strategy development could have been improved to ensure that staff felt they had been included.
- It was acknowledged by senior nursing staff that gathering the views of patients and the public needed to develop and was something that, historically, had been done more actively.

Innovation, improvement and sustainability

- We spoke with the directorate leadership team about sustainability and both the clinical director and directorate manager had met with the chief executive about this. The directorate manager described how continuing to develop processes and building on existing structures were key to sustaining and developing critical care services.
- There was a desire to improve critical care services. When speaking with staff, and from observing care, we found that staff were committed to improving services.
- An area of care that was seen as innovative related to work linked to patient rehabilitation being undertaken by the physiotherapy team. There is specific national guidance on ensuring that patients on an intensive therapy unit (ITU) receive appropriate physical therapy to aid recovery during their stay and after discharge.
- The physiotherapy team had changed its approach to patient rehabilitation and had been seeing improved mobility of patients at discharge.

Maternity and gynaecology

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good
Overall	Requires improvement

Information about the service

Scarborough Hospital provides maternity services. There were over 5,000 births per year for the Trust overall, with more than 1,600 of these at Scarborough hospital.

There was a labour ward, which had five delivery rooms, one with a birthing pool, a four-bed assessment area and a maternity theatre. There was one ward for all women who required an inpatient stay in the ante- and postnatal periods. There was also a midwifery-led unit, which had three birthing suites, two with pools. These suites were suitable for low risk births, however, at the time of the inspection the unit was temporarily closed whilst they refurbished the theatres. There had been a delay in reopening because of staffing levels on the labour ward due to seasonal sickness and they was no date for reopening.

The women's unit at Scarborough Hospital provided services to address a variety of gynaecological problems, which included: early pregnancy assessment (EPA), termination of pregnancy and colposcopy (colposcopy is a medical diagnostic procedure to examine an illuminated, magnified view of the cervix and the tissues of the vagina and vulva). The hospital was registered for termination of pregnancy services and offered both medical and surgical services.

During the Inspection at York Hospital and Scarborough Hospital, we spoke with 26 staff, 17 women and their families and looked at 14 sets of patient records.

Summary of findings

Overall the maternity service at York hospital required improvement. The staff did not always receive feedback / lessons learnt from incidents and there were concerns about staffing of theatres out of hours. There were policies and guidelines on the intranet. However, there were guidelines relating separately to Scarborough Hospital or York Hospital in place, which were out of date and did not adhere to national guidance. There were policies and guidelines on the intranet. However, these were different for each hospital, some were out of date and did not adhere to national guidance. Monitoring of performance was difficult to review.

Staff were caring and treated women with respect. The services were responsive and delivered in a way that met the needs of the women accessing them.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

The service had incident reporting processes in place. There were six serious incidents requiring investigation, which included one intrapartum death and one maternal death in 2014. Staff were encouraged to report incidents, however, they did not always received feedback from incidents.

Staffing levels were planned, set and actively reviewed to maintain adequate staffing levels. However, the ratio of midwives to births was worse that the nationally recommended levels and there were concerns about staffing of theatres out of hours, especially operating department practioners, which could result in delays in providing care and treatment to women.

The wards were clean and equipment was appropriately checked. Medication was stored correctly and checked appropriately. Safeguarding was given appropriate priority and systems were embedded across all the services.

Incidents

- We looked at incident reporting policies, a database that included maternity incidents raised by staff, and we found that there were arrangements in place for reporting patient/staff safety incidents and allegations of abuse.
- There were six serious incidents requiring investigation, which included one intrapartum death and one maternal death in 2014. There were no Never Events (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented) reported by maternity services.
- In November 2014 a review of the maternity services provided from Scarborough Hospital had been undertaken. This review had been commissioned in response to the number of clinical incidents that the service had declared during the six months prior to the inspection.
- We spoke with staff at all levels of the maternity and gynaecology departments; they were familiar with how to report incidents.
- There had been two incidents reported for gynaecology, related to delays in medical staff attending for alternate specialty patients and one for medication administration delays, or incorrect administration of medication.
- There was a quarterly update from the directorate management team, which included feedback on reports and a risk management update. We saw the quarterly update for November 2014 which confirmed this.
- However, staff told us they did not always receive feedback from incidents. The meeting minutes and obstetrics and gynaecology newsletters contained updates on action plans and lessons learned, but we did not see evidence that these were translated into a change in practice.
- There was a monthly clinical governance perinatal mortality meeting at York Hospital and all staff were encouraged to attend.

Safety Thermometer

- The service completed a Safety Thermometer dashboard, for the wards, which showed that there had been no patient harms, such as: hospital-acquired pressure ulcers, falls, catheter-related urinary tract infections and venous thromboembolisms (VTEs), during 2014.
- The trust participated in the national maternity safety thermometer pilot which published overall data in October 2014. Maternity Safety Thermometer measures harm from Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety. In addition identifying those babies with an Apgar of less than Seven at Five Minutes and/or those who are admitted to a Neonatal Unit.
- The service took part in the national maternity dashboard, which measured outcomes in maternity care from the perspective of the woman and her baby. A monthly maternity dashboard was collated and performance was measured against safety-related targets. The indicators used included the percentage of caesarean sections and instrumental deliveries and clinical outcomes, such as: third/fourth degree tears, intensive care unit admissions in obstetrics, the percentage of women receiving one-to-one care in labour, the proportion of women with an infection within 10 days of birth and the proportion of undiagnosed breech in labour.

Maternity and gynaecology

Cleanliness, infection control and hygiene

- We found no concerns during the inspection of the maternity unit and gynaecology ward regarding infection control practices. Ward areas appeared to be clean, and we observed domestic staff on the ward.
- Personal protective equipment (PPE), such as disposable aprons and gloves, were available to staff. Staff had access to hand-washing facilities.
- There was a midwife who had responsibility for infection control on the ward.
- We saw staff regularly using hand gel between patients. The 'bare below the elbows' and isolation policies were adhered to.
- There were 'I am clean stickers' on equipment, curtains and furniture.
- There were no reported cases of MRSA or Clostridium difficile (C.difficile) on the maternity or gynaecology wards.
- We saw that monthly environmental audits were undertaken and the maternity wards scored 97% in December 2014.

Environment and equipment

- There were appropriate storage facilities, and staff confirmed that the equipment for the safe monitoring of patients was available.
- The trust had refurbished the maternity theatre at Scarborough Hospital and this had recently reopened.
- Resuscitation equipment was in line with national guidance, and we saw it was checked regularly.
- The cardiotocography (CTG) electronic equipment used to monitor foetal heartbeat and uterine contractions during labour was available and regularly checked by staff.
- The maternity wards had restricted access and doors to the wards were controlled by buzzers and CCTV.
- Babies were electronically tagged for security and safety.
- There was a lack of gynaecology theatre capacity on the Scarborough site and no access to specific day unit facilities.

Medicines

- There was a ward pharmacist who reviewed medication. Medication was stored correctly and appropriately. Controlled drugs were reviewed daily and fridge temperatures were monitored and recorded correctly.
- Drug cupboards and fridges were locked when not in use.
- We looked at medication administration charts and found that medication had been given to patients appropriately and information accurately recorded.

Records

- We looked at nine sets of patient records. Patient records were kept in a paper format. We found records were completed appropriately and maintained without gaps.
- Patient records included risk assessments, such as: falls risk assessments, mental health risk assessments and nutritional risk scores.
- Records were stored in lockable trollies behind the nursing station and were stored according to data protection and information governance guidelines.

Safeguarding

- The Trust required 75% of staff to have completed the relevant level of safeguarding training.
- One hundred per cent of nursing and midwifery staff had completed level 3 safeguarding children training and 64% completed level 2.
- Data indicated there was only 17% of nurses and midwives had completed level 2 adult safeguarding training.
- Staff we spoke with were aware of the named midwife for safeguarding, who attended the safeguarding meetings and approved protocols.
- There was a safeguarding vulnerable adults policy, which included contact numbers for local safeguarding teams and staff were familiar with the process for raising concerns. Midwives gave examples where they had raised recent safeguarding issues.
- There was a full-time named midwife based at York Hospital, who was responsible for child protection across all sites and they had the support of a part-time midwifery child protection adviser based at York Hospital.
- Best practice regarding safeguarding children and related record keeping had been reviewed by the named midwife and had been cascaded across the trust.

Mandatory training

Maternity and gynaecology

- The maternity dashboard for York Hospital showed 88.9% of midwives and 67.5% of doctors had attended training. Between March 2014 and February 2015 no training had been cancelled.
- Ninety-two per cent of nursing and midwifery staff had completed manual handling training. Seventy-five per cent of nursing and midwifery staff had completed medicines management training. However, only 7% of nursing and midwifery staff had completed pressure ulcer training.
- All midwives had access to a supervisor of midwives who would provide guidance and support to staff.

Assessing and responding to patient risk

- The service used an obstetric early warning score (OEWS) to identify patients who were becoming unwell. There was guidance for staff on escalating patient care if a patient became unwell and their condition was deteriorating.
- The service used the 'five steps to safer surgery' procedures (Patient Safety First campaign – an adaptation of some of the steps in the WHO surgical safety checklist) in obstetrics and gynaecology. There were plans for the service to audit the use of the checklist in 2015.

Midwifery staffing

- Data from the Scarborough hospital midwifery dashboard indicated that there was one midwife to 38 – 44 births for the period January to November 2014 which was a monthly average of 42.
- From September to November 2014, the levels had improved to one midwife to 38 births.
- This was not in line with accepted figures, of a ratio of 1:28 midwives per births, for a safe service recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour and the Nursing and Midwifery Council guidelines to allow staff to provide one-to-one care for women in labour.
- The labour ward had introduced an acuity tool on the delivery wards to improve staffing levels for delivery. Staff told us they found the tool had indicated that staffing levels were at 70% and there was a staffing shortage on the labour ward.
- In February 2015, the labour ward achieved one-to-one care for 117 deliveries (96.3%). Overall, the average for 2015 was 92% of women with deliveries at Scarborough Hospital who had received one-to-one care. For 2014 the average monthly figure was 93.1%.
- However, out of hours there was only one operating department practitioner (ODP) for the hospital, so if they were busy then obstetrics had to wait for the ODP to become available before they could perform a caesarean section. For example, there was a case in 2014 when a patient needed a category one caesarean section and had to wait for one hour for an ODP to become available. The trust were aware of this issue and were reviewing ODP cover and theatre scrub nurse training for midwives.
- In 2014, the maternity ward had an average day fill rate for midwives of 87% and a night fill rate for midwives of 113%. The day fill rates for unqualified care staff were 79.2%.
- The gynaecology ward had an average day fill rate of 69.6% for nursing staff and an average night fill rate of 91.4% for nursing staff. The average day fill rates for unqualified care staff were 96.2% and the average night fill rate was 93%.
- There was a teenage pregnancy midwife who provided care in the community and was based at Bridlington and District Hospital.
- We attended a handover and found the handover included information about staffing and patients who were at a high risk.

Medical staffing

- In 2007 the Royal College of obstetricians and gynaecologists (RCOG) report 'Towards Safer Childbirth' set a gold standard for resident labour ward cover going forward at 168 hours per week. In the interim it set some minimum standards based on the number of births annually per unit. For a unit of 2,500-4,000 births there should be a minimum of 60hours consultant cover.
- At Scarborough hospital data indicated that for all of 2014 there was cover on the labour ward for 40 hours per week.
- There were five consultants, two registrars, one clinical fellow and four trainees (three foundation year 2 doctors and one GP trainee) for the Scarborough Hospital site.
- Two consultants were on duty during the day and there was a consultant ward round on the labour ward every day.

Maternity and gynaecology

- There were only three sessions a week for dedicated anaesthetic cover on the labour ward and this was highlighted as an issue of the Scarborough maternity dashboard.
- S staff told us there was not an issue with anaesthetic cover outside of the three sessions as there was always an anaesthetist available from theatres to provide cover when performing caesarean sections.

Major incident awareness and training

- Staff were aware of the RCOG guidelines, which included the potential closure of the maternity unit, with contingency planning to ensure that any decision to close the unit was appropriate. We found the unit had been closed on two occasions in 2014.
- There were other escalation policies available to staff, including intrapartum National Institute for Health and Care Excellence (NICE) guidelines and an abduction policy. Staff we spoke with were confident regarding reporting mechanisms, and that support from senior managers and the head of midwifery would be good in the event of a major incident.

Are maternity and gynaecology services effective?

Requires improvement

Staff were appropriately qualified to carry out their roles and there was effective supervision and appraisal for staff. There was a multidisciplinary approach to care and treatment. Staff understood the requirements of the Mental Capacity Act 2005 and obtaining consent.

There were policies and guidelines on the intranet. However, there were guidelines relating separately to Scarborough Hospital or York Hospital in place, which were out of date and did not adhere to national guidance. Monitoring of performance was difficult to review. Some guidelines were out of date and did not adhere to national guidance.

Evidence-based care and treatment

- There were policies and guidelines on the intranet. However, there were guidelines relating separately to Scarborough Hospital or York Hospital in place, which were out of date and did not adhere to national guidance. For example, the Trust's "Breech presentation" policy dated September 2010 was not in the trust format and the anaesthetic handbook was dated May 2007. Neither had been reviewed since these dates.
- The service was implementing joint guidelines for use across both sites.
- The service was not identified as outliers in the maternity outcome measures programme (readmissions, neonatal deaths, puerperal sepsis).
- The Royal College of Paediatrics and Child Health National Neonatal Audit Programme Annual Report 2012 (published August 2013) showed that Scarborough Hospital was below standard on four out of five standards. For example, Scarborough Hospital scored 69% for all mothers who delivered babies between 24 weeks and zero days (24+0) and 34 weeks plus six days (34+6) gestation, who were given any dose of antenatal steroids compared to the national average of 85%. Zero per cent of babies at 33 weeks and zero days (33+0) gestation at birth who received any of their mother's milk when discharged from a neonatal unit compared to the benchmark figure of 58%.
- The service had completed a fundal height measurement audit in July 2014. The service found that 11 patients at Scarborough Hospital were seen that did not need an appointment and eight patients were not seen at 36 weeks gestation. An action plan was developed, which included the guidelines being amended and the results and actions from the audit were discussed at the Labour Ward Forum in Scarborough.
- Staff told us it was difficult to review the performance of the directorate because the electronic system for collecting the data was difficult to use and it was also difficult to use it to provide reports. We looked at the electronic system and were able to confirm that it was difficult to use and there were limited standard reports set up on the system.
- The maternity services were not outliers for readmissions, neonatal deaths or puerperal sepsis.
- The average ratio of midwifery supervisors to midwives for Scarborough hospital was 1 to 14 throughout 2014 which was in line with recognised best practice.

Pain relief

- Pain relief was available that included epidural anaesthetic, ENTONOX® and pethidine.

- Women who had had a caesarean section told us the anaesthetist had spoken with them and explained what would happen.
- Anaesthetic cover on the labour ward was for three sessions per week. Outside of these hours there was cover from anaesthetists within theatres and also on-call cover.

Nutrition and hydration

- There was a part-time infant feeding coordinator for the hospital to provide support to patients to breastfeed.
- The service had achieved UNICEF Baby Friendly Initiative level 3 across all sites. This is a worldwide initiative which encourages hospitals to promote breastfeeding. All midwives, healthcare support workers, midwifery support workers, student midwives and medical staff were trained to support women to breastfeed to UNICEF standards.
- There were also breastfeeding peer supporters and their contact details were given to patients.
- There was a frenulotomy (tongue tied) service available for women and their babies to access.

Patient outcomes

- Between March 2014 and February 2015 there was an average of 134 births per month. Between March 2014 and February 2015 there were three undiagnosed breech presentations, one antepartum stillbirth and one intrapartum stillbirth.
- During 2014 there was an average of 70.8% spontaneous vaginal births, 5.6% operative vaginal births and 22.7% caesarean section deliveries (emergency and planned).
- In February 2015, there were 125 births, which included 30 (24%) instances in which labour was induced, 17 (13.6%) emergency caesarean sections, 14 (11.2%) elective caesarean sections, three (2.4%) ventouse deliveries and nine (7.2%) forceps deliveries.
- There were two undiagnosed breech presentations in labour in 2014.
- The percentage of women with 3rd/4th degree tears varied per month during 2014 from zero to 4.9% with a monthly average of 1.4%.
- The number of women that had a post-partum haemorrhage (PPH) of more than 2000mls from March 2014 to February 2015 ranged from zero to three per month, with an average of one per month.
- There were no uterine ruptures in 2014 recorded for Scarborough Maternity services.
- Figures for transfer/admission to NICU (neo-natal intensive care unit), NNU (neonatal unit) or SCBU (Special care baby unit) from the harm-free care maternity safety thermometer tables indicated that for March 2014 - February 2015 the Trust had zero to eight per month. This ranged from zero to 18.2% per month.
- The service had no unplanned admissions to the intensive therapy unit (ITU) or the high dependency unit (HDU) between March 2014 to February 2015. However, they had an average of two women per month on high dependency unit charts per 24 hours on the labour ward.
- During 2013/14 there were three medical and two surgical terminations of pregnancies at Scarborough hospital.

Competent staff

- All newly qualified staff were offered preceptorship. Preceptorship is a period of transition for the newly qualified staff during which time he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.
- All new staff received a comprehensive induction, which included access to training and provided support for them to develop their knowledge and skills in order to enable them to provide patient care.
- All staff had access to a supervisor for midwives and clinical supervision arrangements were in place. Staff told us there was good access to, and attendance of, mandatory training.
- Information for appraisals was collected for the directorate and 82% of staff had had an appraisal in the 12 months prior to the inspection. Staff confirmed they had had appraisals.

Multidisciplinary working

- There was good communication between hospital and community midwifery staff. Doctors covered hospital and community services.
- The midwives for safeguarding worked closely with GPs and social services when dealing with safeguarding concerns.
- The trust highlighted the good midwifery/consultant relationships as a strength within its obstetrics and gynaecology strategy.

- Patients who had complex specialist needs, such as mental health concerns, could access specialist services.

Seven-day services

- Consultant cover adhered to the RCOG guidelines. There was consultant cover seven days a week supported by registrars and junior doctors.
- A consultant was on call out of hours to provide support to junior staff.
- There was a ward clerk available during the day and a healthcare support worker provided cover out of hours.
- Rotational working had been introduced for community midwives.

Access to information

- There was information available to patients about antenatal and postnatal care and breastfeeding.
- Information was available for patients who attended gynaecological services. For example, there was information about the colposcopy service.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff had an understanding of consent including the Gillick competencies and Fraser guidelines (for deciding whether a child is mature enough to make decisions and give consent) and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The patients we spoke with confirmed that staff had obtained their consent prior to treatment. We looked at patient records and found that signed consent forms were present in the notes.

Are maternity and gynaecology services caring?

Good

Staff treated women with respect. Women felt supported and well cared for. Staff involved women and their families in decisions about their care and treatment. Staff were kind and caring and spent time speaking with women and their families.

Compassionate care

- Women we spoke with were complimentary about the care they were given.
- Women and their families were asked to complete the NHS Friends and Family Test survey. The NHS Friends and Family Test is a survey which gives patients an opportunity to give feedback on the quality of the care they receive. In February 2015, Scarborough Hospital scored 94% for women and their families who would recommend the labour ward to their family and friends. Ninety-six per cent of women would recommend the postnatal and community services to family and friends.
- The gynaecology service NHS Friends and Family Test had a 30% response rate and patients were positive about the service.
- During the summer of 2013, a questionnaire was sent to all women who gave birth in February 2013 (and January 2013 at smaller trusts). Responses were received from 171 patients at York Hospitals NHS Foundation Trust.
- Women were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question (the higher the score the better). The trust was performing about the same as most other trusts that took part in the survey.

Understanding and involvement of patients and those close to them

- Patients who completed the maternity survey felt they were spoken to in a way they could understand during labour and birth and felt involved enough in decisions about their care during labour and birth.
- We spoke with eight patients on the ward, who told us they were involved in the decisions about the care they received. We spoke with patients who had had planned caesarean sections who told us they had met with the consultant, midwife and anaesthetists.

Emotional support

- There was a specialist midwife for diabetes who provided support and advice to patients.
- Patients had access to bereavement services. There was a chaplain available to support patients following a still birth. Patients were given information about a support group they were able to access. There was a yearly memorial service and patients were invited to attend this event.

Maternity and gynaecology

- There were breastfeeding peer supporters and their contact details were given to women prior to discharge.

Are maternity and gynaecology services responsive?

Good

Women were supported to access the right care at the right time. Services were delivered in a way that met the needs of the women accessing the service.

Women understood how to complain and the provider reviewed and acted on complaints and feedback received.

Service planning and delivery to meet the needs of local people

- The trust was aligning services at York Hospital and Scarborough Hospital and supervisory midwives worked across sites. The trust had an escalation policy for dealing with staff shortages and staff worked flexibly to manage staffing issues and the service needed.
- The service did not have a bereavement room at Scarborough Hospital, however, the service had raised money and planning for a bereavement suite was in progress.

Access and flow

- Antenatal visits were consultant-led in the community and in the hospital.
- The average length of stay for obstetrics was 1.2 days and for gynaecology was 1.4 days. The trust had seen an increase in bed occupancy over the 18 months prior to the inspection, but was now in line with the national average occupancy rate of 60.2.
- The service had a Commissioning for Quality and Innovation (CQUIN) payment framework target of 75% for women accessing antenatal care and, in February, 91.6% of pregnant women accessing antenatal care who were seen within 13 weeks.
- In the 2014/15, quarter one, gynaecology had 29 patients who had waited more the 18 weeks from referral to treatment.
- The unit was closed to admission at Scarborough Hospital once during 2014 in June for a period of six hours. Information was not provided as to why the service closed.
- Patients were able to access a full range of birthing options, including a birthing pool, birthing chairs and beds following appropriate risk assessments being completed.
- The service did have a midwife-led unit for low-risk patients. However, at the time of the inspection the unit was closed due to the refurbishment of the obstetric theatre and staff shortages due to staff sickness. The trust was planning to reopen the unit in March 2015.
- On the gynaecology ward some medical patients were admitted who were outside the criteria for the ward and staff said this was challenging and they felt as though they were caring for patients outside of their competency at times. For example, they would be caring for patients who were living with dementia and staff had not had the training needed to understand their needs and care for them in a way that met their more complex needs.
- Scarborough Hospital held a weekly clinic for six patients for the evacuation of retained products of conception. Patients were seen in the women's unit by a registrar. The hospital had arranged for hospital disposal via the crematorium in Hull.

Meeting people's individual needs

- There was a specialist midwife for teenage pregnancy who would work with teenagers and work with social services to meet young patients' needs.
- Translation services were available for patients whose first language was not English. There was a telephone-based translation and interpretation service available at all sites. However, the service did not have written information routinely available in other languages. Staff told us about how they had access to 'signers' for women who had a hearing impairment.
- Patients were able to access a full range of birthing options, including a birthing pool, birthing chairs and beds following appropriate risk assessments being completed.
- There were no specialist services provided by the Trust such as consultant midwives, substance misuse midwives, teen midwives, or traveller liaison midwives.

Learning from complaints and concerns

- Between March 2014 and February 2015 there had been seven formal complaints and 12 informal complaints received by the Scarborough Hospital maternity services. Lessons from complaints were shared with

staff through the obstetrics and gynaecology newsletter and clinical governance meetings. Information and learning about complaints was displayed in the staff room.
- Staff were aware of the complaints procedure and how to escalate concerns.
- The service responded to comments on NHS Choices.

Are maternity and gynaecology services well-led?

Good

The trust had a statement of visions and values, which was shared with staff. However, not all staff were aware of the trust values.

Risks to the delivery of care were identified, analysed and migrated against. Issues were managed and action taken.

Staff felt respected, valued and supported. The senior team were visible and communicated with staff at all levels.

The service sought feedback from patients and staff. Concerns were listened to and acted upon

Vision and strategy for this service

- The trust had an obstetrics and gynaecology directorate strategy for 2014 to 2019 which clearly articulated the integration of services across all acute and community sites within the trust.
- There had been an analysis of the strengths, weaknesses, opportunities and threats for varying elements of the maternity and gynaecology services and a high level plan developed to reflect these.
- The trust values were displayed in all areas and they were also published in the 'Obstetrics and Gynaecology Newsflash' publication.
- However, not all staff were aware of the values and commitment the trust had put in place to improve care and quality of care.

Governance, risk management and quality measurement

- The service had a risk register and published risk register news in the 'Obstetrics and Gynaecology Newsflash'. Risks included delays in the labour ward theatre project and no dedicated operating department practitioner (ODP) for maternity theatres at Scarborough Hospital, out of hours. The publication also had details of who to contact if staff identified other risks that needed to be on the risk register.
- The service held monthly clinical governance committee meetings. We looked at the agendas and minutes for three meetings. Items for discussion included: performance, policy and guidance, complaints and incidents.
- At the November 2014 board meeting it was reported a senior midwife and an obstetrician from other organisations had been approached to act as a 'critical friend' and to add external scrutiny. Additional quality scrutiny meetings had been planned to review and agree action plans and understand any issues. Actions and findings were reported to the clinical governance committee on a regular basis.

Leadership of service

- There were clear line management arrangements for midwives, nurses, medical and management staff which covered both York and Scarborough hospital and community services.
- Staff told us the management team were very visible on the unit and they could approach them about anything.
- The midwifery manager for the unit at Scarborough Hospital had recently been appointed to the post, following concerns about the service provided at Scarborough Hospital. They had only been in post for three weeks, but staff told us that the running of the service had improved.

Culture within the service

- Staff of all disciplines reported they worked well together and spoke positively about the service. There were some concerns raised about the delay in the reopening of the midwife-led unit, but staff felt that managers were keeping them informed about the delays.
- Maternity staff felt supported by the new ward manager, and they felt there were improvements in the service provided.

Public and staff engagement

Maternity and gynaecology

- The service had completed a 2014/15 staff survey and meetings had been arranged to review the results. An action plan from the 2013/14 survey had been completed and, for example, staff roles acting as advocates on the York Hospital site had been created.
- The service had received patient feedback for their colposcopy services at York Hospital Scarborough Hospital and Bridlington and District Hospital from Public Health England (PHE). The feedback was overwhelmingly positive, with all patients rating the services as 'outstanding' or 'good'.
- The trust had a maternity services liaison committee, where users came together to participate in discussions about maternity services.

Innovation, improvement and sustainability

- Theatres for obstetrics had been refurbished and reopened at Scarborough Hospital.
- The service had reached an appeal target for the provision of a bereavement suite at Scarborough Hospital and was in the process of planning the new suite.

Services for children and young people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The directorate of paediatrics is responsible for services for babies, children and young people at York hospital and Scarborough hospital. Services at Scarborough hospital included the Duke of Kent ward, a 19-bed ward for paediatric medicine and mixed specialty. At the time of the inspection the ward had 14 beds open and surgery was not routinely performed at Scarborough. The service included the children's outpatient department and the SCBU (special care baby unit), which had 10 special care baby cots.

Based on statistics provided by children's services, the Scarborough paediatric medicine specialty (not including sub-specialties or surgery) had a total of 1,695 emergency admissions and 10 elective admissions during the period April to December 2014. Outpatient attendances in the same period were 1,713 first attendances and 2,462 follow-up attendances.

During our inspection we visited all clinical areas where children were admitted or that they attended on an outpatient basis, including the SCBU, Duke of Kent ward and children's outpatient department. We talked with 12 medical staff and eight nursing and allied healthcare professionals, and we examined eight medical/nursing records. We spoke with 10 parents and children and young people.

Summary of findings

There were enough nursing staff to meet the needs of children and families because some beds were closed. Children's services did not have all the necessary individual risk assessment tools in place so staff were not able to conduct a robust, individualised risk assessment when required.

Training records submitted by the trust prior to the inspection showed varying levels of training uptake by members of staff, but not all were achieving the 75% compliance set by the Trust.

Children, young people and parents told us that they received compassionate care with good emotional support. Parents felt informed and involved in decisions relating to their child's treatment and care. Staff of all grades told us that children's services were offered very limited CAMHS (Child and Adolescent Mental Health Services) support for children with mental health needs by other providers; the children's directorate risk register also noted this.

The service was responsive to children's and young people's needs and was well led. The service had a clear vision and strategy.

Services for children and young people

Are services for children and young people safe?

Requires improvement

There were not adequate numbers of registered children's nurses available at all times to meet the needs of children, young people and parents within the inpatient areas.

The service was not meeting the local and national intercollegiate guidance for safeguarding training. Some areas of mandatory training were below the trust's required levels of compliance.

Children's services did not have all the necessary individual risk assessment tools in place so that members of staff could conduct a robust, individualised risk assessment when a need for this may be indicated during the initial nursing assessment of a child's or young person's admission and stay.

Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms; we saw that these were reviewed and acted upon by the management team. We found that risks were assessed and monitored, and control measures put in place. We found that all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected. Members of staff of all grades confirmed that they received a range of mandatory training. Medical staffing had some gaps but these were being managed and addressed.

Incidents

- Staff demonstrated an awareness of how to report incidents using the trust's reporting mechanisms. The management team and ward managers in all clinical areas felt that their staff reported incidents when required.
- The matron told us that 38 incidents had been reported in the previous month across the York and Scarborough sites. An average of 28 to 40 incidents were reported per month; these were usually classified as low risk, with some recorded as moderate. Two serious incidents had been reported previously, but these had taken place over 12 months ago. One related to a failure to act on blood test results and the other related to a grade three pressure ulcer. We saw that both of these incidents had been fully investigated and that learning had resulted from the investigation.
- We saw that the matron had developed a bespoke incident dashboard. This enabled close monitoring of incidents that occurred within children's services across the York and Scarborough hospitals. The matron personally populated the dashboard from the trust's Datix incident-reporting system and was able to apply a range of filters to monitor incidents. The dashboard acted as a reporting tool within children's services and was used to inform monthly clinical governance and directorate meetings. We reviewed a sample of meeting minutes which showed that incidents were discussed regularly within these meetings.

Cleanliness, infection control and hygiene

- We found that the Duke of Kent ward, children's outpatient department and the SCBU were kept very clean and tidy. Various infection-prevention measures were in place, such as multiple wall-mounted hand gel dispensers and hand-washing sinks.
- During our inspection of all clinical areas, we observed members of the medical, nursing and other staff regularly performing hand hygiene measures.
- Regular hand-hygiene audits and infection-control audits were undertaken in the clinical areas by the nominated infection control link nurses. Other audits included a detailed environmental audit completed monthly by the matron. This audit showed reasonable to good levels of compliance for clinical areas managed by children's services. For example, in December 2014 the overall compliance total for the Duke of Kent ward was 97%, with SCBU scoring 100%.

Environment and equipment

- We saw, and staff told us, that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. Records showed that the trust tested and serviced equipment according to its own policies. Some equipment, such as incubators on SCBU, were maintained and serviced by external manufacturers.
- All the children's clinical areas we visited had suitable resuscitation equipment available, which had been checked daily by members of staff.

- We saw two areas where the flooring was damaged and required repair: the Paediatric Oncology Shared Care Unit (POSCU) / cubicle and adjacent to a French door. The ward manager explained that they had submitted a repair request form.
- The Duke of Kent ward was currently recorded as a risk on the children's directorate risk register due to a "lack of appropriate and suitable facilities in which to provide both inpatient and outpatient services". We were told that the current risks were being actively managed and plans were being developed for a new hospital building.

Medicines

- We reviewed a sample of paper-based treatment records on the Duke of Kent ward and SCBU and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered in these two areas.

Records

- We found that records were managed and handled safely during our inspection and we did not identify any unattended medical notes.
- Nursing and medical staff completed a joint 'children's unit multidisciplinary assessment' on admission to capture a range of jointly assessed information such as family/social history, observations, allergies, nursing assessment and clinical notes. This meant that the joint assessment entries were written at the same time, alongside each other, so that it was clear what medical treatment and nursing care the child required.
- We reviewed four medical/nursing records on the Duke of Kent ward. Nursing documentation was paper-based and included an assessment of the child or young person's daily living activities; where necessary, this was individualised to reflect the child's and family's needs.
- The records we reviewed showed that children and young people had care plans that reflected their identified needs on the children's ward. Records on SCBU were tailored to meet the needs of the premature baby. Each baby had a handwritten individualised care plan that met their individual needs.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they were to follow if a safeguarding concern arose.
- The trust had access to the necessary safeguarding staff, including the named nurse and named doctor. The chief nurse was the trust's nominated executive lead for safeguarding.
- The matron explained that the directorate was well supported by the trust safeguarding team.
- Safeguarding children and young people: roles and competences for health care staff intercollegiate document third edition: March 2014 sets out the minimum safeguarding training requirements. It states that all staff including non-clinical managers and staff working in health care setting should have level one training. Level three is for all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Training records provided by the trust prior to inspection showed that it was not meeting the intercollegiate guidance as above: 84% of nursing staff within the child health directorate had received level three safeguarding children training at the Scarborough site against a trust-wide compliance requirement of 75%. However, there was only 8% of medical staff and 58% of additional clinical services staff who were complaint at level 3.
- For level 1 safeguarding children training there was 63% compliance for administrative and clerical staff,
- For adult safeguarding level 1 training there was 68% compliance for nursing and midwifery staff within the child health staff at the Scarborough site and only 21% at level 2 against a trust target of 75%.

Mandatory training

- Members of staff we talked with, including staff from the Duke of Kent ward and SCBU, confirmed that they received mandatory training. This covered subjects such as fire safety, food safety, blood safety, health and safety, infection prevention and control, moving and handling, and safeguarding.
- The matron explained that mandatory training was delivered via a centralised learning hub which could be made more bespoke to the service. For example, children's services could opt out of a particular subject if it was felt that it was not relevant. Ward and unit managers managed the uptake of training with the matron providing an oversight and supportive role.

- Training records submitted by the trust prior to the inspection showed varying levels of training uptake by members of staff. For example, training compliance for fire safety awareness was 91% (nursing), while for health and safety it was 82% (nursing). However, some mandatory training uptake fell below the trust's minimum expected of 75%. For example, 61% of medical staff had completed information governance training with only 6% compliance with manual handling practical training and 66% infection prevention and control training (level 2) for nursing and midwifery staff.

Assessing and responding to patient risk

- Our review of records showed that the 'children's unit multidisciplinary assessment' record involved an initial risk assessment for skin and skin pressure. Staff at Scarborough hospital also routinely completed a separate 'Glamorgan' pressure sore risk assessment tool.
- Although the nursing assessment covered a basic assessment of mobility and nutrition, children's services do not currently use dedicated individualised risk assessment tools for either nutrition or moving and handling where risks might be identified.
- The children's ward used an early warning assessment or clinical observation tool called PAWS (paediatric advanced warning score). The age-related tool included a clinical observation chart and other clinical measures, along with an assessment score to assist clinical staff in determining the action that should be taken for a deteriorating or poorly child. It was explained that the chart would help in determining whether a child required transfer to a tertiary centre for children such as Leeds. Our review of a sample of charts showed that staff completed the PAWS charts appropriately and the service had previously audited the use of these charts.
- The ward included one high dependency room for the close monitoring and stabilisation of poorly children. The room had suitable additional equipment and members of nursing staff were trained on the EPLS (European paediatric life support) course.
- The trust was part of the EMBRACE network; this was a specialist transport service for critically ill children and neonates in Yorkshire and the Humber region. The management team and other grades of staff told us that access to this service for advice and for the transfer of children worked very well.

Nursing staffing

- The Duke of Kent ward had 14 of its 19 available beds currently open to admissions. At the time of the inspection no paediatric surgery was being performed at the Scarborough site. The ward had expected staffing levels of four registered nurses plus one support worker for morning shifts, three plus one for evening shifts, and two plus one for night shifts. These staffing numbers gave a ratio of one registered nurse to four patients during the day and one registered nurse to seven patients at night. Based on these numbers, the ratio of registered children's nurses falls outside the RCN guidelines for evening and night shifts.
- The ward manager and staff felt that there were currently sufficient numbers of staff to meet patient need based on 14 beds but there would not be enough staff (particularly at night) should more beds be opened again in the future.
- There was currently a historical arrangement in place with the emergency department which occasionally impacted on nurse staffing levels on the ward. The emergency department either 'fast bleeped' or called for a children's nurse to attend its resuscitation room when there was a poorly child there. This was because the ward children's nurses were trained to EPLS standards and the emergency department nursing staff were not trained to this level. The ward manager and staff told us that this could have a negative impact on staffing on the ward, particularly in the evenings and at night, as it potentially meant staffing fell below acceptable levels when a nurse left the ward and went to the emergency department.
- One nurse was asked to attend the emergency department during our inspection. We followed the nurse as an observer and saw that permanent emergency nursing staff stood back and let the children's nurse take over all nursing aspects of care. We fed back our observations to the children's management team, which told us this had been observed previously.
- We were provided with evidence that showed the paediatric and emergency directorates had held a simulation day during September 2014. This involved staff members from both services running through a scenario of emergency stabilisation care for a child. A document noted that the day had been "a success" and

various learning points had been identified for emergency and paediatric staff. For example, a paediatric 'grab bag' was established following the exercise; we saw that this had been introduced.
- The SCBU manager and staff we spoke with confirmed that they had enough staff to meet the needs of premature babies and families. The unit had two registered nurses plus one neonatal support worker on duty for each shift, which met current guidelines.

Medical staffing

- We found that medical staffing was reasonably covered within paediatric medicine and SCBU. At Scarborough hospital we talked with doctors of all grades, including consultant paediatricians and trainee doctors.
- We were told that there was a gap of two whole-time equivalents (WTE) at tier two (middle grade) in the medical staffing rota. This gap was covered by regular locum doctors or a consultant paediatrician.
- We attended part of a ward round during our inspection and observed appropriate discussion of children's condition and treatment.
- Nursing staff were particularly positive about the cross-site consultant paediatricians recruited to work at both York and Scarborough hospitals. We were told that relations between the more senior Scarborough-only consultant staff and ward nursing team had not always been positive but had significantly improved over the last 12 months.

Major incident awareness and training

- The trust had a major incident plan in place that set out actions to be taken for major incidents and other similar events. The matron demonstrated awareness of the plan although they did not recall whether children's services had been involved in any exercises over the last few years. None of the training records we reviewed showed that there had been any specific training in the use of the major incident plan.

Are services for children and young people effective?

Good

The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. We reviewed information that demonstrated children's services participated in national audits monitoring patient outcomes when these were applicable.

Children and young people had access to a range of pain relief if needed and the service used an evidence-based pain-scoring tool to assess the impact of pain. The nutritional needs of children were addressed.

Staff had received an annual appraisal and received support and personal development.

Evidence-based care and treatment

- The trust had systems and processes in place to review and implement NICE guidance and other evidenced-based best practice guidance.
- The trust submitted a spreadsheet prior to the inspection that set out which child- and neonate-specific NICE guidance the service was compliant with and which guidance was being acted upon to change policies and processes. For example, the spreadsheet noted that the service was compliant with several guidance documents such as those relating to urinary tract infection in children and constipation. The sheet noted that the service was partially compliant with guidance for children and young people with cancer but comments noted an action plan was in place to develop the service to achieve compliance. We saw evidence showing that, during 2014, clinical staff had audited the effectiveness of some NICE guidelines such as the guideline relating to urinary tract infection in children.
- Discussion with clinical staff and the review of submitted documents demonstrated that the service participated in national audits such as those on diabetes, epilepsy and asthma. Evidence, including action plans, had been submitted. This showed that the service had reviewed the audit results of these national surveys and had taken action to identify and implement improvements.
- Children's services conducted clinical audits that were organised via an audit programme. The programme set out ongoing audits, including national audit requirements along with specific clinical audits covering conditions such as asthma. We saw that clinical audit led to recommendations and reinforcement of good

practice. For example, an audit had been completed regarding asthma and wheeze which made recommendations including the reinforcement of discharge processes.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia.
- The service used evidence-based pain-scoring tools to assess the impact of pain. Our review of the 'children's unit multidisciplinary assessment' documentation showed that all children underwent an initial assessment of pain as the documentation included a specific section on this. The PAWS observation tool required ongoing monitoring and observation of a child's pain.
- We reviewed a sample of pain score ratings; these showed that members of staff regularly assessed pain when required.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment of the child's daily living activities. Children were able to choose their food from the daily menu with the support of parents and staff. Children could eat food from the adult menu or have a meal from the two-week children's menu. Snacks and drinks were available between meals. The service did not currently use a specific nutritional risk screening tool.

Patient outcomes

- We reviewed information which demonstrated that children's services participated in national audits in order to monitor patient outcomes when this was applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Programme (NNAP).
- We reviewed the action plan for the 2013 NNAP audit and saw that it gave examples of learning from this audit. For example, in relation to the audit question "Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?", the plan noted that 59% of eligible episodes in Scarborough were seen within 24 hours (the national average was 84%). The action plan noted measures to clarify and address this standard by reminding clinical staff to document all discussions and to ensure that they were timed and dated correctly.
- Children's services also participated in other national audits such as those on diabetes and asthma and the Epilepsy 12 audit. The latest available diabetes audit from 2013 showed results that similar to the England and Wales average. For example, median HbA1c (average blood sugar) at Scarborough hospital was 66 mmol/mol compared with an England average of 69 mmol/mol.
- Children's services do not participate in the adult-based NHS Friends and Family Test. However, a children's version had been developed and we saw that the trust had arrangements in place to introduce the new child version in April 2015. Other surveys had also been set up previously to gain the views of children, young people and families about their experiences.

Competent staff

- Formal processes were in place to ensure that staff had received training and an annual performance development review (appraisal).
- We did not review any documents that captured appraisal statistics but the matron for children's services stated that appraisal completion was 95% across all children's wards and departments at York and Scarborough hospitals.
- Members of staff in the Duke of Kent ward and SCBU gave positive feedback about the individual support they received regarding their personal development.
- Trainee medical staff we spoke with were positive about the training and support they received to develop their clinical and educational knowledge and skills. They felt well supported by the consultant staff within paediatrics.

Multidisciplinary working

- Medical and nursing staff within children's services gave positive examples of multidisciplinary working. We were told, and we observed, how the paediatricians and nursing teams worked together closely. They also worked well with other professionals such as dieticians, occupational therapists and physiotherapists.

Services for children and young people

- Formal adolescent transition arrangements were in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty.

Seven-day services

- Children's inpatient services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. The children's management team and members of staff did not raise any significant concerns about accessing these services.
- Trainee doctors working out of hours and at weekends told us they felt well supported by consultant staff, who were on call and readily available.

Access to information

- Staff we talked with told us that they were readily able to access patient information and reports, including at weekends and out of hours.
- The wards and departments had a range of information leaflets available for parents and children.

Consent

- At the time of the inspection, paediatric surgery was not being performed at Scarborough hospital. This meant that there were no written consent forms available to review during our inspection.
- Staff we talked with showed that they understood the Gillick competency standard relating to consent for children.

Are services for children and young people caring?

Good

Children, young people and parents told us that they received compassionate care with good emotional support. They felt they were informed and involved in decisions relating to treatment and care. We spoke with 10 children and parents who provided examples of how they had been provided with supportive care centred on their personal needs.

Compassionate care

- Throughout our inspection we observed members of medical and nursing staff who provided compassionate and sensitive care, which met the needs of the child or young person and their parents.
- We observed members of staff who had a positive and friendly approach towards the child and parent. Staff explained what they were doing and took time to speak with them at an appropriate level of understanding.
- We spoke with 10 parents and children and young people on the Duke of Kent ward and SCBU. The parents provided examples of how they had received considerate and supportive care. Parents described staff as being caring, "friendly" and "approachable", with one parent stating that the staff "go the extra mile".
- We saw that children's services in Scarborough conducted 'exit questionnaires'. We reviewed a number of monthly reports compiled since January 2014. The January 2015 report showed that 26 responses had been received. Feedback was positive: 24 families (92%) were always happy with the care their child had received on the children's ward, 25 families (96%) were always happy with the information they had received from the doctors, and 26 families (100%) would recommend this ward to their family and friends. A number of positive comments were also received.
- The SCBU exit questionnaire presented similar findings: 98% of families were always happy with the care that their babies received while on SCBU and 96% of families always felt well supported in their choice of feeding on SCBU. A number of positive comments were also recorded.

Understanding and involvement of patients and those close to them

- We observed that members of staff who talked with children and young people used language appropriate to their age-related level of understanding.
- Families we talked with told us that they had felt involved in the planning and decisions relating to their child's care. One parent told us: "They tell me everything that's going on and what's happening."
- The views of parents and children differed about the information they had received. Some families explained how they had been given sufficient information to make an informed choice about their child's care.

Services for children and young people

- Information leaflets about various treatments and other care were available within the hospital. Leaflets at this trust were written in English. Members of staff explained that they could get leaflets translated when required.

Emotional support

- Parents and children told us that they had been well supported during their visits or stays on the SCBU and the Duke of Kent ward and in children's outpatients.
- We observed members of staff who were responsive to, and supportive of, children's emotional needs. For example, we observed nurses, play specialists and other staff providing emotional care and support to children who were upset during our inspection.
- Parents we talked with gave examples of how the service and staff supported their children and themselves. For example, one parent told us how staff explained everything very well and how their child had been admitted three times and they could not think of anything they could improve.

Are services for children and young people responsive?

Good

We found that the service was responsive to children's and young people's needs. Children's services planned and delivered services to meet the needs of local families. However, staff of all grades told us that children's services had very limited CAMHS support for children with mental health needs; this issue was noted on the risk register. We saw evidence showing that complaints were reviewed and the service learned from them.

Service planning and delivery to meet the needs of local people

- Various evidence was available that demonstrated how children's services engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population.
- The consultant paediatricians and nursing team explained how children's services had very limited support from CAMHS available in Scarborough. For example, the ward manager gave examples of how difficult it was to find a specialist CAMHS inpatient bed with the external NHS provider. We were told it often took well over three days and a bed was only found when the directorate manager escalated the issue with the CCG (clinical commissioning group). We were told that CAMHS were reluctant to attend the ward and it was difficult to obtain support and help when handling particular adolescent mental health needs.
- This was an identified risk on the directorate risk register, which stated: "There is a significant and material risk to patient safety caused by a lack of available psychiatric assessment for CAMHS service for the Scarborough, Whitby, Ryedale area as this is not currently commissioned. This may result in patients not receiving treatment they need in a timely manner." The risk register noted that letters had been sent to the CCG and all issues were reported as incidents and shared with the CCG. The directorate manager explained that this issue was ongoing.

Access and flow

- Systems to monitor access and flow had been established within children's services provided throughout the trust. The emergency department facilities for children were limited at Scarborough and were part of the adult service. The children's directorate had no direct influence over the provision of emergency services within the emergency department.
- Children's services currently had limited facilities for assessment and did not have a dedicated child assessment unit like the one provided at York hospital. A small treatment room with one examination couch was currently used as the initial assessment area for children received directly from their general practitioner. The proposed new-build hospital and children's ward would address this issue.
- The Duke of Kent ward had one established high dependency room. This room included additional monitoring and stabilisation equipment. In addition, the ward had clear escalation guidance for members of the nursing staff to contact medical staff and to escalate actions when additional staff may be required.
- Children's services made use of a comprehensive age-related PAWS monitoring chart. This assisted staff in identifying a deteriorating child and determining whether a child required stabilisation or transfer to a tertiary service such as Leeds. The management team and other staff told us that the regional retrieval service EMBRACE was very responsive, offered advice and facilitated transfer where this was required.

- The SCBU had facilities and appropriately qualified staff to stabilise babies prior to transfer to a level two or three neonatal unit within the Yorkshire area.

Meeting people's individual needs

- Staff told us that interpreting services were available when they needed them, and that they did not normally have any issues when accessing these services.
- The children's ward had facilities to promote family-centred care. For example, parents had access to a seated room with facilities to make hot drinks. Parents were able to sleep next to their child at night. There was a dedicated area where children could play.
- The ward had limited facilities available to meet adolescents' needs due to the physical layout and age of the ward. The ward manager explained that they always tried to place older children together away from babies but it was difficult at times.
- There were formal adolescent transition arrangements in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty.
- The ward manager told us that there was equipment, such as hoists, and other support for children and young people with complex physical health needs.
- We talked with a consultant paediatrician who worked across both York and Scarborough hospitals and was the children's palliative care lead. The consultant outlined with confidence and enthusiasm the range of palliative care services available. Children's services allowed the child and family to choose where they wished to receive palliative or respite care. The consultant explained how they decided together with the nursing team which families to meet. The first consultation took place within the family's own home rather than in a clinic.

Learning from complaints and concerns

- The management team explained that complaints were handled and resolved straight away where possible. The children's directorate complaints register for the last 12 months was shared with us. This had logged six individual formal complaints for Scarborough hospital. Where necessary, formal investigations had taken place. Learning points and actions were included for these complaints.
- We reviewed a sample of Scarborough directorate business meeting minutes, which showed that complaints were discussed.

Are services for children and young people well-led?

Good

The service was well led. There was a clear vision and strategy for the service. The service was led by a strong leadership team that worked well together. Governance arrangements were in place at Scarborough but required development to mirror the more robust arrangements in York. People's views were sought regularly.

The service implemented innovative improvements with the aim of constantly enhancing the delivery of care for children and families. For example, the SCBU manager, in partnership with others, had introduced and developed the role of the band three grade neonatal support worker.

Vision and strategy for this service

- The children's management team had a clear vision and strategy for the provision of children's services in York and Scarborough and the other areas served.
- The directorate had its own strategy: 'Child health – directorate aspirations 2014/19'. The strategy's stated aim was: "The child health strategy will achieve a safe, quality service for all children within the York and Scarborough area, working with partner organisations to ensure that every child is supported through their development to achieve outcomes that maximise their full health potential, developing the healthy adults of the future."
- There was a three-year strategy summary contained within the document that centred on management of the directorate and included clinical, corporate and commissioning areas. The strategy also incorporated the trust's vision and values. The document contained a number of aspirations and priorities for development. For example, one aspiration was to establish a dedicated paediatric website. The directorate manager and matron demonstrated how this had been developed and was close to final release on the internet. The website was to contain a large range of information and support for children, young people and families.

Services for children and young people

Governance, risk management and quality measurement

- The risk register for children's services included 13 risks that related to all aspects of child health service delivery, including the school nursing service. All risks identified included key actions being undertaken to mitigate the risk, the named person leading on the actions, and the expected completion date. The register included risks such as the environment of the Duke of Kent ward, limited CAMHS support, poor uptake of paediatric life support training within the trust, and the lack of a paediatrician with an audiology qualification.
- Regular meetings included the paediatric directorate business meeting, which was held monthly. This meeting covered areas such as updates, finance and governance. This meeting was well attended by consultant paediatricians and other staff such as ward and directorate managers.
- We were told that one senior consultant paediatrician no longer performing clinical duties had been tasked with developing clinical governance arrangements and meetings. In comparison with York hospital, meeting minutes were less well structured. We were provided with only one set of clinical governance meeting minutes, from 9 December 2014. These minutes were not structured but presented a brief 'discussion' of the meeting. Attendance was poor, with four members of staff. No actions were identified or recorded. We asked the clinical director and directorate manager about this; they explained that the meeting should follow the same structure and format as the York clinical governance meetings.
- The management team explained that the York and Scarborough teams currently held separate governance and directorate meetings due to the distance between the hospitals. They hoped to develop and hold joint meetings soon, at least on a quarterly basis.

Leadership of service

- Children's services had a clear leadership structure which fed into the trust-wide leadership structure. The clinical director acted as the lead for the directorate with direct management responsibility for the consultant paediatricians and the lead clinician for Scarborough hospital. The clinical director was supported by the directorate manager and their deputies. The matron led the nursing team and reported to the clinical director for children's services and professionally to the assistant director of nursing.
- The matron was supported by band seven ward managers. There was one ward manager for SCBU while the other ward manager was responsible for the Duke of Kent ward and children's outpatients.
- During our interviews with the leadership team (clinical director, matron and directorate manager), we observed that the team appeared cohesive and had a clear feel and understanding of the directorate as a whole. The band seven leaders we talked with told us they felt well supported by the matron and other members of the leadership team. Similarly, staff members and clinicians felt well supported by their respective managers.
- The leadership team told us that the chief nurse had very recently been appointed to the executive team as a representative for children's views and rights (as distinct from their executive lead role for safeguarding children); the chief nurse confirmed this to us directly. We were told that the chief nurse intended to attend directorate meetings.
- We were also told that there was a non-executive director on the board who had been nominated to represent children's views. Staff felt that children's rights had not always been adequately represented at a senior trust level in the past, but it was hoped that these arrangements were a positive step forward. They were based on good practice as it was a requirement of the NSF (National Service Framework) standard for hospital services for children.

Culture within the service

- We found a positive culture among all medical, nursing and other staff we met within children's services. Staff spoke positively about the care they provided for children, young people and parents. We saw how staff placed the child and the family at the centre of care delivery.
- The children's leadership team had a clear vision about future developments within the service. This was captured via its strategy, which considered staff members at ward and unit level.
- We were told how the culture within children's services had previously been poor in Scarborough, particularly between the nursing and medical staff. We saw that staff

now worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children.

Public and staff engagement

- We found that details of people's experiences of the service were sought regularly via exit questionnaires, which had been reviewed monthly and collated into reports. We saw that the leadership team had new children's NHS Friends and Family Test cards printed and ready for introduction in April 2015. In addition, the service planned to introduce an electronic exit survey via tablet or other IT devices. We saw examples of how people's views had been listened to and acted upon.
- The leadership team told us that they wished to improve public engagement by developing forums for parents and young people. Staff views were sought via the annual staff survey and the leadership team gave other examples of how they tried to involve members of staff. The matron explained that they had held two shared learning sessions during 2014 to share information regarding complaints, incidents and similar matters. These had not been well attended due to staffing pressures, although the matron intended to continue to explore ways of engaging staff and disseminating learning.

Innovation, improvement and sustainability

- The children's leadership team provided examples of areas of practice they felt were innovative and had brought positive improvements to the service. We also observed areas of good practice and measures to improve the quality of service.
- The leadership explained how they were particularly proud of the staff working within children's services in Scarborough because they had overcome significant obstacles over the last few years to develop and sustain improvement. The Duke of Kent ward had recently been taken out of the trust's own internal 'special measures' system, which was applied when a ward was identified as failing. A new band seven ward manager had been put in place during 2014 along with a range of other measures. We reviewed the detailed action plan in place for the ward; this illustrated how the ward had developed.
- The SCBU manager explained that they had introduced and developed the role of the band three neonatal support worker. They had worked with Edexcel to develop a diploma that allowed the support worker to perform additional neonatal roles. The course also included components for maternity and paediatrics so that these staff could help in these areas. The SCBU manager explained how other units were showing an interest in this development.
- The directorate manager explained that they were proud of the work children's services had put into the development of a dedicated website for the children's acute and community services. We saw the offline draft version of the website, which will include a range of support and information for children, young people and families.

End of life care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Scarborough Hospital forms part of the York Hospitals NHS Foundation Trust and provides end of life care services on site and in partnership with York and Bridlington Hospitals, community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team. Specialist palliative care was provided as part of an integrated service across both hospital and community teams. At Scarborough Hospital, the specialist palliative care team comprised four sessions of a palliative care consultant, 2.0 whole time equivalent (WTE) specialist palliative care nurses, 1.4 WTE end of life care facilitator posts and an administrator/coordinator post. We saw that referrals to the integrated service from April to November 2014 totalled 1,452, 90% of whom were patients with cancer.

During our inspection, we spoke with a palliative care consultant, the lead end of life care nurse, the medical director, director of nursing, specialist palliative care nurses, mortuary staff, chaplaincy staff, porters, medical staff, ward managers, nursing staff, allied health professionals, quality managers and administrative staff. In total, we spoke with 32 staff. We visited a number of wards and clinical areas across the hospital, including: general medicine, geriatric medicine, cardiology, critical care medicine, gynaecology, general surgery, stroke medicine, orthopaedic surgery, and the intensive therapy unit (ITU). We also visited the chapel, the mortuary and we spoke with administrative staff who provided support following bereavement. We reviewed the records of four patients at the end of life and reviewed 26 do not attempt cardio-pulmonary resuscitation (DNA CPR) orders. We spoke with two patients and two relatives and we reviewed audits, surveys and feedback reports relating specifically to end of life care.

End of life care

Summary of findings

We saw that end of life care services were safe, effective, caring and responsive, with elements of outstanding practice in terms of being well led. We observed specialist nurses and medical staff provided specialist support in a timely way that aimed to develop the skills of non-specialist staff and ensure the quality of end of life care. Staff were caring and compassionate and we saw the service was responsive to patients' needs. There was good use of auditing to identify and improve patient outcomes.

The trust had a clear vision and strategy for end of life care services. There was consistent leadership including the development of a number of initiatives, such as non-cancer end of life care and the development of training to improve advance care planning discussions, including those relating to DNA CPR.

Are end of life care services safe?

Good

There were effective procedures in place to support safe care for patients at the end of life and staff demonstrated a good understanding of reporting procedures. There was evidence of learning from incidents. There were good examples of incidents being shared and discussed at board and end of life care forum meetings so that learning could be identified and used to develop the service. Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patient's at the end of life.

Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were completed consistently. Of the 26 forms we viewed, all but one were appropriately signed and dated and there was a clearly documented decision provided, with reasoning and relevant clinical information to back it up. A risk register showed specific risks relating to end of life care and we saw that the trust had adequate equipment and appropriate safety checks in place for end of life care.

Incidents

- There had been no Never Events (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented), or serious incidents relating to end of life care reported in the twelve months prior to our inspection. We did not see specific incident reports relating to end of life care. We were told that all incidents were reviewed on a weekly basis by the director of nursing, the chief executive and the medical director and that, if they related to end of life care, they would be passed on to the end of life care lead nurse for review.
- Staff were aware of their responsibilities in reporting incidents. Staff also told us there was the opportunity to review the care patients received at the end of life to identify learning from this. One junior doctor described learning relating to a death prior to our visit, stating that they had time to reflect and learn from the experience.
- Staff told us they generally received feedback from incident reports they had made and that incidents were discussed, where appropriate, at staff meetings. We saw

that a section titled 'compliments and complaints' had been added as a standing agenda item to the end of life care forum meetings. The end of life care lead nurse would provide feedback around investigations and share outcomes.

- Members of the specialist palliative care team told us that incidents were historically recorded based on the directorate in which the team sat. In this case, the medicine directorate. We were told that recent work had been carried out to redesign the reporting system so that end of life care incidents and complaints would be more easily identifiable.
- Patient stories were taken to end of life care forum meetings and strategic partnership board meetings. As a result, learning was identified and action taken to improve services for patients at the end of life.

Environment and equipment

- We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we viewed manual handling training records that showed staff had been appropriately trained in its use.
- There was specialist mortuary equipment available, including bariatric and height-adjustable trolleys and storage units.
- Staff told us that, generally, there were no issues with obtaining relevant equipment for the care of patients at the end of life and that equipment was stored centrally, but was easily accessible to ward staff. On one ward we visited, we were told there had been previous issues with obtaining air mattresses for patients and that, following discussions with matrons and reporting concerns using the Datix system, there had been an improvement in this.
- We were told that McKinley syringe drivers were used on the wards and that nursing staff had been trained in the use of the pumps. We viewed a syringe driver policy that included the use of a syringe driver monitoring chart, with safety checks of the administration of medicines every four hours via the pumps required.

Medicines

- We saw that the trust used the Palliative Care Formulary 4 (PCF4) Fourth Edition as guidance in prescribing medicines at the end of life. The specialist palliative care team provided up-to-date guidance in the form of algorithms and clinical handbooks for use on the wards. These were also available to staff electronically via the intranet.
- The guidance included the use of medicines in the management of symptoms, including: pain, nausea and vomiting, breathlessness, chest secretions and anxiety. Medical and nursing staff we spoke with were aware of the guidance and told us they could access it via the trust's intranet and in end of life care folders, which were kept on the wards.
- Nurses within the specialist palliative care team were nurse prescribers or were working towards this qualification.
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that they may need to make them more comfortable). The guidance they provided was in line with end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- The trust had implemented a syringe driver chart that included information on discontinuing unnecessary medicines at the end of life. The chart included advice around diluents, the type of syringe to use with the pump, medicine combinations and advice specific to patients with renal failure or diabetes.
- We reviewed four medication record charts of patients who were considered to be at the end of life and, in all cases, we saw that anticipatory medicines were prescribed appropriately and were in line with the guidance.
- We saw that controlled drugs were stored, administered and recorded in line with controlled drug guidance and that medicines for anticipatory prescribing for key symptoms were available and accessible.

Records

- We saw that, on admission, all patients were assessed and that these assessments were recorded, including: patient details, medical, nursing and risk assessments, as well as care plans.

End of life care

- Patients identified as being in the last days of life were cared for using a specific care plan that had been developed by the specialist palliative care team. The 'last days of life' care plan included daily reviews and regular assessments of the patient's condition.
- We viewed the records of four patients who were considered to be ill enough to die. In most cases, we saw that assessment and care records were completed appropriately and accurately.
- We reviewed 26 do not attempt cardio-pulmonary resuscitation (DNA CPR) forms. In all cases, we saw that decisions were dated and approved by a consultant and there was a clearly documented reason for the decision recorded on the form, with clinical information included. One DNA CPR form did not include a detailed clinical reason recorded on the form. However, this was recorded in the patient's notes.
- Discussions about DNA CPR with patients and relatives were recorded in sufficient detail within the patient's notes.
- As part of the policy for the administration of subcutaneous medication via the T34 syringe pump, we saw there was a syringe pump infusion monitoring chart available as part of the newly devised syringe driver chart. We did not see any patients receiving medicines via this route at the time of our inspection.

Safeguarding

- We viewed mandatory training records and saw that all members of the palliative care team had attended safeguarding training at level 1 or 2.
- Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns.
- We saw that a safeguarding system was in place for reporting all incidents and concerns and staff told us the safeguarding team were accessible and responsive to concerns and issues.

Mandatory training

- We viewed training records and saw that members of the palliative care team had attended training in a number of mandatory areas. Examples included: moving and handling and basic life support.
- End of life care awareness training was part of the trust's mandatory training programme. End of life care training was incorporated into induction programmes for band 5 nurses, healthcare assistants and junior doctors.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls and nutrition and hydration risks.
- Early warning tools were in use throughout the hospital, with regular assessments guiding staff in identifying a patient whose condition was deteriorating.
- Members of the specialist palliative care team told us that, in addition to a weekly multidisciplinary team meeting, they would discuss patient issues and care on a daily basis while prioritising their workload. Issues relating to risk and patient need would be incorporated into these discussions.
- End of life care guidance documents included advice on identifying when a patient may be at the end of life and who should be involved in that decision.
- We viewed a risk register relating to end of life care. A particular area of risk related to data collection and poor IT systems that did not allow for data to be shared across services. Staff had identified this as being a potential risk to patients if information was not readily available and they were concerned that this could result in patient wishes not being known or shared. Staff worked to reduce the risk of this by sharing information in multidisciplinary meetings and discussing when patients were deteriorating. The aim was to eliminate the risk and drive forward the changes at board level.

Nursing staffing

- There were 2.0 whole time equivalent (WTE) specialist palliative care nurses and 1.4 WTE end of life care facilitators based at Scarborough Hospital.
- Specialist palliative care nurses were available from 8.30am to 4.30pm, Monday to Friday. There was no on-call specialist palliative nursing cover out of hours.
- Generally, nursing staff on the wards told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns should they arise. However, we were told that staffing challenges had an impact on nurses from some wards being able to attend end of life care training.
- The palliative care team provided training and education programmes for ward-based nursing staff within the trust. Since 2014, end of life care was mandatory as part of the trust induction programme.

End of life care

The palliative care team had developed an additional one day end of life care training session for nursing staff. At Scarborough Hospital, 44% of nursing staff had attended this training up to November 2014.
- Training covered aspects of end of life care including the five priorities of care: symptom management, advance care planning, preferred place of care and spiritual care.

Medical staffing

- There was a service level agreement (SLA) in place with a local hospice to provide four specialist palliative care consultant sessions per week. We were told that these were provided by the hospice medical director with flexible cover built into the agreement. We were also told that, although the consultant input was scheduled for certain days, there was flexibility and arrangements would be made based on patient need.
- Junior doctors attended an end of life care training session as part of their induction into the trust. The junior doctors we spoke with told us they felt confident about caring for patients at the end of life and that advice was readily available from the specialist palliative care team.
- Out of hours, 24-hour specialist palliative care telephone advice was available from the on-call palliative medicine consultant in the region who could be contacted via either of the two local hospices.
- Ward staff told us they would refer to the written guidance out of hours and that they could access more specialist advice from local hospices.

Major incident awareness and training

- We viewed a business continuity plan and saw that arrangements for major incidents included the use of temporary mortuary facilities.
- Major incident planning included the use of the chaplain in a support role and we saw that the on-call chaplain was included in a call out when a major incident occurred.

Are end of life care services effective?

Good

The trust had taken action to plan and develop services in line with national guidance, with the implementation of a 'last days of life' care plan for the assessment and coordination of care and symptom management of patients at the end of life. We saw that the Liverpool Care Pathway was no longer in use since the national phase out date of July 2014.

Assessments of patients' pain were generally consistently carried out, although there was limited use of pain assessment tools. Nutrition and hydration assessments were carried out and staff we spoke with were aware of quality of life issues relating to nutrition and hydration at the end of life. We saw that the trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit and that a number of areas had been addressed at the time of our inspection.

We saw that, where patients were identified by staff as lacking the mental capacity to be involved in DNA CPR decisions, family members were consulted and decisions taken in the patient's best interests. We saw evidence that mental capacity assessments were recorded in relation to DNA CPR decisions, although this was not always done consistently.

Evidence-based care and treatment

- We viewed end of life guidance and a 'last days of life' care plan, which had been introduced in November 2014.
- We saw that end of life care documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health (DoH) End of Life Care Strategy and the National Institute of Health and Care Excellence (NICE).
- An internal audit of the 'last days of life' care plan had identified changes to improve the document following discussion with staff that had used it.
- The Liverpool Care Pathway (LCP) had been phased out nationally by July 2014 and staff we spoke with at Scarborough Hospital told us it had not been used since this time.
- The specialist palliative care team had been involved in developing services for people with heart failure at the end of life. This work had been based on research undertaken by one of the clinical leads from a local hospice who provided sessional hours at Scarborough Hospital.

Pain relief

End of life care

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available, as needed, both during the day and out of hours.
- The wards we visited had adequate stocks of medicines in line with anticipatory prescribing guidance around the five key symptoms most commonly experienced at the end of life.
- We saw that a zero to 10 pain assessment score was available on the trust's electronic system. However, we did not see this in use in relation to patients who were at the end of life. There was no alternative pain assessment tool in use that prompted staff to make a full assessment of a patient's pain, incorporating the assessment of body language or facial expressions when patients were unable to score their pain. We also did not see clearly documented evaluations of pain in relation to the effectiveness of medication given.
- Regular comfort rounds were carried out and included staff asking patients regularly about their level of comfort. Staff were also prompted to assess patients' pain as part of the 'last days of life' care plan.

Nutrition and hydration

- A nutritional screening and assessment tool were incorporated into the patient admission record to assess patients on admission.
- The 'last days of life' care plan incorporated both medical and nursing assessments of nutrition and hydration. Incorporated into this was guidance around the use of clinically-assisted hydration and nutrition. There were also prompts to involve patients and their families in discussions around hydration and nutrition. In addition, nursing assessment/intervention prompts were undertaken every four hours, these included offering the patient oral fluids and nutrition, as appropriate.
- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in as much of the patient's care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Staff we spoke with told us they were led by patient wishes in relation to oral intake of food and fluids and we were given examples of when patients had been able to access food and drinks of their choosing.
- We viewed guidance on the use of mouth care in the last days of life that included action to be taken in the event of a patient having a dry mouth, coated tongue or pain/ulceration.

Patient outcomes

- The trust had taken part in the 2013/14 National Care of the Dying Audit, where they had not achieved six out of seven organisational key performance indicators. The trust performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust performed below the England average in some of the clinical key performance indicators, including communication relating to a patient's plan of care for the dying phase, a review of interventions during the dying phase and a review of care after death.
- The trust had addressed a number of issues following the audit, including the appointment of a layperson to the trust board with specific responsibility for care of the dying, the development of bereavement care, ensuring training in end of life care was mandatory for staff caring for dying patients and the development of the 'last days of life' care plan.
- The implementation of the 'last days of life' care plan addressed a number of clinical areas identified as part of the National Care of the Dying Audit, including: the assessment of nutrition and hydration, the identification of spiritual needs and the ongoing communication and involvement of patients and family members in planning care.
- We viewed examples of internal audit programmes. One example included the trust's own care of the dying audit, which focused on examining care of the dying practice prior to the implementation of the 'last days of life' care plan. The aim of the audit was to establish current practice to ensure the care plan was focused on supporting sustained quality practice in end of life care.

Competent staff

- There were 2.0 WTE specialist palliative care nurses and 1.4 WTE end of life care facilitators based at Scarborough Hospital.
- We saw that the specialist nurses visited the wards on a daily basis to review patients at the end of life and to support ward-based medical and nursing staff in planning and delivering care to patients.

End of life care

- There were end of life resource folders kept on the wards and in clinical areas, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- A number of nurses across the hospital had attended a full day of training in end of life care. At the time of our inspection, 44% of nursing staff had attended the training. The end of life care lead nurse told us that at least one member of nursing staff on each ward had attended the training and we saw records that demonstrated this.
- Ward staff and the specialist palliative care nurses told us that training around the use of the 'last days of life' care plan had been delivered on the wards so that nursing and medical staff felt confident in its use.
- Ward-based nurses were able to shadow the specialist palliative care nurses so that they could develop more specialist knowledge and there was a programme in place for specialist nurses to mentor staff who were undertaking the programme.
- An end of life care facilitator role had been developed to support ward staff in the delivery of ongoing learning around end of life care on the wards.
- Key members of the specialist palliative care team had particular interests and specialist areas they kept up to date on. For example, two nurses had undertaken heart failure modules as part of their degree courses, as this was an area the team had identified to focus on.

Multidisciplinary working

- Members of the specialist palliative care team participated in multidisciplinary team meetings, working with other specialists to support good quality end of life care across clinical specialties.
- Members of the team also attended specialist lung and upper gastrointestinal multidisciplinary team meetings and were involved in heart failure and chronic obstructive pulmonary disease (COPD) multidisciplinary team working.
- The specialist palliative care team told us they met daily to discuss patient care and workloads and had a weekly multidisciplinary clinical meeting, which was attended by other professionals.
- A member of the specialist palliative care team also attended the community multidisciplinary team meetings each week.
- Regular end of life care forum meetings were attended by multi-professional hospital and community staff.

Seven-day services

- The specialist palliative care team provide a five-day, 8.30am to 4.30pm, face-to-face service, with no out-of-hours input.
- Out-of-hours advice was available 24 hours a day, seven days a week by telephone via the local hospices.
- Plans to implement a pilot of a seven-day, face-to-face service had been discussed at board level and we saw plans for the pilot to start in 2015.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out-of-hours cover via an internal on-call system.

Access to information

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being in the last days of life, staff would use the Trust's guidance for care of patients in the last days of life. The guidance incorporated prompts for staff to assess patient symptoms, identify advance decisions, discuss values and spiritual needs and agree options regarding hydration and feeding.
- We viewed records that included detailed information about the management of symptoms, as well as discussions and interventions. We also saw that, when patients were seen by the specialist palliative care team, information and advice was clearly recorded so that staff could easily access the guidance given.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The trust's 'resuscitation and do not attempt cardio-pulmonary resuscitation policy' provided guidance for completing a DNA CPR form for an individual who does not have capacity, stating that, when a specific care decision was to be made, the 'best interests' process under the Mental Capacity Act 2005 must be followed.
- Of the 26 DNA CPR forms we viewed across a variety of wards in the hospital, 20 were for patients who staff identified as lacking mental capacity to be involved in resuscitation decisions. We did not see the trust's

mental capacity assessment form in use specific to resuscitation decisions, however, in 11 of the 20 cases we viewed a record in the patients' notes relating to their inability to be involved in the discussion, due to a lack of capacity. An example of documentation included details of the person's inability to understand, retain or weigh information.

- In most cases, we saw that the decision was discussed with the patient's family in order to make a decision that was in the person's 'best interest' and staff told us that, if a patient did not have family then a court-appointed independent mental capacity advocate (IMCA) would support the process of decision making on the patient's behalf.
- The trust had identified issues relating to involving patients in resuscitation decisions through a process of auditing and review. As a result, they had developed specific training for medical staff relating to this, including the development of a DVD and e-learning resources. In addition, we were told of plans to develop advance communication training for clinical staff around initiating discussions about treatment and care, including resuscitation decisions.
- We saw that two patients had received formal mental capacity assessments as part of a Deprivation of Liberty Safeguards application.

Are end of life care services caring?

Good

End of life care services were caring. Patients and relatives told us that, in general, they were happy with the quality of care they received and that staff were kind, caring and compassionate in their approach. A business case had been developed to improve the bereavement service facilities at Scarborough Hospital as this had been identified by the trust as an area for improvement due to the lack of dedicated space to support relatives following bereavement.

Emotional and spiritual support was considered to be a priority within the trust and we saw this through the development of comfort boxes, the use of handmade cards for relatives, referrals for bereavement support from a local hospice and the development of communication training in relation to end of life care.

Compassionate care

- During our inspection, we saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that showed respect for their individual choices and beliefs.
- Patients and relatives we spoke with told us that, in general, they were happy with the quality of care they received. One patient told us, "I am lucky to be in this hospital." Another said, "I have nothing but respect for staff."
- Patient's told us that, although staff were often busy, this had not affected the quality of care they received.
- Following bereavement, relatives would receive support from a dedicated administrative staff member, who would facilitate the completion of the death certificate and provide advice. There was no dedicated bereavement office, although there was a room that could be used for this. We were told a business case had been submitted to develop a bereavement room in line with the one based at York Hospital.
- We saw that care after death honoured people's spiritual and cultural wishes. Members of the chaplaincy team told us they were able to source expertise from the local community around different cultures and faiths and that there were staff within the trust that had specific knowledge in this area.
- A bereavement support leaflet was available for relatives offering guidance on: how to register a death, organ and tissue donation, funeral arrangements and a list of advice and support organisations and how to contact them.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved the care delivered.
- We saw that staff discussed care issues with patients and relatives, where possible, and these were generally clearly documented in patient notes.
- The end of life care guidance used by the trust included prompts for discussing issues of care with patients and their relatives.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen. There were also

information leaflets available for patients and their relatives around the 'last days of life' care plan and the processes involved in caring for patients at the end of life.

- The trust was participating in the National Bereavement Survey (VOICES) 2011. The survey worked to collect information from relatives and friends about the quality of care provided at the end of life. The research looked at areas such as respect and dignity, pain relief and whether the person died in their preferred place of care. At the time of our inspection, there was no data available relating to the survey, however, staff confirmed that some families had participated and the data had been submitted.
- We saw that a procedure for weddings at the end of life had been developed and staff told us they had supported patients who wanted to get married at the end of life.

Emotional support

- Members of the specialist palliative care team participated in the delivery of communication skills training to staff relating to discussing care and treatment issues at the end of life. This training included supporting patients and family members who were distressed.
- We saw that visiting times were flexible for family and friends when patients were at the end of life and we saw that relatives were able to stay with patients at the end of life, if they wished.
- There was a dedicated flat available for family members of patients who were at the end of life. Staff told us that washing and sleeping facilities were available to relatives and they were provided with refreshments. Concessionary car parking was also available to relatives of patients who were at the end of life.
- Where possible, patients at the end of life were given the option to move to a side room to ensure their privacy and dignity was maintained and that they had time with relatives. When this wasn't possible, staff would pull the curtains round the bed to give more privacy and, where possible, this would ensure patients were nursed in a quiet part of the ward.
- There was a multi-faith chapel available that held information relevant to people from different faiths and religions. The chaplaincy services within the trust were geared towards providing support for patients and their relatives irrespective of their individual faith, or even if they did not follow a faith. There was also a prayer room available next to the chapel. Patients and visitors were able to add requests for prayers in the chapel.
- There was no chaplain based at Scarborough Hospital at the time of our visit, however, we were told the trust had just successfully appointed to this post. In the meantime, chaplaincy support could be accessed via York Hospital.
- Comfort boxes had been developed as part of an initiative started by a member of the housekeeping team. Comfort boxes included: blankets, toiletries, drinks, snacks and a lamp for use at the patient's bedside. We also saw that, on one ward, handmade cards were available for staff to record messages and give to relatives following bereavement.
- Staff were able to refer relatives to a local hospice for both pre- and post- bereavement support.

Are end of life care services responsive?

Good

All patients requiring end of life care had access to the specialist palliative care team. We saw that referrals to the Scarborough Hospital specialist palliative care team between April and December 2014 totalled 341. Specialist palliative care referrals were mostly for support with pain and symptom management, with additional support provided for patients and family members for people with complex end of life care needs. Staff, patients and relatives told us that end of life care services were responsive and we saw evidence of this during our inspection. Complaints, compliments and incidents were reviewed to identify learning and this learning was explored and fed back through a number of processes including board and locality meetings. Preferred place of care was recorded by the specialist palliative care team and was incorporated into training for generalist staff in end of life care.
Fast-tracked discharges were prioritised for patients at the end of life and we saw that discharge processes were reviewed to ensure the service remained as responsive as possible. Staff were able to refer patients to nurse-led bed at a local hospice in the last days of life, ensuring greater choice was available to patients who may not be able to come home. However, there was no mechanism in use to monitor achievement of preferred place of death.

End of life care

Service planning and delivery to meet the needs of local people

- Preferred place of care at the end of life was recorded by the specialist palliative care team, but not as part of routine admission data collected on the wards. This meant that patients who were referred to the specialist palliative care team would have their preferences recorded, but those who weren't referred may not.
- The end of life care lead nurse participated in the end of life care strategic partnership board that was run by local clinical commissioning groups (CCGs) and was, therefore, involved in the development of a regional strategy for end of life care. The specialist palliative care team was also represented at the Scarborough Hospital locality board meetings for end of life care.
- The trust has developed its own end of life care strategy, identifying key priorities relating to meeting the needs of people in the region. Emphasis included work on raising awareness of issues relating to death and dying among the local population. One aspect of this that had been identified was to develop local initiatives to engage more with people during the annual 'Dying Matters' week.
- We were told that 32% of patients referred for specialist palliative care had a diagnosis other than cancer. In response to increasing numbers of referrals into specialist palliative care of patients with a non-cancer diagnosis, the integrated team had worked to develop clinical pathways for patients at the end of life with specific conditions. Examples we were given included patients with heart failure and patients with chronic obstructive pulmonary disease (COPD).

Meeting people's individual needs

- Staff on the wards told us that patients with complex needs would be referred to the specialist palliative care team for additional support, particularly when there were issues around managing their symptoms effectively. We also saw that clinical nurse specialists from other specialties would be involved in care as necessary. Examples we saw were oncology and lung clinical nurse specialists, who worked with ward staff to ensure appropriate care at the end of life.
- Patients and family members we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious and spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.
- Staff told us that interpreting services were available for patients who didn't speak English and for those who had other communication difficulties.
- Assessment documentation by the specialist palliative care team included recording patients' preferred location of care at the end of life.
- We saw that advance care planning had been identified as one of the trust's priorities in terms of developing end of life care services. We viewed advance care planning documentation and information on the wards and we saw one advance care plan in place. We saw that the specialist palliative care team were developing initiatives around advance care planning, including teaching other staff about the processes involved and the communication needed to ensure each patient's wishes and individual needs were met.

Access and flow

- All patients we saw had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team and that the team were responsive to the needs of patients. We saw referrals being made in timely and appropriate ways. The aim of the specialist palliative care team was to review urgent referrals within 24 hours and routine referrals within 48 hours. Staff we spoke with told us that the palliative care nurses would generally see patients straight away if they had problems with symptoms.
- Staff on the wards told us they were able to access the specialist palliative care team for any issues or concerns. One example we were given was staff requesting support from the team following a difficult death. We were told that one of the specialist palliative care nurses had attended the ward and supported staff through reflection and evaluation of care, with an emphasis on support and learning.
- Members of the specialist palliative care team and ward staff alike told us that, generally, patients would be seen within hours of a referral to the specialist team. We saw examples of specialist palliative care nurses assessing patients on the same day as the referral was made.

End of life care

- We saw that resource folders on the wards included information for ward staff on how to access specialist advice outside of normal working hours when the specialist palliative care team were not available.
- The chaplaincy service was accessible seven days a week via an on-call system.
- Staff across the trust told us they felt they were able to discharge patients quickly at the end of life if they chose to be cared for at home.
- The trust and the local clinical commissioning group (CCG) had secured an agreement with a local hospice to have access to nurse-led beds for patients who were thought to be likely to die within seven days. We were told the beds created an element of choice for patients in the last days of life when hospice would not normally be an option. This project was recognised as best practice by Hospice UK and recorded in The Telegraph on January 20 2015 as a new way of providing care and choice.
- We were shown a 'rapid discharge at end of life integrated pathway' for all rapid discharges that had recently been developed to improve the documentation, coordination and sharing of information.
- There was no data available measuring end of life care discharges against preferred place of care and fast-tracked discharges had not been recorded at Scarborough Hospital. However, we were told that plans were in place to record data relating to fast-tracked discharges from April 2015.

Learning from complaints and concerns

- We were told that work had been carried out on the reporting and recording system for complaints to ensure that complaints relating to end of life care were categorised appropriately so they could be reviewed by the end of life care lead nurse.
- We viewed end of life care forum minutes that included a section dedicated to compliments and complaints, where issues relating to end of life care could be discussed, learning identified and cascaded.
- All complaints were reviewed weekly by the director of nursing and the chief executive. From this, complaints relating to end of life care would be passed to the end of life lead nurse who would review the issues, identify action and learning and disseminate this to relevant staff.
- We did not see reports of specific complaints relating to end of life care. However, we were told that the lead end of life nurse was in the process of reviewing a relevant complaint.

Are end of life care services well-led?

Good

The trust had a clear vision and strategy for end of life care services and had applied resources appropriately to develop end of life care services as a priority, including the appointment of a non-executive director to lead. The trust was part of regional and locality end of life care planning structures and participated fully in these. Gaps identified as part of the National Care of the Dying Audit had been addressed and there was a clear system of quality and safety measures being developed and reported on, including the use of mortality reviews.

There was visible, motivated and committed leadership in terms of end of life care at board and service levels and a number of initiatives were in place to develop services. Initiatives included the development of non-cancer pathways for patients at the end of life, the development of communication training around DNA CPR discussions and the development of mandatory training in end of life care for key staff.

Vision and strategy for this service

- There was a non-executive director nominated as the lead for end of life care within the trust and we saw minutes of meetings they attended where end of life care was discussed both at board level and with specialist staff at the end of life care forums.
- The senior end of life care team was made up of a lead nurse for end of life care, specialist palliative care consultants, the directorate manager and the non-executive board member, who met and produced quarterly reports that were submitted to the executive board to inform them of end of life care issues.
- A clinical commissioning group (CCG) led 'end of life care board' was in operation and was attended by the lead nurse for end of life care. We were told that the

board provided the structure for all strategic planning work across the region. A locality board had been developed in Scarborough Hospital to implement work plans and feed into the end of life care board.
- The trust's strategic objectives for end of life care included: increasing public awareness of end of life care, ensuring dignity and respect, minimising suffering and focusing on patients' needs and preferences.
- We viewed evidence of strategic priorities being discussed at end of life care meetings and we saw that they were incorporated into the trust's action plans in relation to developing end of life care services. For example, we saw that a patient story relating to poor communication over an advance care plan for a patient with chronic obstructive pulmonary disease (COPD) was discussed at board level. In addition, we saw that training in advance care planning had been delivered to COPD staff and that a pathway had been developed to identify trigger points when discussions about advance care planning should be initiated in patients with COPD.

Governance, risk management and quality measurement

- Specialist palliative care reports within the structure of the specialist medicine directorate.
- We viewed minutes from the end of life care forum that was attended by nursing and medical staff, as well as allied health professionals. Quarterly meetings were also attended by the non-executive director who was leading on end of life care. From this, a quarterly report on end of life care within the trust was produced for the quality and safety committee.
- The quality and safety report included the identification of issues affecting end of life care. Examples of issues reported on included complaints, risks, the implementation of the last days of life care plan, improving patient discharge at end of life, IT risks and data collection and the development of trust-wide bereavement services.
- We saw the results of the National Care of the Dying Audit had been used to develop an action plan that was led by the end of life lead nurse and the palliative care consultants. We saw that the action plan had been implemented to address all areas identified from the audit. Key areas that the trust had addressed since the audit included the appointment of a non-executive director to lead end of life care, the implementation of the last days of life care plan and the appointment of end of life care educators. The trust had also made end of life care training for medical, nursing and care staff mandatory since 2014.
- The trust had developed an internal audit programme for end of life care, including a care after death audit, DNA CPR audits, a 'last days of life' audit and audits of the use of specific medicines used for patients at the end of life.
- Weekly multidisciplinary meetings were held, where the specialist palliative care team and other professionals would discuss the care of patients at the end of life.
- Weekly mortality reviews were carried out, involving the chief executive, the director of nursing, the medical director and where appropriate the end of life care lead nurse. Learning from patients' experiences would be shared and cascaded through the end of life care forum, the end of life care board and the end of life care locality meetings.

Leadership of service

- We saw evidence of good local leadership at ward level, with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- Staff spoke positively about the leadership of the specialist palliative care service and we saw evidence of specialist palliative care staff providing clinical leadership to ward staff in relation to end of life care.
- Staff we spoke with told us there was good senior level engagement, including the executive board, in improving end of life care.
- There was a non-executive director with responsibility for end of life care and we saw evidence that they were involved in meetings and discussions about end of life care. We also saw that both the medical director and the director of nursing had a good awareness of the issues affecting end of life care within the trust. We observed a commitment to address these issues and develop end of life care services in line with national guidance.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that ward staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.

End of life care

- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- One of the trust's strategic objectives was to shift the perception that 'death is failure' to one where 'a good death is a successful care outcome'. We viewed training programmes and education materials that supported this and the last days of life care plan provided a structure that supported this.

Public and staff engagement

- Staff were encouraged to provide feedback and evaluation of training programmes relating to end of life care and this was used to further develop the training programme to meet staff needs.
- Staff had been involved in the audit of the last days of life care plan and they were encouraged to provide feedback. We saw that changes were made to the document as a result of this.
- Relatives of patients at the end of life were encouraged to participate in National Bereavement Survey (VOICES), where they were asked to document their experiences of care in the last days of life, although results of the survey were not yet available.
- We viewed a strategy action plan that included the plan to raise public awareness of advance care planning. Specific actions included suggested activities to engage with 'Dying Matters' week.

Innovation, improvement and sustainability

- The specialist palliative care team were focused on continually improving the quality of care and we observed a commitment to this at ward level also.
- Patient stories were taken to the board and end of life care forum meetings and used as a tool to reflect on practice, in order to learn from these stories and to use this learning to inform practice.
- The trust had developed non-cancer pathways to support quality care for patients who were at the end of life. Specific innovations included pathways for patients with COPD, Parkinson's and heart failure and included working on advance care planning initiatives to ensure patients' preferences and choices were clear.
- Comfort boxes were designed to provide toiletries and other items of comfort to relatives of patients at the end of life in the hospital.
- The trust had developed literature for relatives of patients at the end of life. The information included details of the changes that may occur before death and other issues, including: the use of medication, food and drink and the last days of life care plan.
- The trust had developed a mandatory end of life care training programme for medical, nursing and care staff that addressed issues identified through audit, feedback and observation. For example, the trust had identified that conversations about DNA CPR decisions were not happening or being recorded as they should. As a result, the trust has identified the need for advance communication skills training specific to these types of conversation and were developing training to meet those needs.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Scarborough Hospital outpatients and diagnostic imaging (including radiology) services were situated on the main hospital site on the outskirts of Scarborough. There were a total of 156,297 outpatient appointments between July 2013 and June 2014. Of these, 40,637 were new appointments and 76,585 were review appointments. The ratio of new appointments to review appointments was approximately 1:2.

The outpatient services were part of the theatres, anaesthetics and critical care directorate. Outpatient clinics were held in a number of different locations on the site. Radiology services were provided from one main location. The outpatients departments ran a wide range of clinics, led by different professionals, including nurses, allied health professionals and medical doctors, across a large number of specialties.

Radiology provided a trust-wide diagnostic imaging service. The acute work of the trust was concentrated at York Hospital and Scarborough General Hospital, which offered a range of diagnostic imaging and interventional procedures, as well as substantial plain film reporting and an ultrasound service. Radiology services were managed by a directorate manager, across the trust, and a clinical manager on the Scarborough site.

During the inspection we spoke with 22 patients and three relatives, five nurses of different grades, one healthcare assistant, one allied health professional and one member of administrative staff. We observed the radiology and outpatients environments, checked equipment and looked at patient information.

Outpatients and diagnostic imaging

Summary of findings

Overall the care and treatment received by patients in Scarborough General Hospital outpatients and diagnostic imaging departments required improvement. Some policies and procedures were not being followed and staff were not attending mandatory training. There were also a significant number of vacancies: a 27% vacancy rate for nurses in outpatients; a 12% vacancy rate for additional clinical services staff and a 43% vacancy rate for radiologists.

The managers told us that they reported any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents from Scarborough Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action had been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

The morale of staff was low, especially within radiology, and staff felt that they only ever received negative feedback from managers. Many staff we spoke with felt the acquisition had not been handled sensitively and they felt excluded. Staff survey results had deteriorated from the previous year's results.

Patients were very happy with the care they received and found it to be caring and compassionate. Services were on the whole responsive to patient needs and the care patients received was effective.

Are outpatient and diagnostic imaging services safe?

Requires improvement

There were a significant number of vacancies for some staff groups in both radiology and outpatients. This meant staff in post were working extra shifts and covering for the shortage, and therefore unable to take part in the required training and development to maintain their skills and knowledge. Although recruitment was underway, managers had not looked at alternative ways of managing this.

The managers told us that they reported any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents from Scarborough Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action had been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

The information on staff training especially on mandatory training was submitted at directorate level. Outpatient's staff training records were included within the theatres, anaesthetics and critical care directorate training records. Therefore we were unable to report the compliance within the outpatients department. Compliance with mandatory training rates for staff was poor in both radiology and outpatient services' directorate. Although the trust provided training days for staff about safeguarding children and vulnerable adults, uptake of this training was very poor due to staff shortages.

There were high vacancy rates: a 27% vacancy rate for nurses in outpatients; a 12% vacancy rate for additional clinical services staff and a 43% vacancy rate for radiologists in Scarborough.

Checks on fridge temperatures and resuscitation equipment were not regularly carried out. We also found some pieces of equipment that had not been regularly serviced in line with requirements. Incidents were reported

using an electronic reporting system and all the staff we spoke with assured us they were able to report incidents using the system. Incidents were investigated and lessons learned were shared with the staff. Cleanliness and hygiene in the departments was within acceptable standards.

There was sufficient personal protective equipment in all of the areas we inspected and staff were aware of how to dispose of it safely and within guidelines. Some seating in patient waiting areas was covered in absorbent material, contrary to infection control best practice.

Staff in all departments were aware of the actions they should take if there was a major incident.

Incidents

- Across the trust, there had been 85 incidents within the services between October 2014 and March 2015: 52 caused no harm, 28 caused minor harm, one caused moderate harm and four were still under investigation.
- The manager told us they encouraged a culture of openness when reporting incidents across all of the diagnostic modalities and staff we spoke with confirmed this.
- The trust used an electronic system to record incidents and near misses. All staff who worked in the departments were able to access the system to record incidents.
- We spoke with staff about their knowledge of the incident reporting system. All staff said they could access the system and knew how to report incidents.
- The departments had a system in place to report and learn from incidents, to reduce the risk of harm to patients.
- All of the staff we spoke with were able to describe how they reported incidents and how they used Datix (the hospital incident reporting system).
- There were no Never Events reported in 2013/14 (Never Events are serious, largely preventable patient safety incidents that should not occur if the available, preventable measures have been implemented).
- In 2014, trust-wide the department had reported three serious incidents to the Strategic Executive Information System. Two related to radiology/scanning incidents and the third related to delayed diagnosis.
- We looked at two of the serious incidents reported and saw the incidents had been categorised, described and investigated. The outcomes from the investigations were recorded and these had been discussed with the patients and an apology given. This demonstrated the trust's commitment to duty of candour.
- The managers told us that they reported radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations. Information sent to us by the trust related to reporting of films between January and March 2013. More recent information was not sent to us. An action plan had been implemented to ensure that improvements were made. There was no further report to demonstrate whether improvements had been made and sustained.
- We requested a copy of the latest radiation protection advisor report from the trust, but this was not supplied to us. We therefore had no way of knowing when the latest checks were done, or whether there were any problems that required action. The trust was not consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

Cleanliness, infection control and hygiene

- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as rubber gloves, protective eye glasses and aprons were available to staff.
- Once used, personal protective equipment was disposed of safely and appropriately.
- The outpatient areas and clinic rooms were clean and tidy and we saw staff maintaining the hygiene of the areas using appropriate wipes to clean equipment between patient use, thus reducing the risk of cross infection or contamination between patients.
- We noted that some of the chairs in the outpatients departments were made of absorbent material. This was contrary to infection control best practice guidelines. The manager told us that new chairs had been ordered some time ago, but had not yet been delivered despite the delivery being followed up a number of times. They were unaware of the reason for delay.
- All equipment had been labelled to show when it had last been cleaned.
- The diagnostic imaging and outpatients' department's staff took part in regular hand washing and environment audits. We saw that these were part of an ongoing

process. We received information from the trust showing the results for audits in March and April 2015. The 100% target was not always being met. For example, medical staff and allied health professionals only reached the 100% hand hygiene target 50% of the time. The bare below the elbows target was also 100%. Allied health professionals had not met this target at all, nurses had met the target 50% of the time and doctors had met the target 100% of the time. The use of gloves target was 100%. The target had been met 50% of the time.

- The radiology department appeared clean, tidy and uncluttered.
- Patient waiting and private changing areas were clean and tidy. Single-sex and disabled toilet facilities were available and these areas were also generally clean.
- Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control standards.
- Staff told us that for patients with infections, infection prevention and control principles were applied.

Environment and equipment

- The outpatients departments were well lit and pleasantly decorated, but they were small and sometimes struggled to accommodate the number of patients attending appointments.
- During our inspection we saw that the waiting rooms got busy and staff told us that sometimes there were not enough seats for patients in the waiting areas, particularly if clinics were running late.
- Overall, the outpatients departments were not big enough to meet the needs of all patients and relatives. Staff and the manager told us that demand had outgrown the capacity of the outpatients departments.
- We saw and staff confirmed that there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments.
- We looked at the resuscitation equipment in the departments. The crash trolley equipment in outpatient clinic C had not been checked daily as required in March 2015. Five dates from 22 had not been competed to show checks had taken place. These were 4, 5, 6, 10 and 16 March 2015.
- On the whole, equipment was cleaned regularly and serviced in line with manufacturers' guidance. However, we found that some equipment had not been serviced in line with requirements. For example, we found pieces of equipment overdue a service. For example, a blood pressure machine due for service in March 2014 had not been marked as serviced and an electronic thermometer due to be serviced in January 2015 had not been serviced.
- Staff showed us how they cleaned equipment. The equipment we looked at was clean and had been labelled as such.
- The departments were able to replace broken equipment in a timely manner and to order new equipment if the equipment was needed for clinical reasons.
- We requested a copy of the latest radiation protection adviser report from the trust. The trust informed us that there had never been a report for the trust but they had discussed the radiation protection at the medical exposures committee. This does not comply with the requirement of the Ionising Radiations Regulations 1999 (IRR99).
- We saw the department had radiological protection/ hazard signage displayed throughout the department. Illuminated treatment room 'no entry' signs were clearly visible and in use throughout the department at the time of the inspection.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas.
- There were systems and processes in place to ensure the maintenance and servicing of imaging equipment.
- Within radiology, emergency resuscitation equipment for both adults and children was checked and readily available for use. We saw daily checks of this equipment had been documented.

Medicines

- The outpatients departments kept a limited supply of medication.
- Medication that needed to be refrigerated was stored in locked fridges.
- We looked at the temperature record charts for the fridges. We found one fridge in clinic C where the fridge had only been checked on five dates out of 22. Checks had been carried out on 4, 5, 9, 11 and 13 March.
- Some staff used patient group directives to dispense drugs to patients. We checked these and found that they had been reviewed appropriately.
- The trust had a system in place for quickly informing GPs about changes to patients' medication.

Outpatients and diagnostic imaging

- In the outpatients departments, 71% of eligible staff had completed medicine management training. In the radiology department, 33% had completed this mandatory training.
- Patients who needed medication such as insulin were asked to bring their own supply when they visited the outpatients departments.
- Within radiology, medicines were stored correctly in locked cupboards or fridges.
- Medicines stocks were checked weekly by the nursing and pharmacy staff. We looked at a random sample of the medicines stored, including contrast medium, and found these items to be in date.
- We also looked at the controlled drugs register and saw stock counts were recorded correctly.

Records

- Records in the outpatients departments were electronic. All staff had been trained to use the system. Staff were able to access patients' current and previous medical records using the system.
- Within the diagnostic imaging department, records were digitised and available to be viewed across the trust.
- Records contained patient-specific information relating to patients' previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatients departments. We observed people being weighed and measured during our inspection.
- At the time of inspection within radiology, we saw patients' personal information and medical records were managed safely and securely.
- Patient x-ray records were held electronically. We looked at three records and saw these records were up to date and completed correctly.
- The Picture Archiving and Communications System is a nationally recognised system used to report and store patient images. This system was available for use by radiologists from across the trust and external reporting providers under contract with the trust.
- Records were audited monthly and the outcomes from the audits were reported and discussed with the staff at departmental governance meetings.

Safeguarding

- Information provided by the trust indicated that 40% of eligible staff from the theatres, anaesthetics and critical care directorate had completed safeguarding children level one training and 60% of eligible staff had completed level two training. This information included staff within the outpatients departments.
- In the radiology department safeguarding training data was incomplete and figures varied dependent on staff group, 100% of eligible administrative and clerical staff had completed children's level one training. For level two training figures varied from 33% completion by nursing staff to 71% completed by additional clinical services staff.
- 73% of eligible staff in the outpatient's directorate had completed safeguarding vulnerable adults awareness training. 68% of eligible staff from the radiology department had completed safeguarding vulnerable adult's level one training but no nursing and additional clinical staff had completed level two training.
- 40% of eligible staff from the theatres, anaesthetics and critical care directorate had completed safeguarding vulnerable adults awareness training; 63% of eligible staff had completed safeguarding vulnerable adults level one training and 60% had completed level two.
- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.
- We saw evidence of information available to staff and patients about who to contact if they had any concerns about the safety of children or vulnerable adults. This was displayed in some staff rooms and on the noticeboards of some outpatients departments.
- Within radiology, we observed patients reporting to the main reception and staff undertook a number of checks to verify the patient's identity, for example, name, date of birth and GP.
- All of the staff we spoke with were aware of the responsibilities to safeguard adults and children and were aware of the safeguarding leads within the trust.

Mandatory training

- The departments had systems and processes in place to ensure staff training was monitored.
- We looked at staff mandatory training levels provided to us. The outpatients departments were managed by the

theatres, anaesthetics and critical care department. From the information sent to us by the trust, it was not possible to separate mandatory training figures for the outpatients departments.

- The trust's target for mandatory training was 75% compliance. The information provided showed that across radiology only one of 15 training courses we reviewed had a compliance rate above 75% and many were very low, for example, medical devises 27% and pressure ulcer prevention 10%. For the theatres, anaesthetics and critical care directorate, out of 16 courses, this was only met twice by the theatres.
- Some staff had completed mandatory training online using e-learning and some had attended classroom-based training days. Staff told us it was difficult to find time to do online training.

Assessing and responding to patient risk

- There was a process in place for managing patients who were deteriorating. This included transferring patients to the Accident and Emergency department when required, which was on site.
- There were policies and procedures in the diagnostic imaging department to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- We were told that requests for CT and MRI scans were vetted by Consultant Radiologists before making an appointment.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed them before exposure to radiation.

Nursing staffing

- The outpatients departments were staffed by a mixture of registered nurses and healthcare assistants. At the time of our inspection, there was a 27% vacancy rate for nurses in outpatients and a 12% vacancy rate for additional clinical services staff.
- Vacancies were mostly being covered by current staff, or occasionally staff who worked for the trust bank or from an agency. Where possible, staff worked flexibly to cover shifts. There had been no visible impact on patient care, such as the need to cancel clinics. However the required mandatory training levels were not being achieved.
- Recruitment to staff for the outpatients departments was underway and new staff were due to start work in the coming weeks.
- We were told that bank or agency staff could be used if there was no alternative and replacement staff could be advertised for if a business case for the replacement was approved.
- The radiology department had a 10% vacancy rate for allied health professionals.
- According to information provided by the trust, the average sickness level in radiology between May 2013 and October 2014 across administration, additional clinical services and nursing was 4.9%. However, this varied across the period, with medical and dental staff having no sickness, additional clinical services ranging between 0% and 13% and nursing staff ranging between 0% and 33%.
- The average sickness level in the outpatients departments was 2.9% between October 2013 and October 2014. However, the only data available were for additional clinical services staff. There were no data available for nursing or administrative staff.
- All of the staff we spoke with told us that they worked hard but they enjoyed their jobs. They said that staff pulled together and worked as a team to support morale.
- There was no formal system, such as an acuity tool, being used to decide the staffing levels needed in the outpatients departments to cover clinics. This was because each clinic needed different numbers and skill mix of staff according to the levels of support patients and doctors needed as well as the type of clinic. The nurse in charge explained that staff numbers were based on the knowledge and experience of the manager to judge how many staff were needed.

Medical staffing

- Medical staffing was provided to the outpatients departments by the various specialties that ran clinics. Medical staff undertaking clinics were of all grades, but we saw that there were always consultants available to support lower grade staff when clinics were running.
- Staff told us that locums were used within the outpatients' clinics depending on the staffing levels of the specialty. There was a 43% vacancy rate for radiologists at Scarborough Hospital. This equated to a shortage of 2.75 whole-time equivalent (WTE) consultants and one WTE specialist radiologist. Some of

the vacancies were covered by locums. For example, between December 2013 and May 2014 locum use was between 11% and 17%. There was no reported locum use in radiology between July 2014 and November 2014. The trust was using consultant radiologists on weekends to cover the workload
- There was ongoing recruitment in place however there was a national shortage or radiologists and this trust also had a shortage. Out–of-hours reporting was outsourced to a private company in Australia.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- There were business continuity plans in place to make sure that specific departments were able to continue to provide the best possible safest service in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment were evidence-based and patient outcomes were within acceptable limits. On the whole staff understood their responsibilities when taking consent, or working with patients who lacked or had fluctuating mental capacity, but some groups of staff needed to improve their working knowledge.

From the limited information we received about appraisals, the staff in the departments were competent but there was no formal clinical supervision in place for staff.

There was evidence of multidisciplinary working and some limited out–of-hours radiology and phlebotomy provision.

Evidence-based care and treatment

- We saw that National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments throughout the trust with a lead clinician taking responsibility for ensuring implementation. Staff we spoke with were aware of NICE and other guidance that affected their practice and could talk to us in detail about patient treatment pathways.
- We saw that the departments were on the whole adhering to local policies and procedures. Staff we spoke with were aware of how they affected patient care.
- The trust had a standard operating procedure in place for Ionising Radiation (Medical Exposure) Regulations.
- The diagnostic imaging department carried out quality-control checks on images to ensure that imaging met expected standards.

Pain relief

- Staff told us that the departments did not keep pain-relief medication but that the doctors in clinic could prescribe medication for any patient needing pain relief during their attendance.
- Patients we spoke with had not needed pain relief during their attendance at the outpatients departments.
- There was an on-site pharmacy where patients could purchase pain relief if required.

Patient outcomes

- The follow-up to new appointments ratio, for the trust, was consistently worse than the national average.
- All images were quality-checked by radiographers before the patient left the department.
- The outpatients departments took part in trust-wide audits such as on record-keeping, but there was little clinical audit being carried out that was initiated within the department.

Competent staff

- Staff we spoke with confirmed that they had received appraisals in the last year.
- From the information sent to us, there was only detail about additional clinical services staff appraisal levels for radiology in Scarborough Hospital. This information showed that as of November 2014 no staff had undergone appraisal within the last 12 months. There was no information about appraisal rates for other staff groups in radiology.
- 92% of additional clinical services staff in the outpatients departments had undergone appraisal by November 2014. There was no information about other staff groups from the outpatients departments.

Outpatients and diagnostic imaging

- Staff and managers told us that there was no mechanism for formal clinical supervision as per the trust policy. Staff did however tell us that they felt supported and that the department managers were accessible.
- In both the outpatients and radiology departments, there were formal arrangements in place for induction of new staff. All staff completed full local induction and training before commencing their role.
- In both the outpatients and radiology departments, performance and practice was monitored through competency assessments.
- All qualified radiographers completed equipment competencies. Continual professional development was planned by the manager and topical subjects were covered.
- Medical revalidation was carried out by the trust. There was a process in place to ensure all consultants were up to date with the revalidation process.
- Managers told us of the formal arrangements in place for mentoring students and new staff.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients and radiology departments. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as radiology and community staff when this was in the interest of patients.
- Radiologists were part of the multidisciplinary teams (MDTs)working between specialities, for example, gastrointestinal and breast MDTs. However, radiographers told us that they were not routinely included in MDT meetings.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the departments had links with other departments and organisations involved in patient journeys, such as GPs and support services.
- A range of clinical and non-clinical staff worked within the outpatients departments and they told us they all worked well together as a team. We observed staff working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, audiologists, nurses, booking staff and consultants.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.

Seven-day services

- The outpatients departments often ran clinics on a weekend and later on an evening, however most activity within the outpatients departments happened between Monday and Friday.
- Weekend clinics were held because of capacity and space problems in the outpatients departments, which the manager and staff told us had been outgrown by demand.
- The radiology services across all of the trust's locations provided a range of services. Some covered seven-day a week and out-of-hours services, while some locations provided services within normal working hours five days a week.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information, such as imaging records and reports, medical records and physiotherapy records, appropriately through electronic records.
- Radiology reports were partly outsourced with an external provider under contract.
- We spoke with the managers and they told us of the systems and processes in place for monitoring the quality and tracking of outsourced radiology reports.
- Information leaflets in relation to diagnostic imaging, for example CT and MRI, were sent out in the post with the patients' appointment times.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff we spoke with were aware of how to obtain valid consent from patients. They were able to describe to us the various ways they would obtain consent from patients. Staff told us that in the outpatients departments, consent was obtained verbally. This was the case for the majority of imaging procedures, although consent for any interventional radiology was obtained in writing before attending the imaging department.

Outpatients and diagnostic imaging

- There appeared to be a lack of clarity among radiology staff about who could give consent when a patient had fluctuating mental capacity, with one person stating that if a patient was accompanied, that patient's carer could give consent. This is not the case. Carers of people are only legally able to give consent in very limited circumstances.
- According to information given to us by the trust, non-medical consent was not part of mandatory training for radiology and outpatients staff at Scarborough Hospital.
- Patients told us that staff were very good at explaining what was going to happen to them before asking for consent to carry out procedures or examinations.
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients undergoing diagnostic procedures.

Are outpatient and diagnostic imaging services caring?

Good

During the inspection we saw and were told by patients that the staff working in the outpatients and radiology departments were caring and compassionate at every stage of their journey. People were treated respectfully and their privacy was maintained. There were services in place to emotionally support patients and their families and patients were kept up to date and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Compassionate care

- All of the patients we spoke with spoke highly of the care and treatment they received in the departments. There were no negative aspects about care highlighted to us.
- During our inspection we saw patients being treated respectfully by all staff.
- People's privacy and dignity were respected.
- Patients reported that, most of the time, staff made sure that patients were kept up to date with waiting times in clinic.
- We saw that patients and staff had a good rapport. Staff were friendly and made sure that patients were at ease.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas.
- We spoke with 22 patients using radiology and outpatients services and their relatives. The vast majority told us they were very happy with the services provided.
- Staff presented as skilled, caring and helpful.
- Staff were courteous when caring for patients and staff were seen responding to patients' individual needs in a timely manner.

Understanding and involvement of patients and those close to them

- We spoke with 22 patients and their relatives in the outpatients and diagnostic imaging departments. All but one we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment. One patient was confused, but once staff realised this was the case, they took the patient aside and explained the situation fully.
- Patients felt that they were given clear information and time to think about any decisions they had to make about different treatment options available to them. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care, however they respected the decision of patients when they chose not to involve their loved ones.
- We saw patients and people close to them being consulted before radiology procedures and staff were attentive to the needs of the patients.
- There were no delays evident in patients' care and treatment during the course of our visit to the radiology department.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that if they had any concerns, they were given the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.

Outpatients and diagnostic imaging

- Formal and informal networks had been created by staff to link patients with people with similar conditions who were further along their patient journey. There were posters on the walls advertising these groups, for example for patients who had cancer, hearing loss or who were facing blindness.
- There was formal counselling support available for patients who needed it.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We found that the responsiveness of outpatients and diagnostic imaging services was good.

Waiting times were mostly within acceptable timescales, with the exception of 2-week cancer waits. The 'did not attend' rate at the hospital was higher than the England average. Outpatients clinics were only occasionally cancelled at short notice. Patients were able to be seen quickly for urgent appointments if required.

There were mechanisms in place to ensure that the service was able to meet people's individual needs, such as those living with dementia or a learning disability, or those whose first language was not English. There were concerns about the number, location and availability of disabled parking facilities.

There were systems in place to capture concerns and complaints raised within the department, review them and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- Staff were supported by colleagues within the wider department at busy times, or when there were absences. This made sure that clinics were only cancelled as a last resort.
- Additional outpatients clinics were run to meet extra demand to ensure that waiting time targets were met.
- Patients were able to attend the radiology department for plain film x-rays without an appointment between 8.45am and 5.15pm.
- The imaging department was able to provide a comprehensive service in Scarborough Hospital during working hours. Out-of-hours services were limited, with no out-of-hours MRI or ultrasound cover in place.
- Referrals for imaging, particularly CT, MRI and ultrasound, were triaged and vetted and booked according to acuity.
- The diagnostic imaging department had the capacity to deal with urgent referrals.
- The phlebotomy service provided daily clinics between 8am and 5pm. They accepted patients arriving at the clinic until 4.45pm. When outpatient clinics were running late, there were occasions when patients had to return to phlebotomy the following day because the phlebotomy service had closed. Information about how often this happened was not collected therefore the frequency in unquantifiable.

Access and flow

- The 'did not attend' rate for Scarborough Hospital was 6%. This was better than the England average of approximately 7%.
- Eighteen week referral-to-treatment times for non-admitted patients were better than the England average from March 2014 to October 2014. The trust was better than the England standard from March 2013 to October 2014.
- Eighteen week referral-to-treatment times for incomplete pathways were better than the England standard of 92% from September 2013 to October 2014. The standard states that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral.
- Since April 2013, the trust had fallen below the England average for percentage of people seen by a specialist within 2 weeks of an urgent GP referral for possible cancer.
- Since April 2013 the trust achieved better than the England average for percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers other than in October, November and December 2013 when performance dipped. As of July 2014, the trust was better than the England average.
- Since April 2013 the percentage of people waiting less than 62 days from urgent GP referral for possible cancer to first definitive treatment for cancer was better than the England average.

Outpatients and diagnostic imaging

- The waiting times for patients waiting longer than six weeks for a diagnostic appointment at the trust fluctuated between 0.5% and 3.5% between March 2013 and November 2014. The trust waiting times mirrored the England average waiting times for this period.
- The trust did not routinely collect information about the average waiting time for patients once they had arrived at outpatients clinics but before they were being called in to their appointment. This meant there was no data on delays experienced by patients once in clinics and the reasons for the delay. Staff told us that there was capacity in clinics to see patients who were referred urgently and that double booking two patients into one clinic slot happened occasionally to make sure that waiting time targets were met. Information about how often this happened was not routinely collected by the trust and therefore it is not quantifiable.
- On the day of our visit patients with appointment times in the radiology department were not left waiting for long periods of time before being seen for their appointment.
- Patients arriving from outpatients clinics and inpatients were booked into time slots within the departments on an as-required basis and according to the acuity of the referral.

Meeting people's individual needs

- Staff told us that they were able to access interpreting services if they needed to.
- Staff told us there was a limited supply of patient information available in different languages. They told us that they would make sure any information patients needed, for example about after care, was explained to them by the interpreter and that the patient understood.
- We saw that the outpatients and radiology departments had leaflets for patients.
- Four patients we spoke with told us that parking on the Scarborough site was problematic. They specifically told us that there were not enough disabled parking spaces.
- Staff were aware of the support that was available within the trust for people with learning disabilities, if it was needed. Staff told us they would allow a patient's carer stay to with them if that was what the patient wanted.
- The learning disability team were available to work with patients who needed extra support. For example, some patients were able to attend mock appointments and be supported by the learning disability team, who explained appointment and diagnostic processes to help to allay people's fears and phobias.
- Within the outpatients departments, healthcare assistants had been trained to be link trainers for dementia issues.
- Staff told us they were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly. Staff were keen to point out that they would be careful not to make people feel awkward or different by treating them differently. Staff spoke of assessing each person as an individual and not jumping to conclusions about what support they may need.
- The departments had access to food and drinks for vulnerable patients or patients who had conditions such as diabetes. There was a system in place to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drinks.
- The departments were able to accommodate patients in wheelchairs or who needed specialist equipment.
- There was clear signage throughout the departments, although some of the departments were difficult to find for people unfamiliar with the layout of the hospital.

Learning from complaints and concerns

- There had been four complaints about the outpatients departments and six about the radiology department.
- Outpatient complaints were about attitude of staff, communication and access to information.
- Five of the six radiology complaints related to missed diagnosis and one about the attitude of staff. Two of the cases relating to missed diagnosis indicated that there may have been harm to patients.
- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the patient advice and liaison service or make a complaint was available within waiting areas.

Outpatients and diagnostic imaging

- Managers and staff all told us that complaints and concerns were discussed at local team meetings and any learning was shared. We looked at two sets of team meeting minutes that confirmed this.
- None of the patients we spoke with had ever wanted to, or needed to, make a formal complaint. On the whole they were happy with the care they received in the departments.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Within the outpatients and radiology departments at Scarborough Hospital, managers had a vision for the future of the departments and were aware of the risks and challenges faced. There was an open culture where incidents were discussed. The departments were supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments.

However, there were concerns about the more senior leadership. Staff site told us that the acquisition of the trust had not been well managed and that there was a disconnect between the executive trust team and staff working in Scarborough. Staff at Scarborough felt as though the hospital was the poor relation in the trust, many did not feel they were listen to and included in decisions.

On the whole, staff felt supported by their line managers and were able to develop to improve their practice. However, staff said general morale across the organisation was low, especially low among the staff who worked on the Scarborough and Bridlington sites. Staff from the outpatients departments felt that they were forgotten about by the executive team. They commented that they had not seen any of the executive team members visiting the department. The national staff survey results showed that the trust was worse than expected for six questions. Additionally, the results had dropped from the previous year's results.

Vision and strategy for this service

- The department managers, matron and senior managers we spoke with were aware of the challenges faced by the departments and the trust as a whole.
- Staff we spoke with in the outpatients departments were unsure if there was an outpatients strategy in place.
- Staff within the services were aware of the challenges faced by the organisation, for example the financial challenges faced. Most told us they were aware that there was an overarching strategy for the trust, but were mostly interested in doing their jobs well on a daily basis.
- Despite a 43% vacancy rate for radiologists, the department had not trained advanced practitioners (other than in sonography) to assist with capacity issues. The trust had been paying consultant radiologists to work overtime on weekends.
- The radiology department had a Directorate Strategy/ Aspirations. This was a five year-plan from 2014 to 2019 and set out changes needed within the department to make it more efficient, cost effective and future-proof. One of the weaknesses identified in this plan was the "Uncertainty regarding recruitment of consultant radiologists in Scarborough". There was an approved business case to augment the current radiologist on-call system with a remote reporting service in order to provide the most effective use of resources. There were plans in place to introduce seven day working in radiology at Scarborough in 2014/15.Radiology staff told us that there were plans to expand the department and increase capacity to meet increasing demands.

Governance, risk management and quality measurement

- There were governance arrangements in place, which staff were aware of and participated in. The departments had staff meetings where clinical governance topics were discussed. These audit sessions were held one afternoon every month in outpatients and on a Wednesday morning in radiology. Sometimes training was offered to staff as part of the meeting.
- The organisation had systems in place to appraise NICE guidance and ensure that any relevant guidance was put into practice.
- Radiology reports were partly outsourced with an external provider under contract. The managers told us that reliance on outsourcing reports was reducing.
- We spoke with the managers and they told us of the systems and processes in place for monitoring the quality and tracking of outsourced radiology reports.

Outpatients and diagnostic imaging

- We looked at the risk register for the outpatients departments at Scarborough Hospital. There were three risks recorded on the register; these had been reviewed and the organisation was looking at ways to eliminate or reduce the risks.

Leadership of service

- Most staff told us that they found the managers of the services to be approachable and supportive, but staff from the phlebotomy service told us they rarely saw their management team and felt they knew little about how the phlebotomy service was run.
- The local managers of the departments were seen as fair and flexible with staff.
- Staff told us they felt that the outpatients departments were often forgotten about when the executive team visited Scarborough Hospital because most visits were to the wards rather than other departments**.**
- Staff working in the Scarborough Hospital did not feel that they were part of the York Teaching Hospitals Foundation Trust. They felt that integration with the trust had left them "as the poor relation". Staff on the whole did not feel that the acquisition had been managed well, more a takeover without taking into consideration existing structures and staff concerns.
- Some staff told us that the management style in the trust was negative. They told us they were never thanked for their hard work and only ever received negative feedback about the things they had not done well.
- Radiology staff we spoke with reported mixed feelings about local leadership. We noted that radiologists worked overtime on weekends to clear any reporting backlogs, however we were told that there was no monitoring in place to look at the productivity and cost effectiveness of this process.
- All of the staff were aware of the trust leadership and could access the relevant information from the intranet about how to contact senior managers.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although this was not easy because of staffing and financial pressures. This was reflected by the very low attendance rates at mandatory training.

Culture within the service

- Staff told us that the chief executive was approachable if they wanted to discuss any concerns and was open to hearing from them. However, because the executive management team was based in York, staff felt that there was a disconnect between the executive team and staff in Scarborough Hospital. This was despite knowing that the executive team visited the site to attend meetings. Staff felt that the executive team was not easily accessible.
- Staff were encouraged to report incidents and complaints, and felt that these would be investigated fairly.
- Staff were aware of their responsibilities in relation to 'duty of candour', to be open and honest with patients when incidents or accidents occurred and where appropriate to involve them in discussions and investigations.
- Managers told us that they felt well supported by the organisation, but one manager felt that communication about changes to services and the department as a whole needed to be improved.
- Managers felt that consultation was true consultation. Opinions were listened to and taken into consideration before decisions were made. People were asked what they would like to happen rather than told what was going to happen.

Public and staff engagement

- We saw that governance arrangements were in place and complaints and comments were discussed at team meetings.
- The outpatients and radiology departments had started to take part in the NHS Friends and Family Test in the first quarter of 2015. Results showed that at Scarborough, 91% of people were either likely or extremely likely to recommend the outpatients departments to their friends or family. In radiology at Scarborough, there had only been one respondent. They said they were extremely likely to recommend the department.

Outpatients and diagnostic imaging

- There was no specific information from the staff survey relating to the outpatients and radiology departments, but the trust as a whole performed within expectations or better than expectations in all but six elements of the 2013 national staff survey: percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; percentage of staff receiving health and safety training in the last 12 months; percentage of staff saying hand washing materials are always available; fairness and effectiveness of reporting errors, near misses and incidents; percentage of staff able to contribute to improvements at work; and percentage of staff having equality and diversity training in the last 12 months. All had fallen since the previous survey in 2012.

Innovation, improvement and sustainability

- Staff all told us that they were being encouraged to look at ways the trust could work more efficiently, make savings and improve quality of care for patients. They told us about how they were encouraged to try changes and then evaluate them to make sure quality of care did not fall when money was saved.
- Staff and managers reported that they were able to influence changes in the way the outpatients and radiology departments were organised and run. We were given examples of changes that had been made to the way the services were run that had improved the patient experience and made the clinics run more efficiently.
- 64% of all staff within the trust who responded to the NHS staff survey felt they were able to contribute towards improvements at work. This was worse than the England average of 68%. There was no specific information for the outpatients or radiology departments.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels, especially in A & E, on the medical and surgical wards, children's wards, operating department practitioner (ODP) cover within theatres, radiology and senior medical cover in relation to cross-site working. Additionally within critical care the provider must ensure staffing levels are adequate to ensure clinical education, unit management, clinical coordination, continuity of care, and effective outreach.
- The provider must ensure that there is adequate access for patients to pain management and dietetic services within critical care.
- The provider must ensure all patients have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.
- The provider must ensure improvements are made in the 18 week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
- The provider must ensure that staff, especially within medicine, outpatients & diagnostics and critical care, complete their mandatory training, and have access to necessary training, especially basic life support, mental capacity and consent (outpatients and diagnostic staff), safeguarding vulnerable adults and safeguarding children.
- The provider must ensure that pathways, policies and protocols are reviewed and harmonised across the trust, to avoid confusion among staff, and address any gaps identified.
- The provider must ensure that patient flow into and out of critical care is improved, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.
- The provider must ensure that all equipment is tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment.
- The provider must ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service.

Action the hospital SHOULD take to improve

Medicine

- Review the arrangements for allocation of patients to consultants, with a view to improving patient safety (particularly for patient outliers), access to senior decision-making, and patient flow.
- Review dedicated management time allocated to ward managers to enable them to have an effective leadership role.
- The provider should consider how the high proportion of delayed transfer of care due to patients awaiting care packages in their own home (37%) or waiting for nursing home placement or availability (22.1%) could be improved.

Surgery

- The provider should continue to work towards integrating surgical services and deliver common standards of care across the three hospital sites, including standardised protocols, guidelines and pathways of care.
- The provider should ensure that all medicine fridges are monitored in line with trust policy.

Critical care

- The provider should review the design and layout of critical care in light of best practice building guidelines.

Children and Young People

- The provider should ensure that children's services have all the necessary individual risk assessment tools

Outstanding practice and areas for improvement

in place so that members of staff can conduct a robust, individualised risk assessment when a need for this is indicated during the initial nursing assessment of a child's or young person's admission and stay.
- The provider should continue to work with other key stakeholders to improve CAMHS provision within the Scarborough, Whitby and Ryedale areas.

End of Life Care

- The provider should agree a consistent process for recording mental capacity assessments when making DNA CPR decisions, whether on the trust's mental capacity assessment form or within the patient's notes. There needs to be consistent, clearly recorded information regarding the patient's ability to understand, retain and weigh the information specific to the DNA CPR.
- The provider should develop the use of pain assessment tools, particularly for patients who may have difficulty in expressing their pain verbally and on the end of life care pathway.
- The provider should ensure there is a mechanism in use to monitor achievement of a person's preferred place of death.

Outpatients and diagnostic services

- The provider should ensure that all patient areas comply with infection control best practice, specifically the chairs within the outpatients department.
- The provider should ensure that it consults and receives regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) Staffing, HSCA 2008 (Regulated Activities) Regulations 2014. We found that the Trust did not always have sufficient numbers of skilled and experienced staff deployed to meet the needs of patients. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels; especially in A&E, on the medical and surgical wards, children's wards, operating department practitioner (ODP) cover within theatres, radiology and senior medical cover in relation to cross-site working. Additionally within critical care the provider must ensure staffing levels are adequate to ensure clinical education, unit management, clinical coordination, continuity of care, and effective outreach.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1), (2)(a),(2)(b) & (2)(e) Safe care and treatment HSCA 2008 (Regulated Activities) Regulations 2014. We found that the Trust was not always providing care and treatment in a safe way. It was not protecting

Requirement notices

patients from the risks of delayed treatment and care as patients were not having an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department. The trust was not achieving the national targets for A&E, referral-to-treatment time targets, and of cancer waiting times.

The trust was not ensuring effective patient flow into and out of critical care, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.

The trust was not ensuring that there is adequate access for patients to pain management and dietetic services within critical care.

Not all equipment was tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment.

This was in breach of regulations 9(1)(b)(i) & (iii) and 16(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1), (2)(a), (2)(b) & 2 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must ensure all patients have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.

The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.

The provider must ensure that patient flow into and out of critical care is improved, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.

This section is primarily information for the provider

Requirement notices

The provider must ensure that there is adequate access for patients to pain management and dietetic services within critical care.

The provider must ensure all equipment is tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) Staffing, Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. We found that the Trust did not always protect patients from unsafe or inappropriate care as not all staff had received mandatory training. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly within medicine, outpatients & diagnostics and critical care, and especially basic life support, mental capacity and consent (Outpatients and diagnostic staff), safeguarding vulnerable adults and safeguarding children.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulation 17(1) & (2)(e) Good governance, Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

We found that the trust did not have a clear clinical strategy for both critical care and outpatients & diagnostics and that staff we spoke with did not feel engaged in agreeing the future direction.

We found that not all pathways, policies and protocols were reviewed and harmonised across the trust.

This was in breach of regulation 10(1) & (2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1) & (2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider must ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service. The provider must ensure that pathways, policies and protocols are reviewed and harmonised across the trust, to avoid confusion among staff, and address any gaps identified.